How Will Rural Areas Fare After Health Reform?

June 2011

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Professor and Associate Dean for Public Health
Washington University in St. Louis

Committed to working with journalists…

- At our campus, and in our public health program we make it a priority to focus on "translation and dissemination" to policymakers and practitioners

Mission for Washington University MPH Program

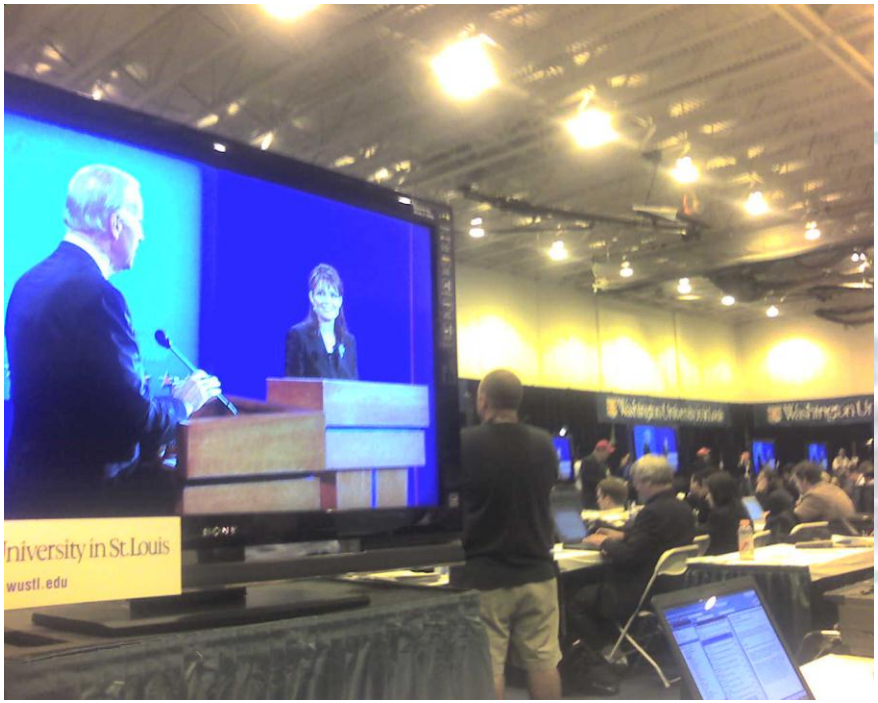
- **The Mission of the MPH Program** within the Brown School is to prepare students to apply transdisciplinary problem solving skills to improve population health, especially in vulnerable communities. Specifically, the program will:
  - Use a transdisciplinary problem-based learning approach to help students understand and apply principles and core functions of public health;
  - Educate public health professionals in the principles of evidence-based public health;
  - Prepare students to work effectively towards eliminating health disparities in the region and nation through research, education, and service;
  - **Help students understand and apply principles of dissemination and implementation science, and educate health professionals in these principles;**
  - Require that students adhere to the highest public health ethical standards in the conduct of all components of our mission.

Six Strategies for effective dissemination of research to the public

1. Engage end users when framing research.
2. Use the media to communicate findings.
3. Tailor the design of products to meet the needs of the diversity of end users interested in health research.
4. Make research products easily accessible to end users.
5. Expand contact and working relationships with end users
6. Invest in developing greater capacity for effective dissemination.

Vice Presidential Debate

Washington University in St. Louis October 2, 2008



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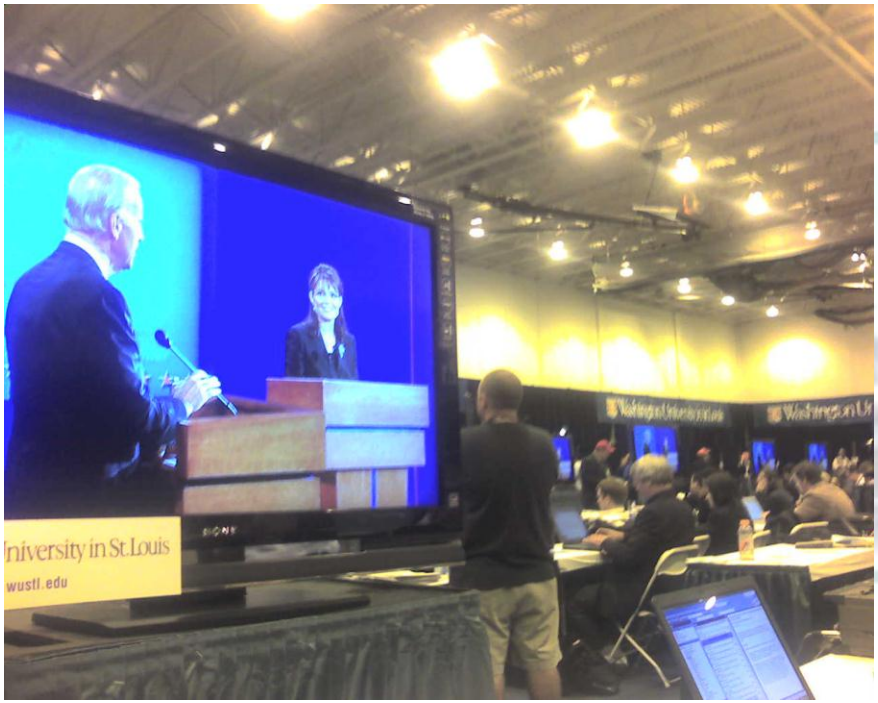
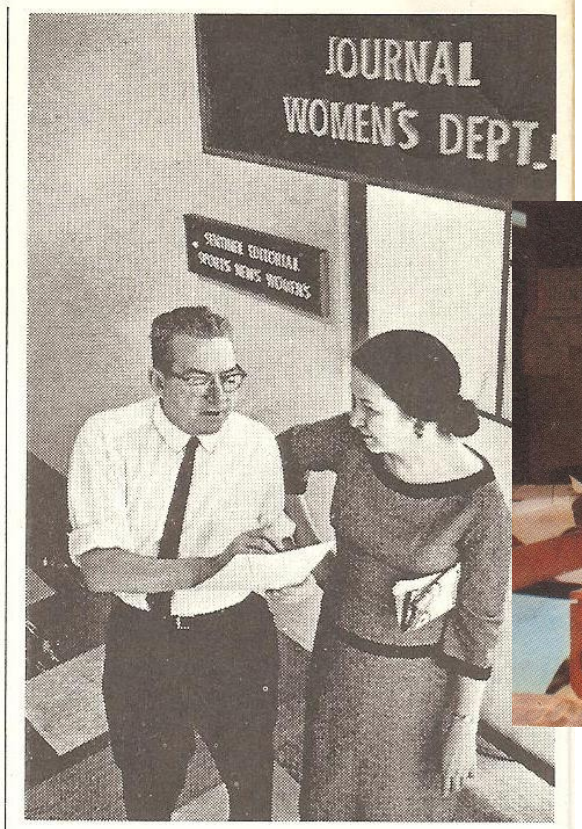
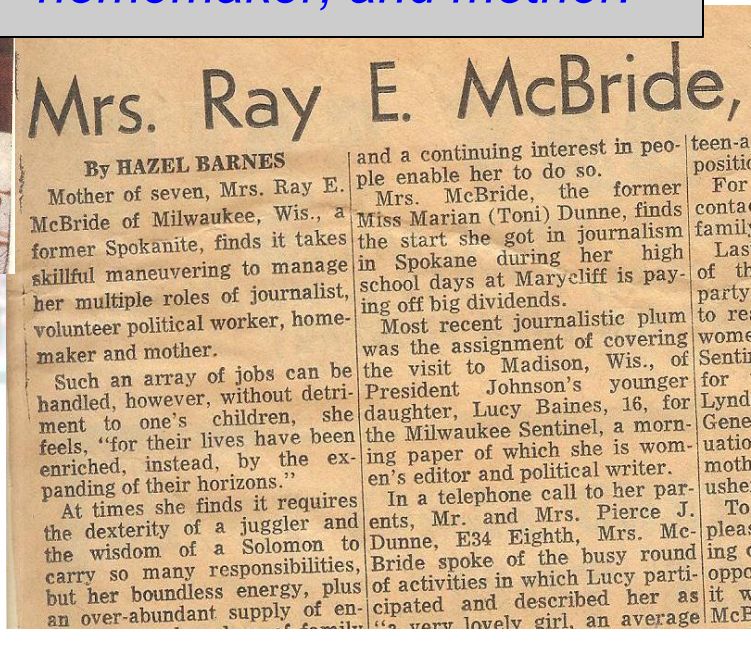


A Family History in Journalism …



RAY & TONI McBRIDE
She calls the office; Ray walks the dog.

"Mother of seven, Mrs. Ray E. McBride of Milwaukee… finds it takes skillful maneuvering to manage her multiple roles of journalist, volunteer political worker, homemaker, and mother."



Mrs. Ray E. McBride,

By HAZEL BARNES

Mother of seven, Mrs. Ray E. McBride of Milwaukee, Wis., a former Spokanite, finds it takes skillful maneuvering to manage her multiple roles of journalist, volunteer political worker, homemaker and mother.

Such an array of jobs can be handled, however, without detriment to one's children, she feels, "for their lives have been enriched, instead, by the expanding of their horizons."

At times she finds it requires the dexterity of a juggler and the wisdom of a Solomon to carry so many responsibilities, but her boundless energy, plus an over-abundant supply of en-

and a continuing interest in people enable her to do so.

Mrs. McBride, the former Miss Marian (Toni) Dunne, finds the start she got in journalism in Spokane during her high school days at Marycliff is paying off big dividends.

Most recent journalistic plum was the assignment of covering the visit to Madison, Wis., of President Johnson's younger daughter, Lucy Baines, 16, for the Milwaukee Sentinel, a morning paper of which she is women's editor and political writer.

