

Rural Health and Health Reform



ALLIANCE FOR
HEALTH REFORM

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As policymakers debate major health reform bills in the House and Senate, are they taking into account the needs and challenges of rural communities? Could health reform help rural communities deal with problems such as provider shortages, an aging population, and high rates of chronic disease, poverty, unemployment and uninsurance? A look at these issues follows.

Health reformers face a daunting picture when considering rural America. For decades rural communities have been struggling with higher-than-average rates of poverty, unemployment, and lack of employer-sponsored health insurance. Today's widespread economic disruptions simply exacerbate the already existing concerns in rural communities.

In the last several years, there has been a significant loss in manufacturing jobs, resulting in unemployment rates in rural areas that are higher

In October 2009, the Alliance for Health Reform, with support from the Robert Wood Johnson Foundation, held a Capitol Hill briefing to examine the challenges of health care delivery in rural communities and the potential impact on rural health care of some aspects of pending health care reform proposals. Panelists were Tom Irons of the East Carolina University Brody School of Medicine; Keith Mueller of the University of Nebraska Center for Rural Health Policy Analysis; and Neal Neuberger of the HIMSS Foundation Institute for e-Health Policy. This issue brief draws from information presented at that briefing.

Fast Facts

- The uninsurance rate in remote rural communities averages 23 percent.
- In rural areas, a high proportion of people work at small firms or are self-employed. Those workers are less likely to have health coverage than those at larger firms.
- More than 15 percent of rural residents are over the age of 65, compared to 12.4 percent nationwide.
- Rural residents have rates of chronic disease such as diabetes, heart disease, high blood pressure and obesity that are greater than urban or suburban populations.
- Seventy-seven percent of rural counties are considered primary care health professional shortage areas.

than in urban areas (9.8 percent in February 2009 vs. 8.7 percent in urban areas). Of those who are working, more are employed by small firms than their urban counterparts. Workers employed by small firms represent 69 percent of the uninsured in nonadjacent rural areas compared to 59 percent in urban and adjacent areas. Small businesses tend to pay lower wages and are less likely to provide health insurance than larger firms.

These economic factors create a greater likelihood overall that rural residents will lack employer-sponsored health coverage and be unable to afford private insurance coverage.

The recession that began in 2008 and the resulting increase in unemployment led to an increase in uninsurance rates that rose faster in rural than urban areas. Though the rates of uninsurance overall have remained very close between rural and urban, the difference between rural areas adjacent to urban areas and non-adjacent ones have always been significant, and they tell an important story—the further a person gets from metro

areas, the higher the uninsurance rate.

Though there is regional variation, the highest uninsurance rates are in the most remote rural areas with the sparsest population. On average the uninsured rate in these communities is 23 percent. In February 2009, the rural, non-metro uninsured rate in New Mexico reached close to 27 percent, the highest in the nation.

Rural residents pay high out-of-pocket costs for their care, a factor that often leads to deferred care. In fact, rural adults are more likely than urban adults to report deferring care because of cost. The problem is even worse among rural minority populations, who are twice as likely as rural whites to defer care.

This problem would be even greater if a critical portion of insurance coverage were not provided by public programs. **Nearly a third more rural people are covered by public programs than are their urban counterparts.**

Several factors contribute to the high use of public programs in rural areas. These include



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higher rates of poverty—14.7 percent in 2005 compared to 11.8 percent in urban areas—and increased eligibility for Medicaid. As already noted, a lower percentage of rural residents have employer-based health insurance.

In addition, rural communities have higher percentages of older and disabled residents, many of whom are dually eligible for Medicare and Medicaid. Also, rural children are particularly reliant on Medicaid. Some 27 percent of children in the most remote counties are covered by Medicaid.

Aging of the population, poor health of rural residents, provider shortages, and geographical barriers provide additional health care challenges in rural communities.

The nation as a whole is aging, but in rural areas it's happening faster. In 2007, more than 15 percent of rural residents were over the age of 65, compared to 12.4 percent nationwide. Because older people as a whole experience more chronic disease and disability than younger people, this means that rural communities that are already medically underserved have an even greater challenge.

Contrary to the popular myth that rural inhabitants are healthier than city dwellers, they in fact have rates of chronic disease such as diabetes, heart disease, high blood pressure and obesity that are greater than urban or suburban populations.

And, though mortality rates are declining in both urban and rural populations, there is a widening gap between urban and rural statistics; the death rate has begun to decline twice as fast in urban areas as in rural populations. Some researchers attribute the difference to the limited access to health care in rural areas, particularly among the poor and undereducated.

