Rural HEALTH NEWS
Volume 9
Number 3
Winter 2003
A Publication of the Rural Assistance Center

Rural Providers Seek Insurance Alternatives

By Thomas D. Rowley

Although health care providers across the United States face rising prices for malpractice insurance, general liability, workers' compensation, and even their own health care insurance coverage, many rural health care providers are struggling to keep coverage of any kind.

Premiums there are doubling and even tripling in some cases. Worse, some rural providers simply cannot get commercial coverage, as carriers pull out of the market or go bankrupt. As a result, providers of all types in rural areas—physicians, ambulance services, and hospitals—are struggling to obtain affordable coverage and keep their doors open.

We see it everyday," said Val Schott, M.P.H., Director of the Oklahoma State Office of Rural Health. "Hospitals, nursing homes, and other providers in rural America whose insurance premiums have gone from reasonable to outlandish to completely unaffordable. We see it in all types of insurance, not just malpractice."

According to Schott, the issue poses particular challenges for rural areas. With fewer health care providers to begin with, some rural areas face losing services altogether if even one provider fails to find or afford insurance.

"When insurance costs for a rural provider get so high that they can't afford to practice, it's the people they serve who lose out," said Schott, outgoing President of the National Rural Health Association. "We're going to have to take a long hard look at how we provide coverage for rural providers. There has to be some kind of protection offered, if we're going to keep health care in rural America."

Charles Cole Memorial Hospital in Coudersport, PA is one of 33 members in CHART.

The Spring-Summer 2002 issue of *Rural Health News* looked at the decline in obstetrical care in rural areas due to rising malpractice rates. What it found were areas across the country without, or in danger of being without, access to OB care.

The problem of rising insurance rates is hitting other areas of the rural health care delivery system, as well.

Out of this trying situation, alternatives to traditional insurance coverage are emerging. Though they vary, these alternatives—self-insurance, insurance captives, and risk retention groups—fall under the umbrella of alternative risk transfer mechanisms. Rather than transferring risk to a commercial insurance company, they allow the insured to retain some or all of the risk themselves.

Popularity of the alternative mechanisms is reflected by their large and growing share of the insurance market. Forty percent of commercial

(continued on pg. 3)

Self Insurance for Dummies

Unlike traditional insurance, self insurance and its many variations allows a person, organization, or group to cover its own claim losses rather than pay someone else to. Captives (and risk retention groups, which are a type of captive) are a popular type of formalized self insurance.

According to the South Carolina Captive Insurance Association (SCCIA) (www.sccia.org) there are several types of captives. The major difference lies in who owns the captives. Regardless of the type, captives are insurance companies "owned by the insured and organized for the main purpose of funding the owner's risks." As such, the owners actively participate in decisions on underwriting, operations, and investments.

Other than that, a captive works very much like a traditional insurance carrier and the policy it issues is the same as one issued by a commercial carrier. The captive collects premiums from the insured, sets aside a portion of those premiums in a loss reserve to cover claims, uses another to purchase reinsurance, and uses the rest to cover administrative costs.

In addition to paying premiums for coverage, the owner-insureds of a captive put up money, equity, or letters of credit to provide for a safety backstop, should the premiums be depleted.

Leonard Crouse is Director of Captive Insurance for the state of Vermont—the world's third largest domicile for captives (behind the Cayman Islands and Bermuda), with 480 active insurance captives. According to him, captives, self insurance and risk retention groups offer several advantages over commercial carriers.

First, in a hard market like the current one, commercial insurance can be too expensive, if it is available at all. Even companies that are a "good risk" get hit with high premiums and non-renewal notices because they are grouped with those that are not such a good risk. Captives (as well as pure self-insurance) are a way to get insurance when commercial insurance isn't available or affordable.

Second, alternative insurance can be, though it isn't always, cheaper. Because groups select their own members, captives can hold costs down by cherry picking, or admitting only providers with good loss records. In addition, captives invest their own loss reserves and pay neither overhead nor profit to an insurance company.

Finally, alternatives help providers better manage their organizational practices by sharing best practices and jointly sponsoring training. Such techniques help improve provider's services, reduce the risk of having a claim filed against them and, in turn, help hold down the cost of insurance.

The SCCIA lists additional advantages: control is maintained by the owner; profits are returned to the owner; premiums are tax deductible as business expenses; and reinsurance (passing some of the risk to other insurers for a price) is allowed.

For more information on the various types of captives, see "About Captives" at http://www.dccaptives.org.

lines' premium dollars (insurance other than what private individuals buy for themselves and their property) is accounted for by alternatives.