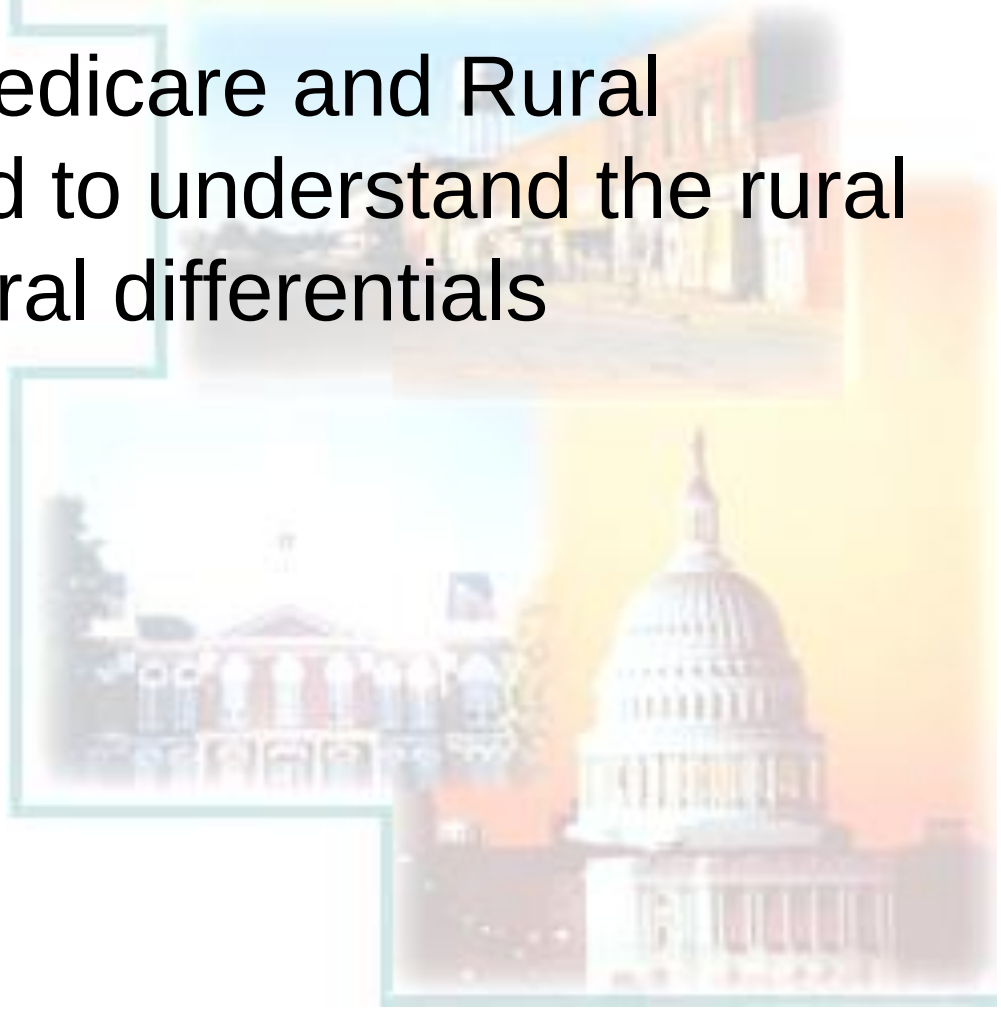
In a telephone call to her parents, Mr. and Mrs. Pierce J. Dunne, E34 Eighth, Mrs. McBride spoke of the busy round of activities in which Lucy participated and described her as

"RAY & TONI McBRIDE
She calls the office;Ray walks the dog."

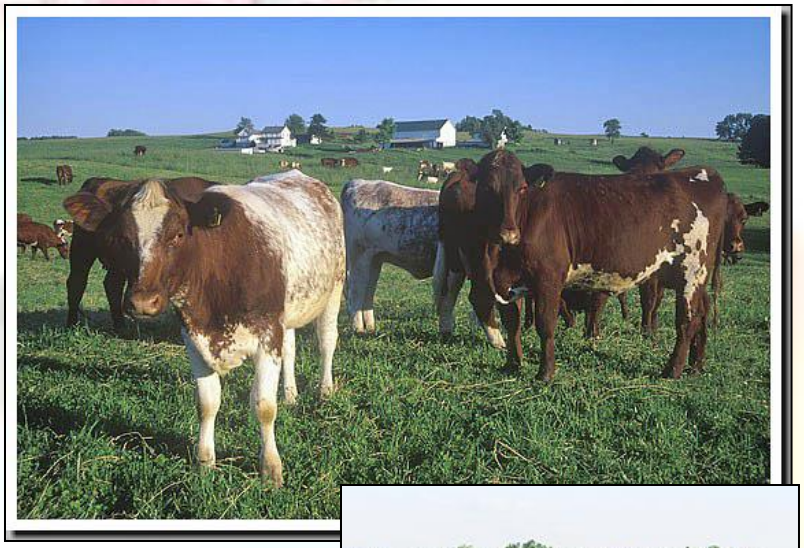
Rural America, Rural Health and Medicare

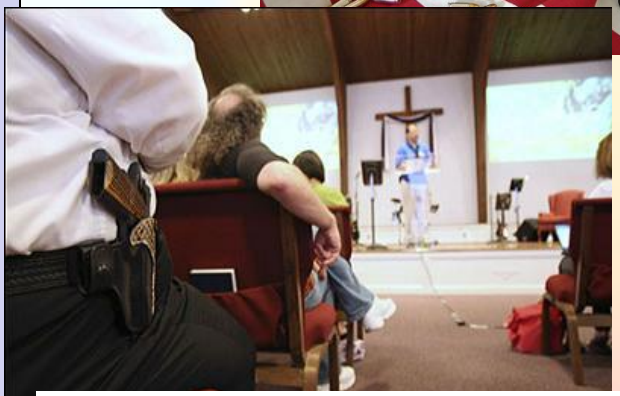
Medicare and the Rural Differential

- To understand Medicare and Rural America, we need to understand the rural disparities and rural differentials



So What is Rural America?





- "You go into these small towns in Pennsylvania and, like a lot of small towns in the Midwest, the jobs have been gone now for 25 years and nothing's replaced them…each successive administration has said that somehow these communities are gonna regenerate and they have not. **And it's not surprising then they get bitter, they cling to guns or religion or antipathy toward people who aren't like them or anti-immigrant sentiment or anti-trade sentiment as a way to explain their frustrations."**
  - **-- Barack Obama, April, 2008.**

Warning: I cling to my guns, religion and my Constitution!

What is the character of an area?

Which of these are rural areas?

	County 1	County 2	County 3
Median family income	$74,875	$42,748	$27,553
Percent below poverty	9.1%	23.8%	30.4%
In Labor Force	66.7%	63.9%	54.1%
College degree or more	38.3%	24.8%	8.4%
Female-headed households	13.1%	20.3%	18.5%
Percent foreign born	5.8%	6.6%	0.9%
Percent non-white	26.7%	53.7%	28.2%

What is the character of an area?

	St. Louis County	St. Louis City	Pemiscot
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Percent non-white	26.7%	53.7%	28.2%
Population	994,098	354,620	20,047
County	Urban	Urban	Rural

Triangulation…
Rural, Suburban, and Urban America

Why Does this matter? Disparities in Health Care

- There has been a great deal of attention paid to disparities in health care
  - Focus mostly on disparities in racial, ethnic and socioeconomic groups
- A disparity that gets much less attention:
  - Urban vs. Rural differences in health and medical care
  - And how are these related?
  - And what is the implication of this for health reform?

The Rural "Differential"

- Most rural health research and policy work focuses on the rural "differential"
  - But the leap is often made to conclude that when a difference is seen, that this must mean that there is a disparity
  - Or to put it another way, when there is a difference seen between urban areas and rural areas, this is somehow inequitable
  - But does this necessarily follow? Is a differential just another word for a "disparity"?

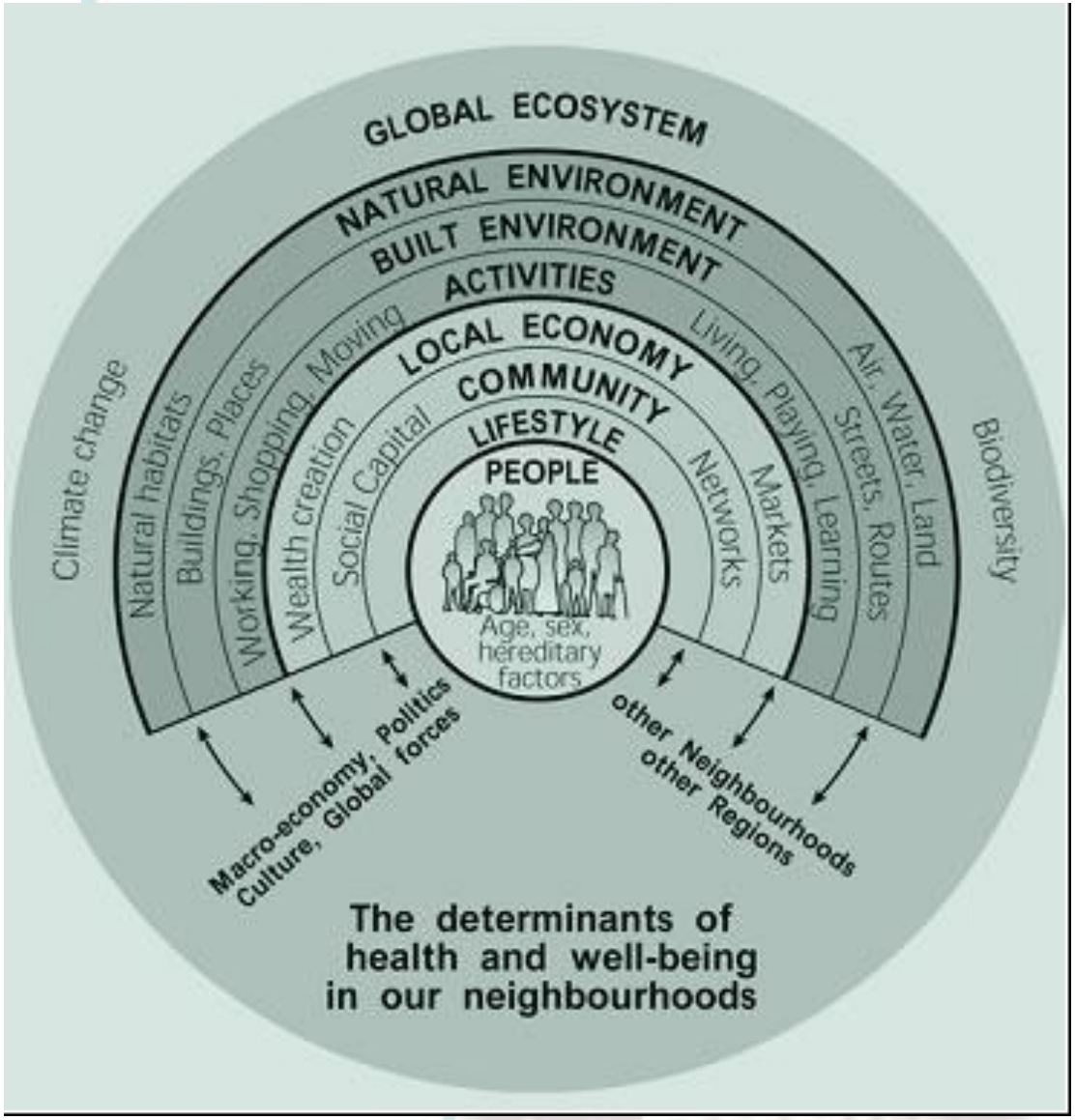
What Accounts for the Rural "Differential"?