Provider shortages are particularly acute in rural America. Recruiting physicians and other providers to practice in a rural area is somewhat

easier and retention more likely if the provider grew up in a rural area. However, few students from rural areas pursue medical careers, either as physicians or as allied health professionals. Levels of educational achievement in general are lower in rural communities and there are fewer opportunities to receive medical or allied health professional training.

Seventy-seven percent of rural counties are considered primary care health professional shortage areas.

Ten percent of rural counties don't have a single primary care physician.

To meet some of this need, rural areas rely on non-physician primary care providers, such as physician assistants and nurse practitioners. However, supervision by a physician may be scarce, and state practice acts may prevent allied health professionals from performing some tasks independently. In addition, these allied professionals, too, are in short supply. It is difficult to recruit and retain these providers for the same reasons as in recruiting and retaining physicians—low financial compensation, professional isolation, limited time off and scarcity of jobs for spouses.

While primary care and emergency care are generally provided locally, patients may have to travel a great distance and/or cross state lines to get specialty care. This may result in patients foregoing care or relying more extensively on generalists (when generalists are available). This may be especially true of older people who often live alone and have difficulty reaching appropriate medical care, and in the mental health field where the specialist shortage is profound.

Telehealth is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance. (“Telehealth” differs from “telemedicine”—see www.cms.hhs.gov/Telemedicine.) One possible way to squeeze the most access out of the relatively scarce sup-

ply of providers is to make greater use of telehealth. But adoption of health information technology (HIT) has been slow and comes with its own set of challenges.

A number of factors contribute to the slow adoption of HIT. However, “The number one issue is money,” according to Neal Neuberger of the Institute for e-Health Policy.

The cost of developing the infrastructure necessary to support telehealth activities is burdensome to financially troubled rural communities, health centers and individual private practices.

Rural Critical Access Hospitals (CAHs) are especially disadvantaged given how far they must go to become “meaningful adopters” of “certified information technologies” in order to qualify for incentive payments. CAH is a Medicare designation that helps acute care hospitals remain open in rural areas through a special reimbursement mechanism. Most of the 1,300 CAHs are currently at a very low state of adoption relative to other hospitals, and they have few resources to help them catch up any time soon.

Beyond financial factors, additional human dimensions slow the adoption of HIT: practitioner and patient acceptance, licensure accreditation and certification, ongoing security concerns and training an HIT workforce. There is little or no technical support in rural communities. Up to 40,000 more rural HIT workers are needed, reported Mr. Neuberger.

Geographic barriers and provider shortages hinder coordinated care delivery in rural areas.

The medical home model may serve well to improve care coordination and outcomes, but the model will need to be adjusted to the unique characteristics of rural areas. A medical home is “a health care setting where patients receive comprehensive primary care services; have an ongoing relationship with a primary care provider who directs and

coordinates their care; have enhanced access to nonemergent primary, secondary, and tertiary care; and have access to linguistically and culturally appropriate care.”

Medical homes rely on an ongoing relationship with a primary care provider to offer coordinated care in treating chronic care patients. Where there is a shortage of primary care physicians, the provider or team leader might be a nurse practitioner, physician assistant or other allied health professional. The team leader or case manager can facilitate care coordination and information sharing between primary care providers and specialists—an aspect of rural health care delivery that is particularly challenging.

A few states have adopted a modified medical home model in rural communities. One example is Community Care of North Carolina, a state-coordinated Medicaid care management system. It consists of physician-led networks that focus on improving quality through care coordination. They require close partnerships among primary care providers, hospitals, health departments and social services agencies.

At the October 2009 Alliance briefing, Dr. Tom Irons of the East Carolina University Brody School of Medicine stressed the important role of allied health professionals to the medical home model, saying, “We will not make this work without nurse practitioners and physician assistant partners.”

How could the House and Senate health reform bills help rural areas deal with their challenges? And what aid is forthcoming from the American Recovery and Reinvestment Act (ARRA)?

Coverage expansion and insurance reform—The reform proposals debated in the U.S. House and Senate in late 2009 would reduce the number of uninsured persons in rural areas, leaving only about 4 percent uninsured, said Keith Mueller of the

University of Nebraska Center for Rural Health Policy Analysis. This would be accomplished by expanding Medicaid and by improving the individual and small business insurance markets through an insurance exchange and with the help of government subsidies.

Unlike providers in most other areas, providers in rural communities rely on Medicaid as an important source of income. **Medicaid accounts for approximately 20 percent of physician patient revenue in rural communities and helps retain health professionals.** Though recruitment and retention is still problematic, it would be even more so if not for public health insurance programs. Medicaid expansion is seen by rural communities as an important provision of health reform legislation.