CHARTing Its Own Insurance Course

Faced a couple of years ago with a 20 percent increase in annual premiums for its employee health insurance, the Pennsylvania Mountains Healthcare Alliance (PMHA) declined its commercial carrier's offer and self insured. As a result, PMHA held its rate increase to seven percent. A year and a half later when malpractice rates shot up, the Alliance thought it could once again do better on its own. Thus was born the Community Hospital Alternate Risk Transfer, CHART for short.

"We needed to do something," said Joe Gribik, executive director of PMHA. "We tried to put together a risk program for our group, but realized we didn't have the mass we needed. We weren't big enough to spread the risk. As it happened, Marsh Inc. [a risk and insurance services firm] was looking to do something with a group of hospitals. We saw it as a good marriage."

With the help of Marsh Inc.'s Pittsburgh office, PMHA joined its eight hospitals with 25 other hospitals around the state to form a risk retention group (RRG)—a group that pools its resources to insure its own members. To join, members must fit a certain profile and be able to put up their share of the money to pay premiums and establish a reserve with which to pay claims. The RRG provides professional and general liability insurance for its members, many of whom would not have been able to find commercial coverage and would have had to turn to the state-run insurer of last resort—an expensive option.

David Acker, CEO of Charles Cole Memorial Hospital in rural Coudersport and a Chairman of CHART, said the liability situation had grown out of control.

"Our premiums were set to go up 48.6 percent," said Acker, who is also incoming chair of the rural hospital section of the American Hospital Association. "At our hospital, that would have been a million bucks. We all said this will kill us. The overwhelming emotion that drove us to do this was a feeling of helplessness."

According to Acker, the increase in rates bore no resemblance to his hospital's actual risk.

"Our hospital had never had a judgment against it," he said. "The premiums were driven by verdicts coming out of metropolitan areas and insurance companies that were not willing to differentiate what we as hospitals look like from others in the state."

With that in mind, CHART admitted only primary care, community-based hospitals with good loss records, avoiding hospitals that perform highly specialized care and those that are in certain "high jury award" districts such as Philadelphia. As a result, CHART is able to get lower rates.

Those lower rates, of course, are good news to CHART members. Still, the future is less than certain.

"It's pretty early to tell," said Acker, "But I like the feeling of controlling our own destiny. Thus far, the claims haven't spooked us, but we won't know for sure for a few more years." Acker cites the fact that when the insurance cycle turns and commercial rates go down, members of CHART may quit the group. "We have members in the group with experience in other captives and when the market softens they've seen people rush to the dollar and abandon the captive." (See textbox on pg. 2 for an explanation of "captives".)

He is, however, optimistic in one sense.

"The whole switch of paradigm from hospitals as competitors to hospitals as collaborators is helped by this," said Acker. "There's a good feeling in the room. You cannot undervalue the importance of relationships."

EMS Units Hoping to Share the Risks

A similar tale is unfolding in Vermont, Maine, and Minnesota. Two years ago Emergency Medical Services agencies in Vermont began getting notices from their insurance carriers that their workers' compensation coverage would not be renewed. All of the commercial carriers were pulling out of the market. Without workers' comp, the units would have to shut down.

"To this day, that remains one of the mysteries of life," said Dan Manz, Vermont State EMS Director.

Manz said that the problems predated September 11, 2001, but that day was "the straw that broke the camel's back. The perception was, wrongly in my opinion, that EMS workers had buildings falling on them. Not where we work. Most of my ambulance service managers have said they never had a year where their workers' comp claims exceeded their premiums."

Manz started getting calls from stricken units all over the state such as Upper Valley Ambulance Service in Fairlee, Vermont which serves eight communities, 10,000 people, and 500 square miles.

"We just got slapped," said John Vose, Administrator of Upper Valley and Vice President of the Vermont Ambulance Association.

He cites a 40 percent increase in Upper Valley's annual premium for workers' compensation on top of a 40 percent increase the previous year, a 20-30 percent increase in general liability, and a 25 percent increase in employee health insurance.

"We can't go out and shop for better rates," said Vose. "And you can't go out and grow your volume. We do about 1,000 runs per year. A big city service may do seven or eight times that many. We could only do two things: cut our service or pass along our costs to our customers."

According to Manz, services were paying $20,000 to $75,000 per year for workers' compensation coverage.

"That's a huge ticket item. That's a full-time employee for a service that may only have eight or nine employees, said Manz. "The numbers look so wildly out of proportion. There's got to be a better way."

However, other than the state-run last resort insurance program—which Manz said is "wildly expensive, bad coverage, and not a good alternative"—there seemed to be no other way.