- What explains the rural "differential"? Is it:
  - Differences in demographic and economics -- characteristics of rural people, as compared to urban people;
    - Such as education, race, ethnicity, age
    - Income, poverty, assets, home ownership
  - Differences in reimbursement/payment rates between rural and urban areas;
    - Payment rates set by government policies
    - Payment rates set by private policies
  - Or is it caused by place -- where rural people live (e.g., their distance from services)
    - Place making it difficult to access services because of distance to providers
    - Or place reducing supply of providers available

What Accounts for the Rural "Differential"?

- Often it seems that when people talk about the rural differential, it seems they are talking about <u>place</u>
  - Differences in access to services because of problems of supply of providers, or because of distance getting to quality providers
  - But the disparity may be more complicated than that

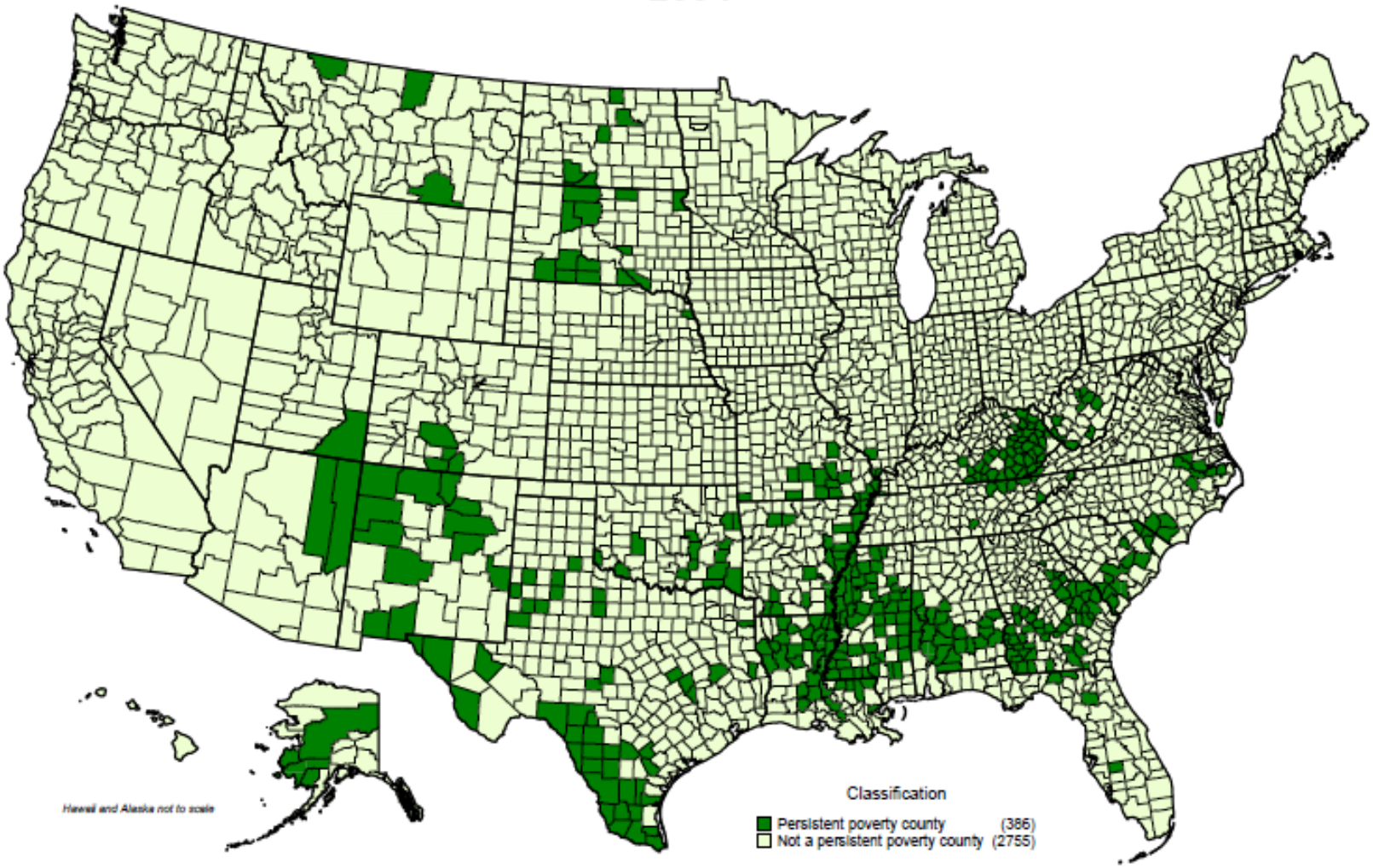
The Social-Behavioral Model And the Determinants of Health



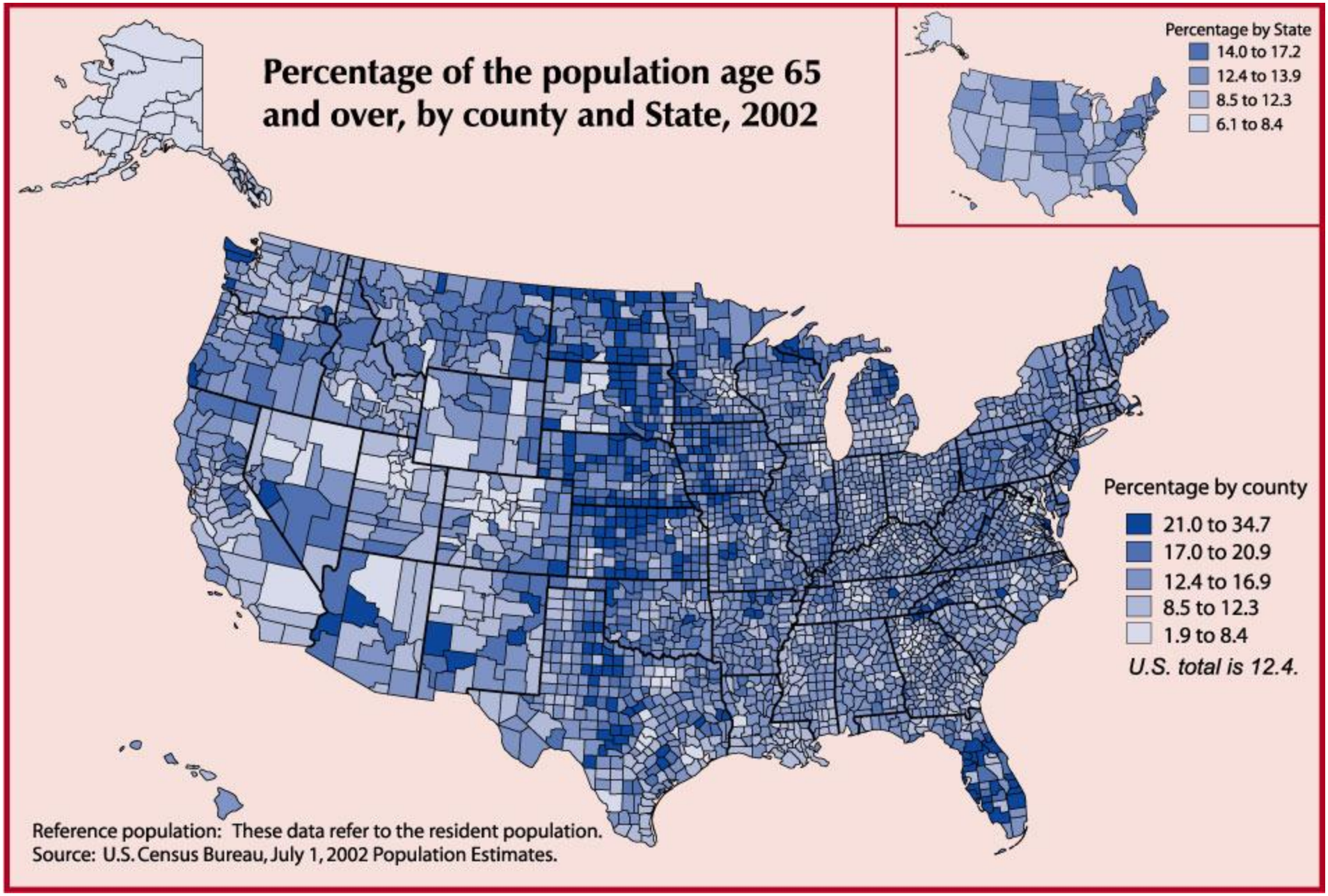
So what do we know about these "determinants" of health?