In the House reform bill, the smallest businesses (those with a payroll not exceeding \$250,000) would be exempt from a requirement that they offer coverage to their employees—an important provision for rural communities with predominantly small businesses. This provision is welcomed by small business owners, although it does not help their employees gain coverage. Many of their employees, however, would be eligible for subsidies that would help them buy coverage through an insurance exchange. The Senate bill would create a sliding scale tax credit to enable rural small businesses to provide health benefits to their employees.

Guaranteed issue and modified community rating also would benefit rural residents who otherwise might not be able to purchase insurance or who may have paid higher premiums because of health status. Rural residents also would benefit from limits on out-of-pocket expenses and elimination of the lifetime benefit maximum. These provisions are especially beneficial to people with lower incomes and higher rates of chronic disease and disability, as are found in rural areas.

Encouraging preventive care—

Rural Americans are less likely to receive needed preventive care, such as mammograms and pap smears for women, or routine foot, eye and blood testing for people with diabetes. The Senate bill would ensure that all Americans have access to free preventive services under their health insurance plans.

Given the aging of the rural population, it is important to note that seniors covered by Medicare would receive free annual wellness visits under health reform. Both the House and Senate bills would eliminate cost sharing for preventive services in Medicare and Medicaid.

Boosting the health workforce—

The House bill builds on ARRA and expands incentives and support for primary care education and practice through the National Health Service Corps (NHSC), increasing scholarships and loan repayment funding levels. The Senate bill would double the funding for the NHSC and establish a loan repayment program for pediatric specialists who agree to practice in medically underserved areas such as rural regions.

In addition, the House bill contains measures to help the workforce adapt to changes in health care delivery, such as practicing in teams led by primary care providers. The bill supports expanded nursing education, and the training of advance practice nurses who will deliver care in shortage areas, possibly leading such teams. It also recognizes the need for diversity in the health care workforce.

A provision in the Senate bill focusing on provider shortages enhances graduate medical education to increase the supply, education, and training of doctors, nurses, and other health care workers, especially in pediatric, geriatric and primary care. It authorizes \$125 million in grants to develop and operate training programs and academic units in primary care, including financial assistance of trainees and faculty, and faculty development in primary care and

physician assistant programs. It gives priority to programs that educate students in team-based approaches to care, including the patient-centered medical home.

Telehealth—Congress has already offered some help in the health information technology arena through the American Recovery and Reinvestment Act (ARRA), authorizing \$2.5 billion for rural broadband loans and grants. ARRA also provides for incentive payments through Medicare to providers and hospitals to accelerate the adoption of HIT. Incentives are also extended through Medicaid for providers to become “meaningful users” of certified electronic health record technology.

A total of \$33.5 billion for Medicare and Medicaid incentives to hospitals and physicians is projected to be expended during the next 10 years. With projected program savings of \$12.5 billion, net entitlement expenditures of approximately \$20 billion are anticipated.

Pending provisions in health care reform legislation would further promote the active use of telehealth and health care information technologies for med-

ical homes, continuous care organizations, through the Medicare Advantage program and for other efforts.

In addition to possible long-term cost benefits, expanding the availability and use of telehealth could go a long way toward improving care coordination in rural communities and would help better manage the disadvantages of provider shortages and geographic barriers to obtaining service.

Though the current reform proposals contain many benefits to Americans who live in rural communities, even if major reforms are enacted, many questions remain. Areas of uncertainty include whether the proposed insurance exchange or exchanges would be able to provide choice of insurance plans to residents of rural areas, and whether these plans would contract with local providers. Also of concern is whether Medicare reimbursement levels would be sufficient to allow

critical access hospitals to survive in rural communities.

In addition there are questions about the capacity of the health workforce, whether it will be sufficient to meet demand when coverage is expanded and whether telemedicine will grow to help fill the need. State practice acts and licensing will play a role in the delivery of telehealth services and in the use of allied health professionals. These policy issues will have to be addressed within states and beyond state borders.

As policymakers look to new models of care delivery, there are yet other questions. Will Medicare and Medicaid patient-centered medical home demonstrations reach rural areas? Will they be allowed to adapt the model as necessary to the unique characteristics of these communities? These and other issues will play out over the coming weeks—and years.

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The Alliance is a nonpartisan, not-for-profit group committed to the education of journalists, elected officials and other shapers of public opinion, helping them understand the roots of the nation's health care problems and the trade-offs posed by various proposals for change.

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Websites

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