"I'd never heard of a captive," he said.

Jeff Spencer had.

Spencer is an attorney and insurance underwriter with a company called Workers Risk Services, which manages workers' compensation claims. He is also a longtime rural EMS volunteer. Spencer knows the insurance industry and he knows the rural EMS industry. He didn't think the risk was anywhere near as bad as the insurance companies were saying.

Indeed, according to Manz, EMS in rural Vermont are a better risk than units in urban areas. As evidence, he cites low run volumes, volunteer crews, and routes that do not encounter heavy traffic.

"These people love what they do," he said. "They're not overworked, tired, or motivated to file a workers' comp claim."

At a national EMS conference in Maine in the spring of 2001, EMS personnel from the three states began comparing notes. Spencer, there to give a presentation on workers' compensation, offered to help. Forming a captive seemed to be the way to go.

"Everybody we've talked to has said it's the only solution they see," said Vose.

Eric Shell, a rural health care consultant with Stroudwater Associates in Portland, Maine, elaborated on why captives make sense. They maintain and/or improve access to care. They improve quality through training, peer pressure, and the sharing of best practices. And they help control costs.

"Captives," said Shell, "are a means to better access, quality, and cost."

People had seen the light. The effort began to grow. The Vermonters bought in to the idea and were soon joined by EMS folks in Maine (who are experiencing the same problem with workers' comp) and Minnesota (who are having trouble getting vehicle liability coverage for their ambulances). The expansion was needed to broaden the pool and achieve critical mass, spread the risk, and raise the necessary capital.

According to Spencer, the small size of rural entities means that a much larger number of organizations are needed in the captive. On the other hand, he noted that smaller entities generally have better risk characteristics and, consequently, make excellent captive members.

"The small nature of the target of our captive represents both the greatest challenge and the greatest opportunity," he said.

The challenge lies in bringing a large group together, gathering and analyzing the necessary data, conducting the required actuarial studies, and then crafting a business plan. And all of that takes money—$120,000 to $150,000 for the planning and approximately one million for capitalization to fund the loss reserve.

Once all the above is done, the captive can be formed.

"When it comes to actually forming the captive, that's the easy part," said Spencer. "Its bark is worse than its bite."

A Growing Presence

Easy or not, captives and other alternative risk transfer mechanisms are taking off.

"This is the wave of the future," said Spencer. "Forty percent of all premium dollars are going to alternative risk methods, up from 34 percent in just a couple of years."

And rural health care providers are getting in on the action. In its November issue, *The Risk Retention Reporter*—an insurance industry publication—reports on other rural hospitals in Pennsylvania and North Carolina forming reciprocal risk retention groups and hospitals in rural Montana forming a group captive to meet their professional and general liability coverage needs.

Eric Shell would not be surprised.

"It's got all the right reasons for making it a national program," he said.

Dan Manz is more emphatic about the possibilities:

"If we can get it going right, it ought to be a win win win all the way around," Manz said.

Alabama

On-Line Program Trains Family Nurse Practitioners

The University of Alabama at Birmingham School of Nursing has created an on-line, culturally competent Family Nurse Practitioner program that has the potential to improve access to health care in some rural Alabama counties.

"A lot of nurses come to school in Birmingham and don't go back to the rural areas," said Pamela Bowen, assistant project director and herself a certified register nurse practitioner. "We're hoping that the people we train will stay in their home areas and improve care there."

The program will train six nurses this year and eight in the next year. The students will be drawn from rural counties across the state identified as lacking sufficient health care access and prepare them to deliver primary care. Graduates of the program earn a Masters degree in nursing and are eligible to take the American Academy of Nurse Practitioners or American Nurses Credentialing Center exam to become family nurse practitioners.

Students in the program remain in their home communities throughout the program, save for two skills validation check-offs. They prepare lessons and confer with instructors on-line, all the while maintaining their job and family responsibilities. Clinical practice time is arranged locally. In addition, computers are available to borrow. If done full time, the program takes a year and a half.

The project addresses several needs: lack of health care in a state with several underserved areas; many devastating health problems; and lack of participation by African Americans in health careers.

For more information, call (800) 485-2778.

Colorado

First CAH Applies for HUD 242 Help

Rio Grande Hospital in Del Norte, Colorado is the first critical access hospital to receive approval to apply for mortgage insurance under the U.S. Department of Housing and Urban Development's (HUD) 242 Program, which guarantees to lenders that principal and interest will be paid.

Should it get the $10 million in mortgage insurance requested, Rio Grande—which serves the San Luis Valley, an agricultural area in south central Colorado—will replace its 50-year-old Hill-Burton facility with a new 14-bed Critical Access Hospital. HUD is expected to respond in 30 days.