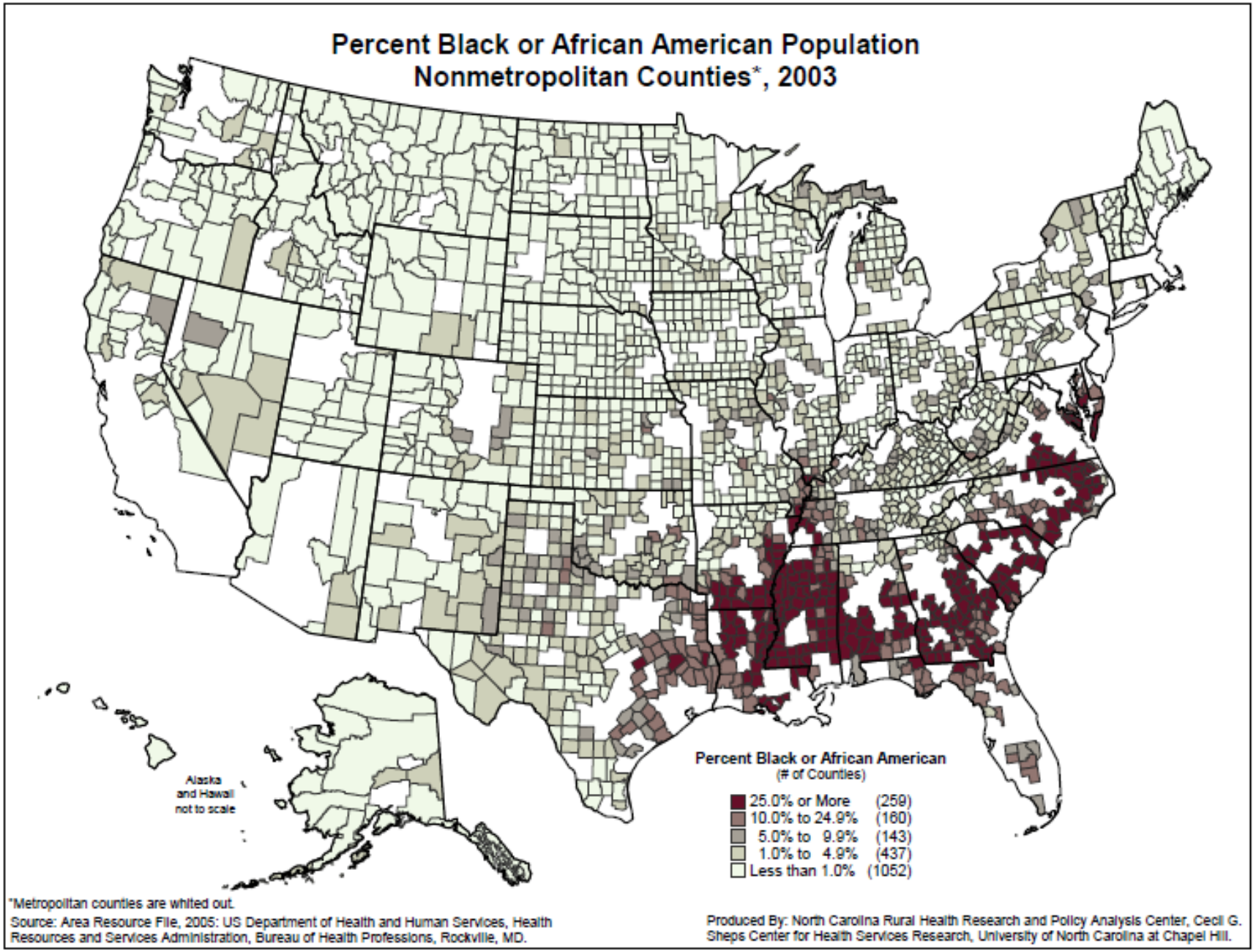
- What do we know about differences in terms of
  - Income and Poverty
  - Race and ethnicity
  - Education
  - Other factors?

USDA County Type: Persistent Poverty
2004

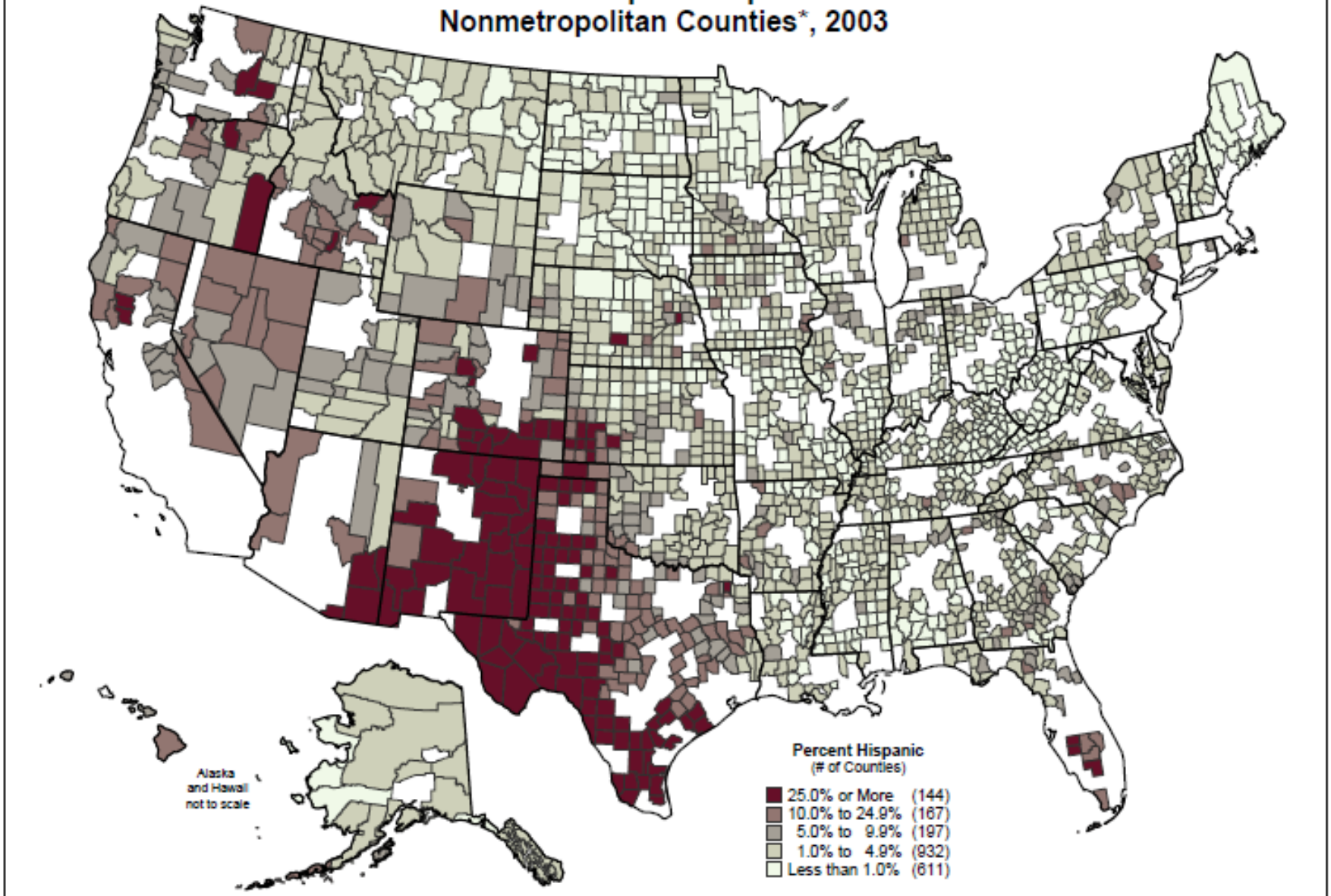


Notes: USDA defines persistant poverty as 20 percent or more of residents were poor as measured by each of the last 4 censuses (1970, 1980, 1990, and 2000).
Source: Economic Resource Service, US Department of Agriculture, 2004.
Prepared by: The North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.


Percentage of the population age 65 and over, by county and State, 2002
Percentage by State
14.0 to 17.2
12.4 to 13.9
8.5 to 12.3
6.1 to 8.4
Percentage by county
21.0 to 34.7
17.0 to 20.9
12.4 to 16.9
8.5 to 12.3
1.9 to 8.4
U.S. total is 12.4.
Reference population: These data refer to the resident population.
Source: U.S. Census Bureau, July 1, 2002 Population Estimates.


Percent Black or African American Population
Nonmetropolitan Counties*, 2003
Alaska
and Hawaii
not to scale
Percent Black or African American
(# of Counties)
25.0% or More (259)
10.0% to 24.9% (160)
5.0% to 9.9% (143)
1.0% to 4.9% (437)
Less than 1.0% (1052)
*Metropolitan counties are whited out.
Source: Area Resource File, 2005: US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Rockville, MD.
Produced By: North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

Percent Hispanic Population
Nonmetropolitan Counties*, 2003



*Metropolitan counties are whited out.

Source: Area Resource File, 2005: US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Rockville, MD.

Produced By: North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

A untold STORY about Rural America

- Stereotypes about rural America do not hold up
- These differences may account for good part of the “disparities” between urban (especially suburban) and rural America
- Crucial to understand this as we move to implementing health reform

The Rural "Differential"

- Analysis has focused on differences in:
  - Access and utilization of health care
  - Health status
  - Disease and conditions
  - Health Outcomes
  - Reimbursement (payment) rates(e.g. Medicare)

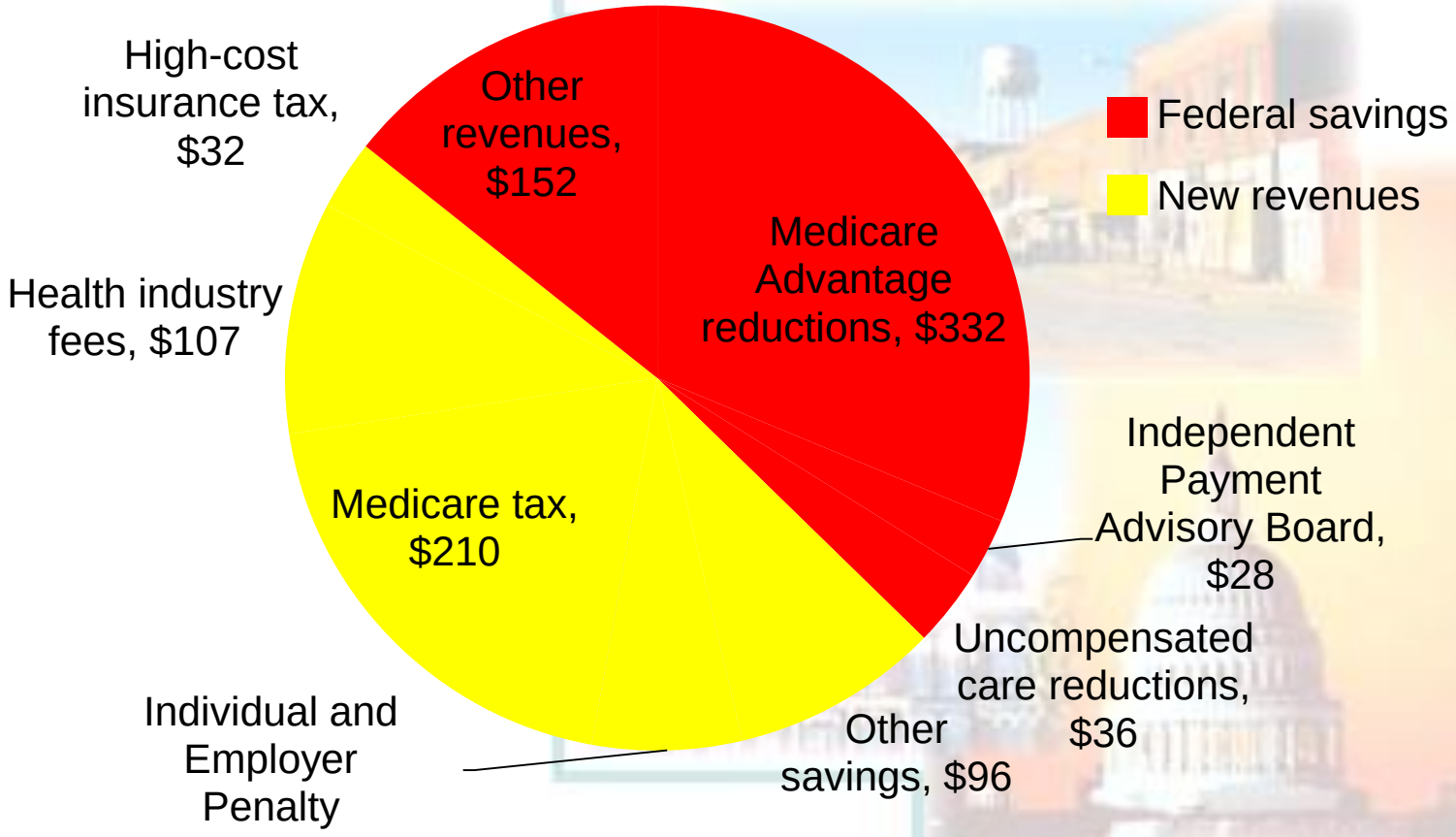
The STORY of Medicare, Health Reform and Budget Crises

The rocky path to health reform…

Key Elements of Reform

- Title I: Quality, Affordable Health Care for All Americans
- **Title II: The Role of Public Programs**
- Title III: Improving the Quality and Efficiency of Health Care
- Title IV: Prevention of Chronic Disease and Improving Public Health
- Title V: Health Care Workforce
- Title VI: Transparency and Program Integrity
- Title VII: Improving Access to Innovative Medical Therapies
- Title VIII: Community Living Assistance Services and Supports Act (CLASS Act)
- Title IX: Revenue Provisions
- Title X: Reauthorization of the Indian Health Care Improvement Act

Financing Health Reform, 2010-2019



Total Cost = $938 Billion

Savings to Federal Deficit = $124 Billion

Source: Congressional Budget Office, 2010

The Health Reform STORY relating to Rural America

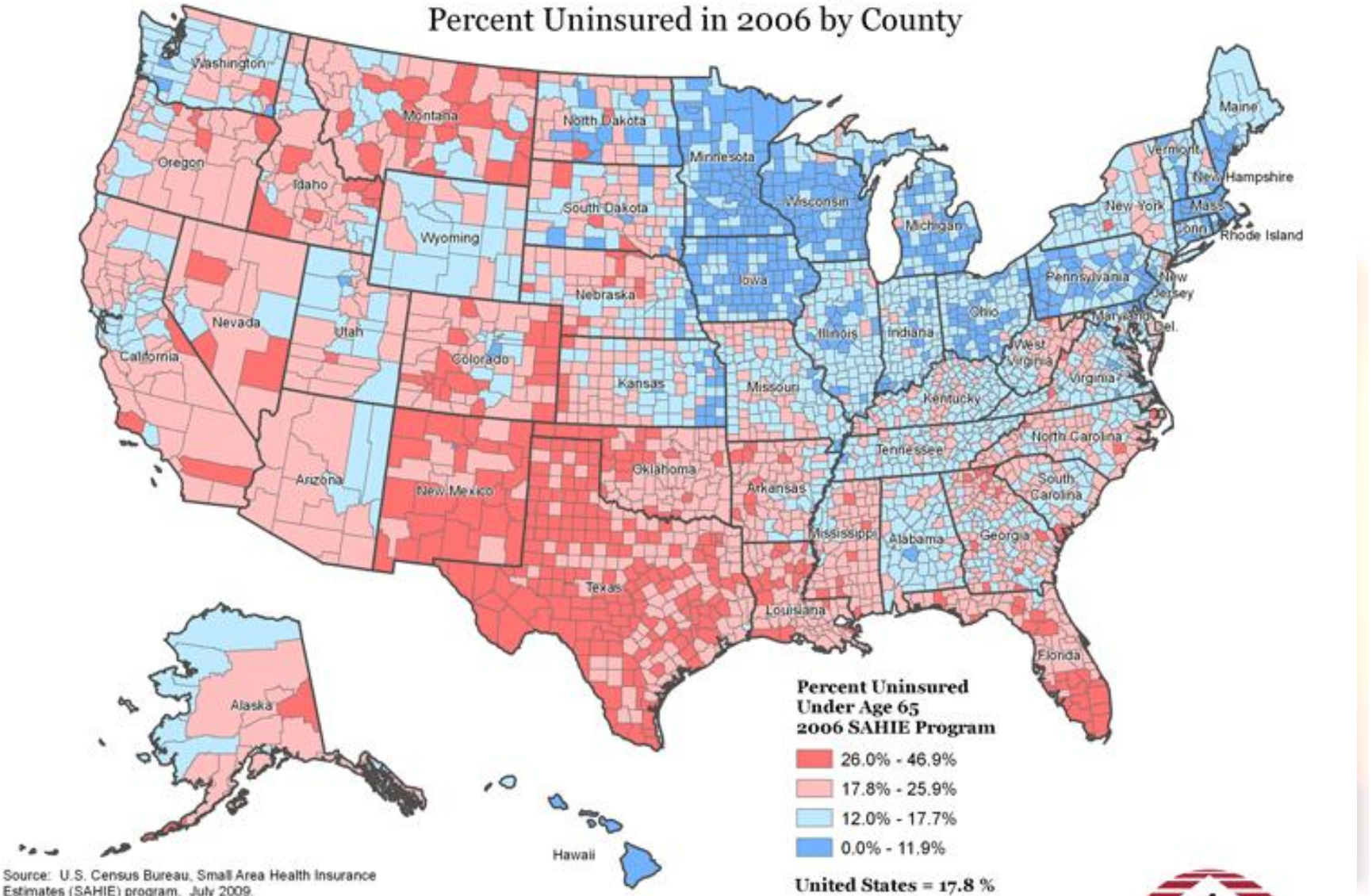
1. Coverage and Exchanges
2. Payment Issues and Health Delivery
3. Public Health and Chronic Disease

1. A big STORY: Coverage

- We know: How people obtain insurance differs a lot in rural compared to urban
  - Rural people have less access to generous insurance
    - Especially employer insurance, individual non-group insurance
- So these will be big issues for the implementation of health reform

Health Insurance Coverage Status

Percent Uninsured in 2006 by County

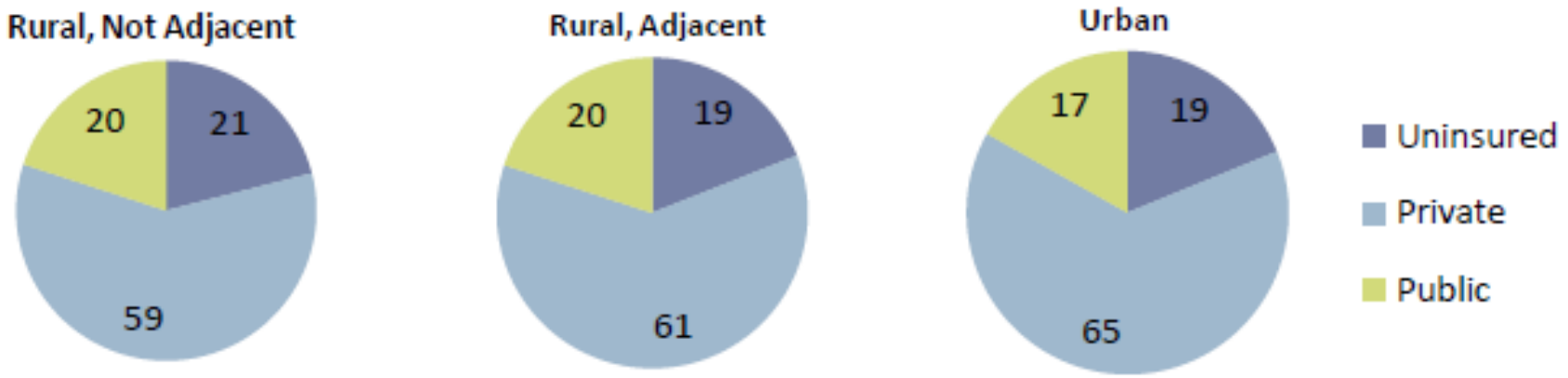


Source: U.S. Census Bureau, Small Area Health Insurance Estimates (SAHIE) program, July 2009.