"Without the HUD 242 program, we'd have a difficult time finding funding," said Dr. Norman Haug, administrator of Rio Grande. "We're a nonprofit hospital in a relatively poor area with a high Medicare population. We're too high of a risk for most lenders."

According to Charles Ervin, regional vice president of TRI Capital Company, Inc.—the real estate finance company that is working with Rio Grande, the key to any hospital's future success depends largely on the way the public views the adequacy of local facilities.

"There is no reason why rural America cannot be provided with state-of-the-art medical facilities, thereby saving lives by providing emergency care close to home," he said. "This new replacement hospital will be designed with the specific needs of the community in mind."

Under the HUD 242 program, hospitals can finance new construction, modernization efforts, or equipment purchase. The program enhances a borrower's creditworthiness by insuring the mortgage and taking the risk out of lending. Consequently, loans are easier to come by and at better rates. As such, the program should provide critical access hospitals with better access to much needed capital.

In an effort to get more help to rural facilities, HUD streamlined and eased its 242 process for critical

access hospitals. And while Rio Grande is the first to apply for 242 assistance, others are already in the pipeline.

For more information, contact Charles Ervin at (678) 624-3099 or charles.ervin@tricapitalco.com or Charles Davis at HUD at (202) 708-0599 or by e-mail at Charles_Y_davis @hud.gov.

Michigan

Center Gives Caregivers Much Needed Help

A small hospital in northwest Michigan is helping prepare and educate home caregivers.

Growing numbers of seniors are taken care of by friends and family. In rural retirement communities—such as Benzie County, Michigan, where 27.4 percent of households have a member over the age of 65—the need for caregiving can be particularly acute. The aim of the Benzie County Caregiver Resource Center and Library at Paul Oliver Memorial Hospital in Frankfort, Michigan, is to provide information and resources to those who take on this often difficult responsibility.

"It takes a lot of work to give care to another person. It can be as simple as shopping for a friend to something as extensive as taking full-time care of a spouse," said Sherri Tomashik, manager of the Center. "We wanted to help them. We set out to provide caregiver education and support to our community members."

The Center, first of its kind in that part of the state, opened October 1, 2002 with a $25,000 Rural Hospital Flexibility Program grant and a $15,000 grant from the local hospital auxiliary. Located in the lobby of the hospital, the Center is staffed intermittently by volunteers and by Tomashik, who also serves as the hospital's dietician. It offers more than 350 caregiving resources—books, audio and video programs, and periodicals—on everything from the fundamentals of caregiving to respite and hospice care. In addition, it provides information on a wide range of diseases and conditions, as well as information on service agencies in and around the county. The hospital, as part of the Benzie County Caregiver Support Network, also offers a caregiver support group that meets weekly.

"People lose their sense of themselves when caregiving," said Tomashik. "The loved one becomes the priority and sometimes they forget to take care of themselves. The support group helps them with that."

To get the word out about its services, the Center placed ads in the local newspaper and a senior resource guide that goes to businesses and healthcare professionals in nearby Traverse City. It also posts information on the hospital's parent group intranet and the Internet.

"In the (first) two months we've been open, we've had 20 patrons become members [at no cost] and check out resources," said Tomashik. "Another 25 have come in and browsed. I'm happy to see that."

As support group facilitator Shirley Cupples put it, "If all the money, time, and effort helps even one person it would be worthwhile, it would be great."

For more information, contact Sherry Tomashik at stomashik@mhc.net or see www.munsonhealthcare.org/locations/pomc/health_info/pomc_library.php.

North Dakota

Rural Assistance Center Opens

The Rural Assistance Center (RAC) at the University of North Dakota Center for Rural Health opened its doors in December and began serving as a rural health and human services "information portal".

Its goal is to help rural communities and other rural stakeholders access the full range of available programs, funding, and research that can enable

them to provide quality health and human services to rural residents.

"Health and human services problems in rural areas differ from those in urban," said Mary Wakefield, Ph.D. R.N. and director of RAC. "Therefore, access to rural-specific information is critical."

RAC is funded by the federal Office of Rural Health Policy (ORHP) at the U.S. Department of Health and Human services. Its creation stems from a recommendation made in the 2002 HHS Rural Task Force Report to create a single point of entry to the 225 HHS programs serving rural areas.

To help meet its goal, RAC will identify and collect sources of rural health and human services research, support programs, funding, and related information; and disseminate information through a variety of mechanisms (including *Rural Health News,* which will become a RAC publication). More than a mere collector and disseminator of raw information, however, RAC will synthesize that information and make it easy to use by policymakers, researchers, providers, and rural residents. "The goal is to make the information actionable," said Wakefield.