Map produced by Center for Applied Research and Environmental Systems (CARES); December, 2009.

RAC
Rural Assistance Center

Type of insurance coverage, by location of residence



Data: Medical Expenditure Panel Survey, 2004-05
Uninsured differences by residence significant at $p < .05$.
Due to rounding, some characteristics may not total 100 percent.

Rural residents rely more on public sources of health insurance than urban residents.

SOURCE: University of Southern Maine, Rural Health Research Center. 2009. "Profile of Rural Health Insurance Coverage: A Chartbook," Muskie School of Public Service.

Why the insurance differential?

- So uninsurance rates are higher in smaller counties, and rural people rely more on public insurance. Why?
  - Differences in employment: more small employers in rural
  - Lower incomes and higher poverty in rural areas

Telling the story on coverage and disparities…

- Why health reform will matter more in rural areas:
  - Access to subsidies, Medicaid more important in rural areas
  - Health insurance exchanges could really help, especially small employers
    - But will the Exchanges work in rural areas, and will rural people have the same access to private plans?
  - Rural America may look more like inner city urban than suburban
    - To understand all this, need to dig deeper into characteristics of rural PEOPLE
    - And not all rural areas are the same

Coverage under reform in rural and urban areas

	Rural	Urban	Total
Number of uninsured persons (in millions)			
Before reform	8.1	41.9	50.0
After reform	2.9	16.5	19.4
Insurance Coverage rate after reform			
Before reform	83.0%	83.1%	83.1%
After reform	93.4%	92.7%	92.8%
Proportion of persons obtaining coverage through:			
Health Insurance Exchange (adults)	44%	46%	45%
With subsidies or tax credits	37%	36%	36%
Employer or individual responsibility	7%	10%	9%
Medicaid expansion (adults)	33%	30%	30%
Children	23%	25%	24%

SOURCE: RUPRI Health Reform Simulation Model, December 2010.

Coverage Provisions:
Impact on Rural Persons, Providers and Places

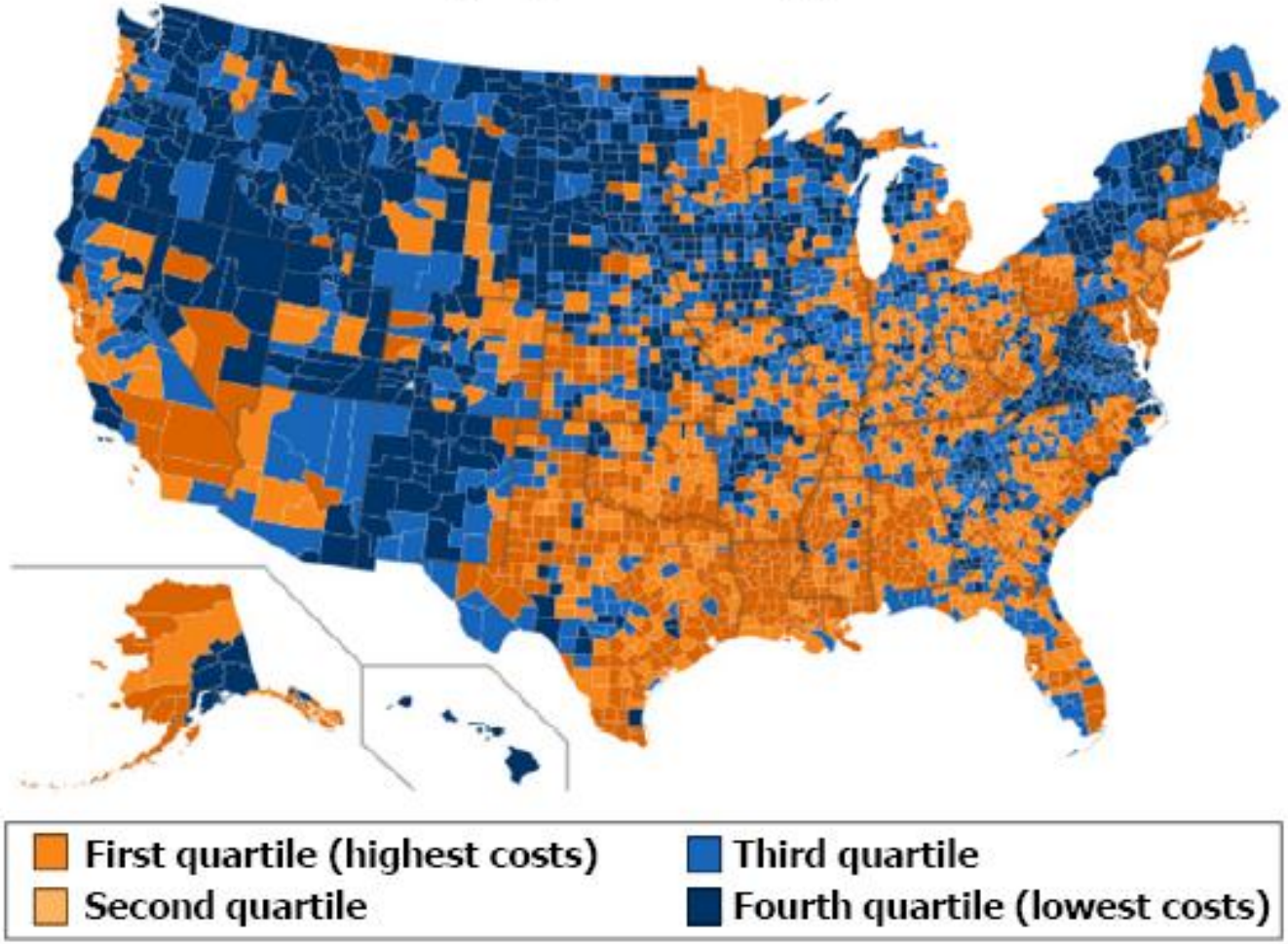
- Significant positive impact on rural coverage rates in the short- and long-run
  - Resulting positive impact on providers
  - Most changes occur after 2014, but some implemented in 2010
- Higher baseline uninsured rates for rural persons in rural non-adjacent and frontier areas
  - Rural persons are more likely to work for small businesses and for low wages
  - Implies that impact will be disproportionately larger in rural areas
  - Expansions of Medicaid and subsidies/tax credits crucial in rural areas due to lower incomes of rural persons
- The ultimate impact of expanded affordability will be realized only if affordable coverage is available and accessible
  - So implementation of Health Insurance Exchanges is crucial
  - Key issues:
    - geographic service areas, choice and competition, information, risk rating, outreach, minimum benefits

2. Payment Differentials

- We know…
  - Payment (reimbursement) rates are lower in rural America under government programs
  - This has been, or could be, a contributing factor to problems rural people have getting access to services
- So a big health reform story:
  - How big are these payment differentials?
  - Will health reform fix these? Should health reform fix these?

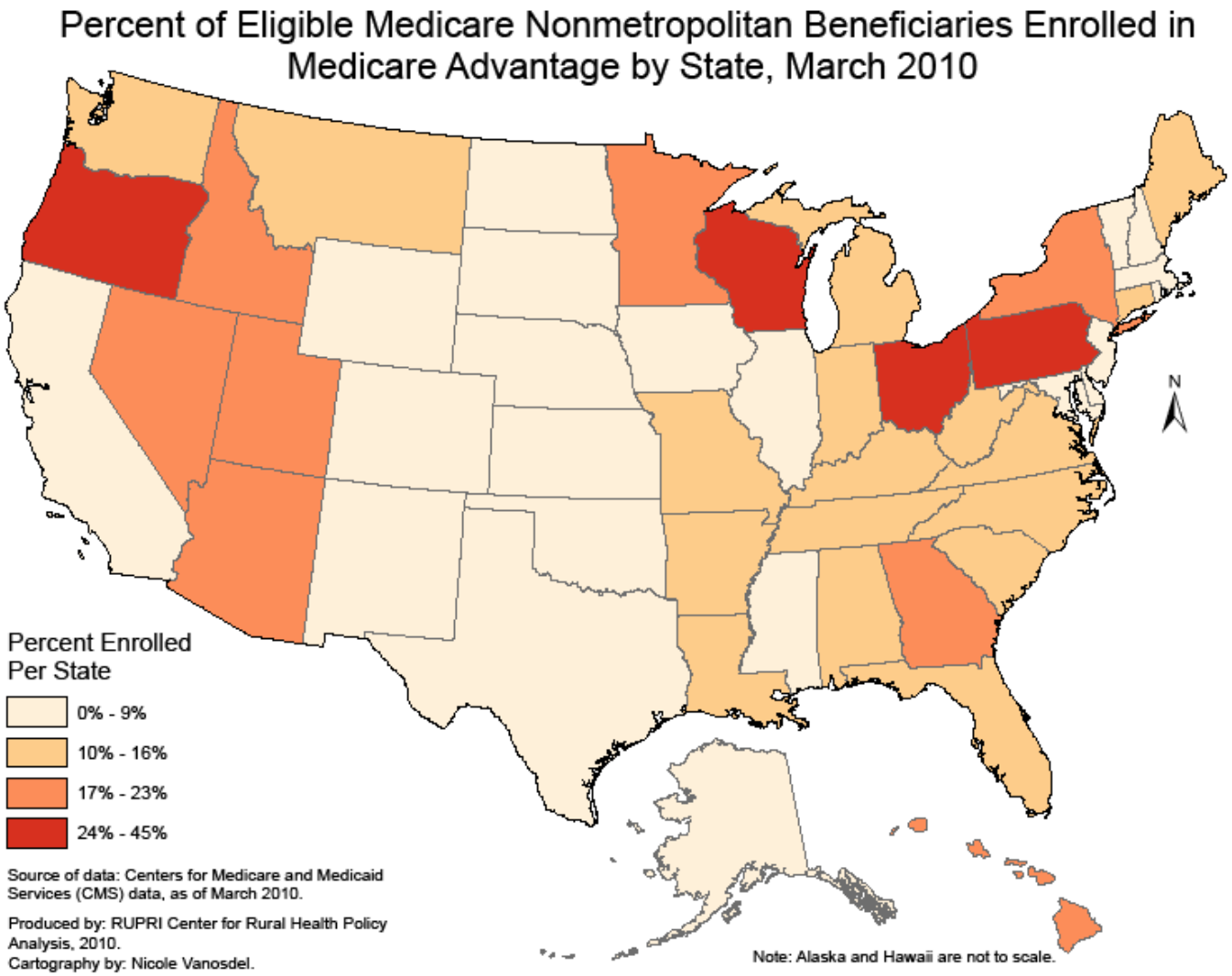
Exhibit 2

Regional Differences in Medicare per Capita Costs, by County, 2008



Source: Kaiser Family Foundation analysis of the Centers for Medicare and Medicaid Services (CMS) Fee-for-service Expenditure data, excluding Indirect Medical Education (IME) Medicare payments, 2008.

Some unintended consequences?
Variation in Medicare Advantage Enrollment



So how much of this can be attributed to policy problems?

- Historically, lower payment to rural providers has been justified by “cost of living” differential (cheaper to live in rural areas, costs are lower)
  - Issues: is it true? Are costs lower, so is differential justified?
  - Self-fulfilling prophecy?
    - Payment lower ➔ less care done, and limited access ➔ lower costs
  - Are rural people healthier, justifying lower payment? (MedPAC conclusion)

Telling the story on payment and reform…

- In health reform, as in previous years, Congress and Administration try to rectify perceived payment disparities
  - Special subsidies to rural programs, such
    - Critical Access Hospitals, Rural Flex Grant Program
    - Federally Qualified Health Centers (FQHCs)
- Key questions:
  - Will these programs, policies work to achieve access?
  - Are these additional subsidies justified?

Payment Policy Provisions:
Impact on Rural Persons, Providers and Places

- ***Impact on Rural Physicians***
  - Geographic Practice Cost Indices (GPCIs) adjustments: increase reimbursement
  - Primary care physicians: 10% bonus for ACA-defined "primary care services"
    - Only if those "primary care services" represent at least 60% of the practice.
    - Definition of "primary care services" requires monitoring
  - Uncertainty about payment formula (RBRVS: Resource Based Relative Value System)
    - if payment reductions occur, this could swamp all other changes
- ***Impact on Rural Hospitals***
  - As coverage increases, hospitals should have less charity care and less bad debt
  - Reductions in Disproportionate Share Hospital (DSH) payments
  - Reductions in market basket updates to prospective payment system hospitals
    - The cumulative impact on revenues should be balanced out to a great extent in the aggregate
    - But net effect may be negative for some hospitals

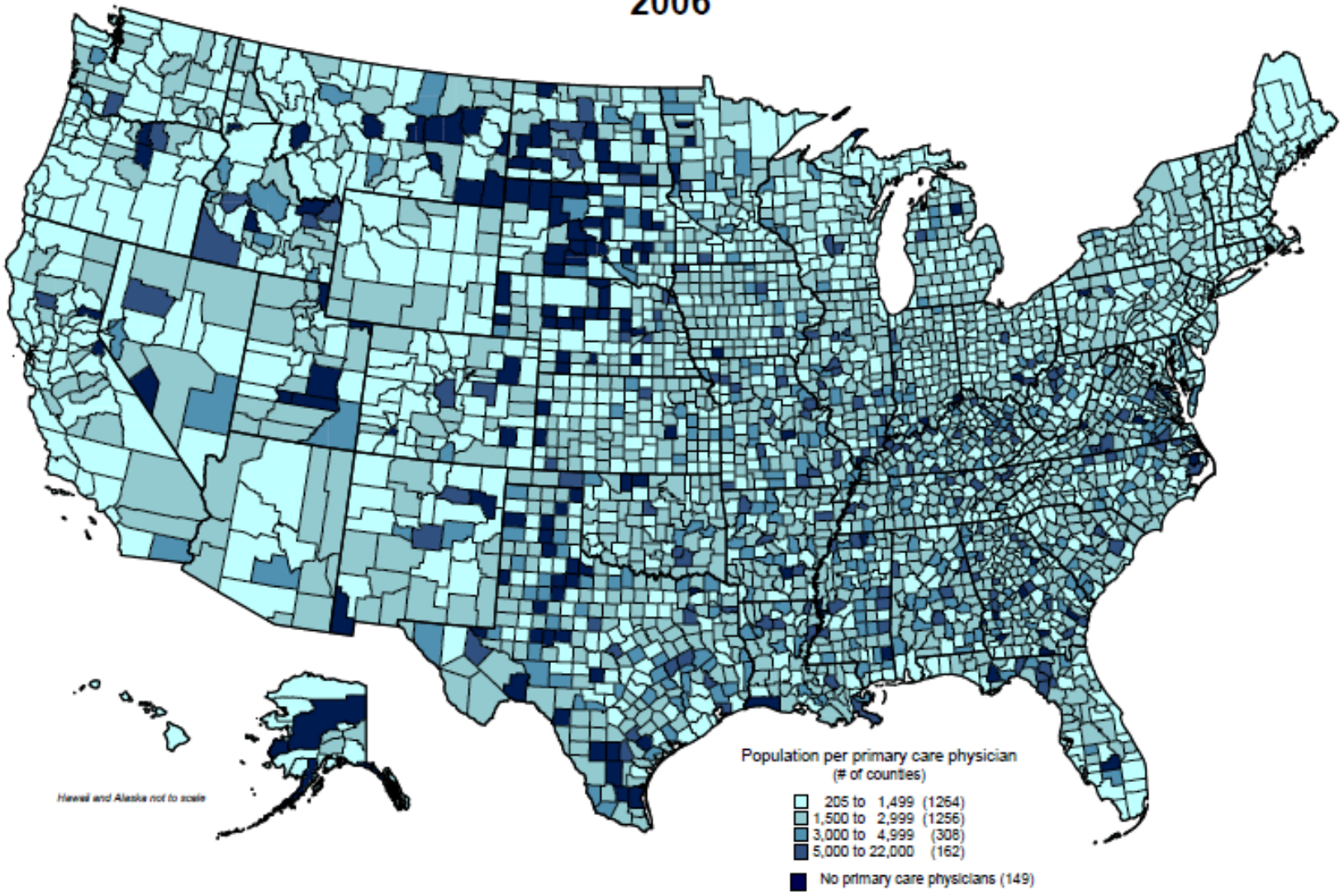
Payment Policy Provisions:
Impact on Rural Persons, Providers and Places

- ***Payment Reforms***
  - New demonstration projects to test new healthcare delivery models
    - Accountable care organizations (ACOs)
    - Bundle payments for acute care episodes
    - Value-Based payment: reward performance based on outcome measures
  - Reductions in payment growth
    - Medicare Advantage
    - Prospective Payment System (productivity adjustment)
  - Encourage efficiency
    - Comparative effectiveness
    - Health information technology
    - Case management and disease management
    - Medical home
  - Impact on rural providers and people: too early to tell? Depends on response of rural providers? Also on regulations

Payment Policy Provisions:
Impact on Rural Persons, Providers and Places

- ***Oversight of Payment Policy***
  - ACA establishes Independent Payment Advisory Board (IPAB)
    - Independent panel of medical experts
    - After January 2014, if Medicare's per capita costs exceed a certain threshold, the IPAB will develop and propose policies for reducing this inflation.
    - Secretary of HHS must institute the policies unless Congress enacts alternative policies leading to equivalent savings.

Population per Primary Care Physicians*
2006

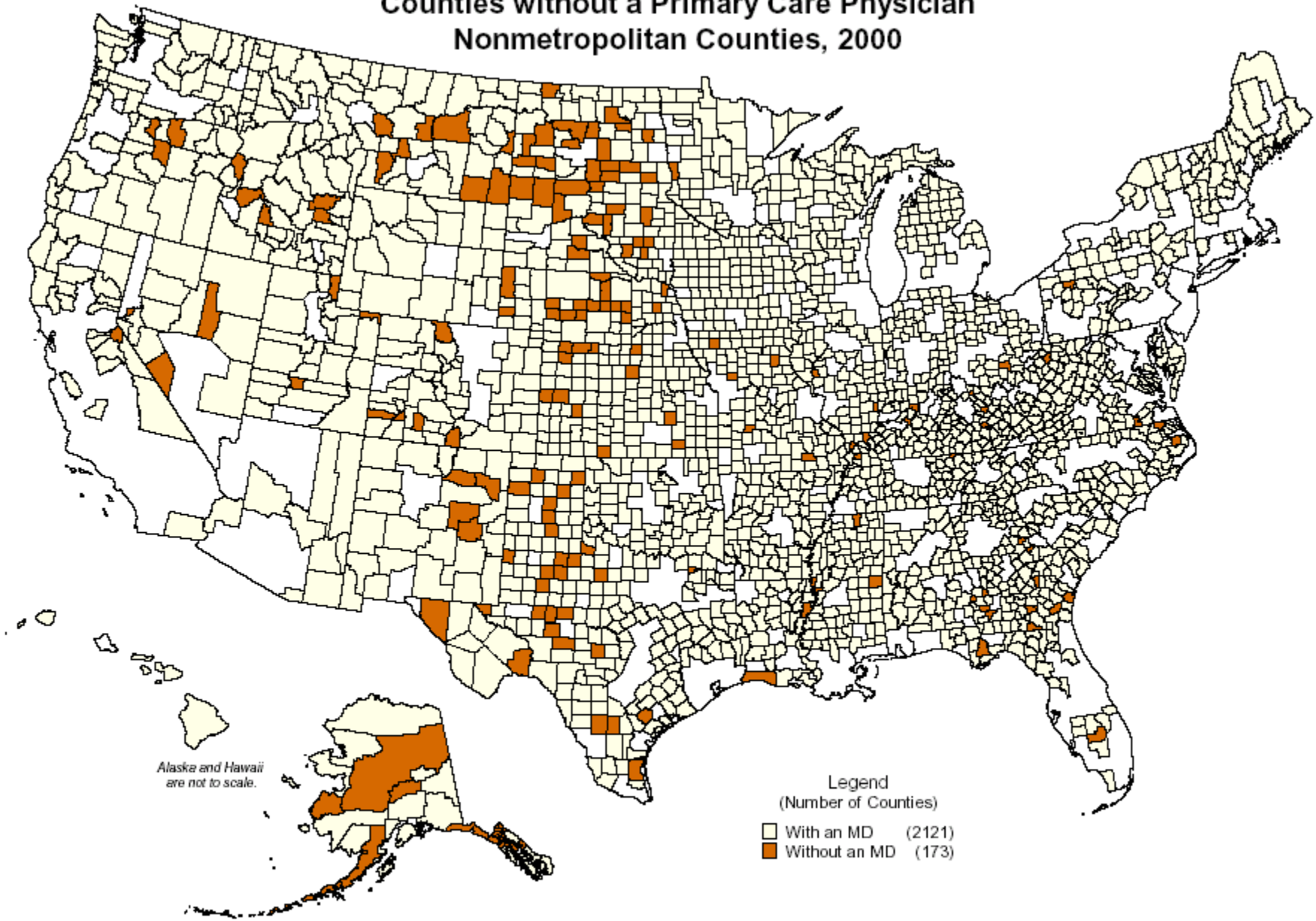


*Includes all active, non-federal MDs and DOs in patient care.