Creation of RAC marks a significant departure from its predecessor, the Rural Information Center Health Services at the U.S. Department of Agriculture, in that it combines health and human services, thus fostering a more holistic and, it is hoped, more effective approach to rural well-being.

RAC is a collaboration of the University of North Dakota Center for Rural Health, the Rural Policy Research Institute, the Welfare Information Network, and ORHP. It will also work with State Offices of Rural Health, Rural Health Research Centers, Poverty Research Centers, Area Agencies on Aging, American Public Human Services Association, the National Association of State Workforce Agencies, the National Association of Counties, and many other public and private organizations.

For more information, call 800-270-1898, or email: info@raconline.org; or check the RAC website at: www.raconline.org

Call for Input

Something newsworthy going on in your part of rural America? Send a one-paragraph summary to the editor at: t-mrowley@juno.com.

Background Paper: Rural and Urban Differences in Nursing Home and Skilled Nursing Supply

K. Dalton, C. Van Houtven, R. Slifkin, S. Poley, and A. Howard, North Carolina Rural Health Research and Policy Analysis Center, 2002.

The University of North Carolina Rural Health Research Center has a new working paper that examines characteristics of nursing facilities and the supply of certified skilled nursing beds in rural areas. The study examines skilled nursing care as the new Medicare prospective payment system (PPS) for skilled nursing facilities is phased in, with particular attention to the differences between urban and rural settings. The study provides a background for future studies of the impact of PPS on the delivery of skilled nursing services in rural areas. The first section of the paper describes the nursing home industry and skilled nursing facilities as a component of that industry. The second section examines urban-rural differences in institutional characteristics.

The study finds that rural-urban differences in the supply of long-term care beds and in the characteristics of long-term care facilities are less pronounced, in general, than rural-urban differences in acute care capacity. The supply of Medicare-certified skilled nursing beds does not appear to be a problem in rural areas, with the possible exception of the most rural counties (those not adjacent to metropolitan areas and with no town with more than 2,500 residents). However, assessment of the availability of skilled services is problematic due to the fact that available data only indicate if a bed is certified for Medicare-reimbursed skilled care, but not how the bed is actually used. Several regions of the country rely heavily on hospital swing beds, rather than certified skilled beds, to meet Medicare demand for skilled care.

The report is available online at: http://www.shepscenter.unc.edu/research_programs/Rural_Program/wp74.pdf.

Health Services at Risk in "Vulnerable" Rural Places

M. Shambaugh-Miller, J. Stoner, L. Pol, and K. Mueller, RUPRI Center for Rural Health Policy Analysis, October 2002.

The Rural Policy Research Institute has released a study with a new methodology for identifying places in rural America that are at risk of being without adequate health care services. Communities were classified as vulnerable according to this new method if:

- They were census blocks located more than 25 miles from communities of at least 3,500 persons or
- They were places with high percentages of unemployed, elderly, minority, poor, and uneducated.

Project researchers believe this new methodology can help a variety of policy makers, particularly those at the state level, target those communities that are most in need of assistance.

The report is available on line at: www.rupri.org/healthpolicy

Minorities in Rural America: An Overview of Population Characteristics

J. Probst, M. Samuels, K. Jespersen, K. Willert, R. Swann, J. McDuffie, South Carolina Rural Health Research Center, June, 2002.

The University of South Carolina Rural Health Research Center has a new study that offers an overview of demographic and economic statistics pertaining to rural minority populations and addresses the following questions: Where do rural minorities live? How is the rural minority population distributed across ages and sexes? What is the economic structure of rural, minority communities? What health resources are

available in rural, minority communities?

The report is available online at: http://rhr.sph.sc.edu/report/MinoritiesInRuralAmerica.pdf.

The Rural Uninsured: Highlights from Recent Research

T. Rowley, Office of Rural Health Policy Grantee, September, 2002

This report highlights findings from 11 recent studies on rural uninsurance to help answer such questions as how does rural uninsurance differ from urban, how does it differ across rural America, and how does it affect rural healthcare providers.

The study finds that regardless of the exact number of rural uninsured and whether it exceeds the urban number, other important differences between the rural and urban uninsured on several dimensions appear to be clearer and more consistent. These differences include those in type of coverage, employment, length of time without insurance, population groups, and need.

This report is available online at http://ruralhealth.hrsa.gov/policy/Uninsured.htm.

Rural Health News is a publication of the **Rural Assistance Center**. For additional copies, please see:

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