Source: Area Resource File, 2008: US Department of Health and Human Services, Health Resources and Services Administration.

Prepared by: The North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

Counties without a Primary Care Physician
Nonmetropolitan Counties, 2000



Sources: US Census Bureau, 2001; Area Resource File, HRSA, DHHS, 2001.
Produced by: North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

Metropolitan areas are omitted. The New England County Metropolitan Area (NECMA) definition is used to classify nonmetropolitan counties in New England.

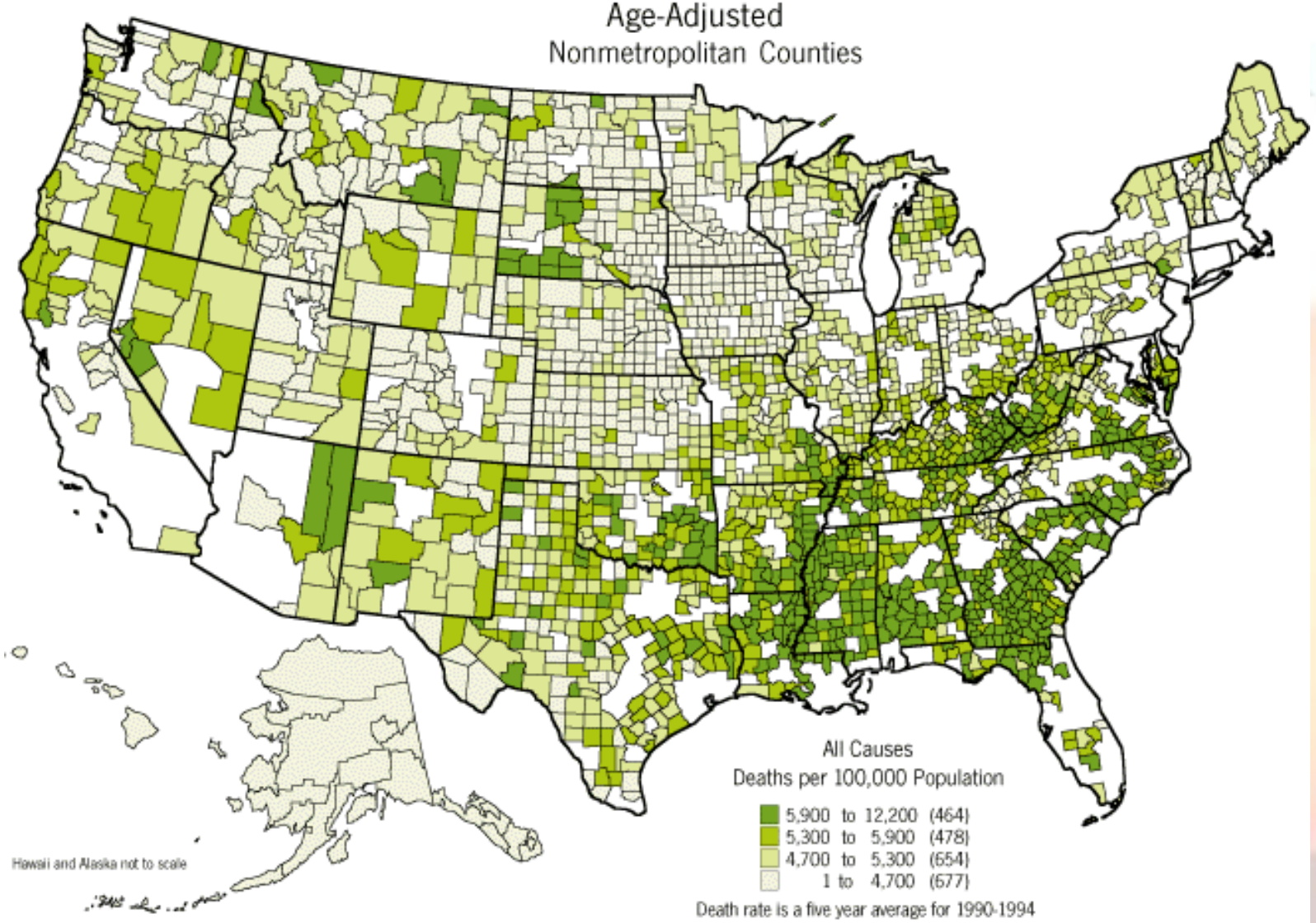
3. Health Status and Chronic Disease in Rural Areas

- There is much focus in health reform on:
  - Public health (e.g., health status)
  - Health Outcomes (e.g. chronic diseases)
- Focus of reform on chronic diseases (e.g. diabetes, obesity, cancer)
  - Will aspects of reform help in these areas?
  - Will these work in rural areas as well as in urban?

MORTALITY RATES, ALL CAUSES, 1990-1994

Age-Adjusted

Nonmetropolitan Counties



Note: Metropolitan counties are aggregated into white areas on the map

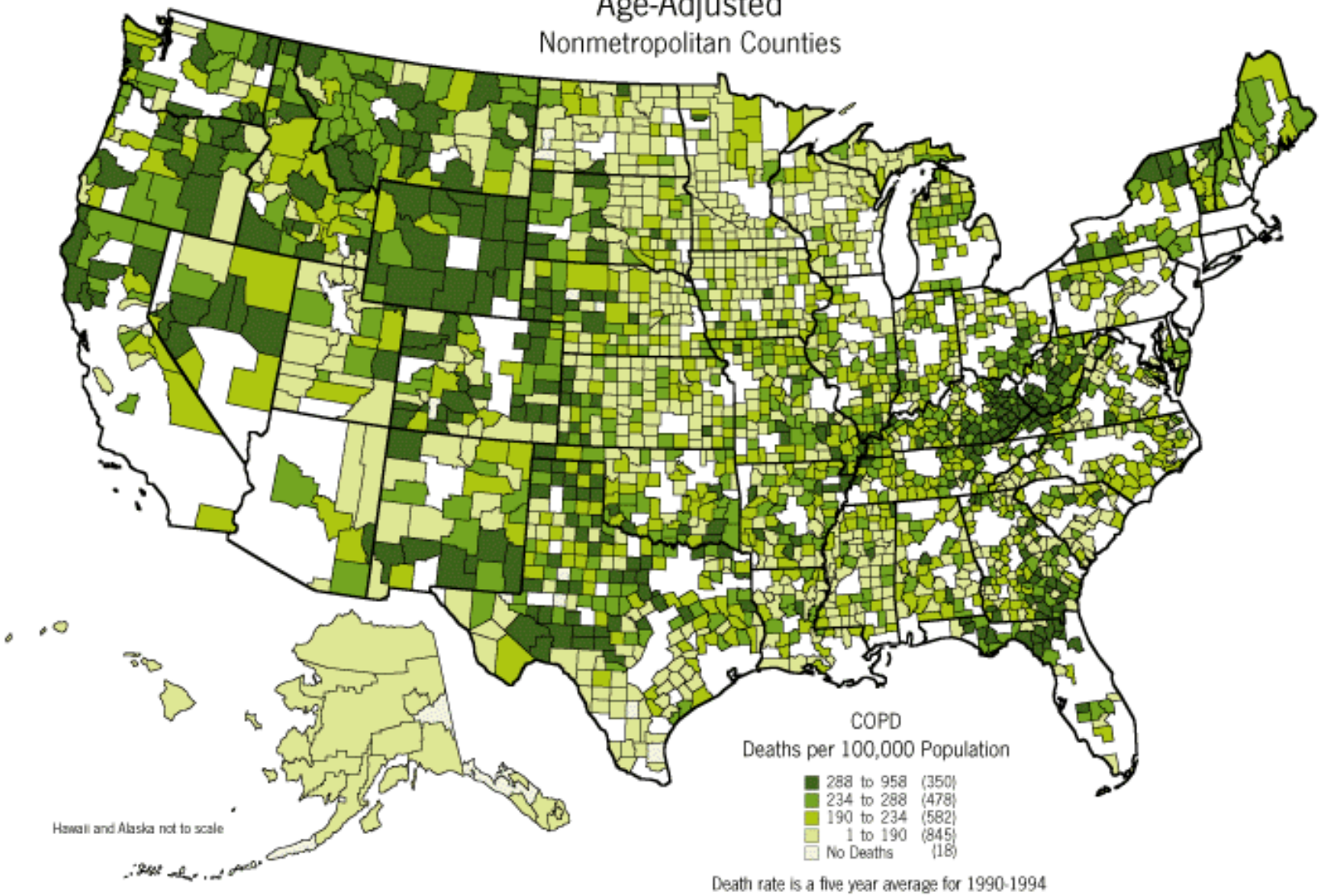
Source: National Center for Health Statistics, 1994; Alaska Bureau of Vital Statistics, 1994.

Produced by: North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, with support from the Federal Office of Rural Health Policy, HRSA, US DHHS.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE MORTALITY RATES, 1990-1994

Age-Adjusted

Nonmetropolitan Counties



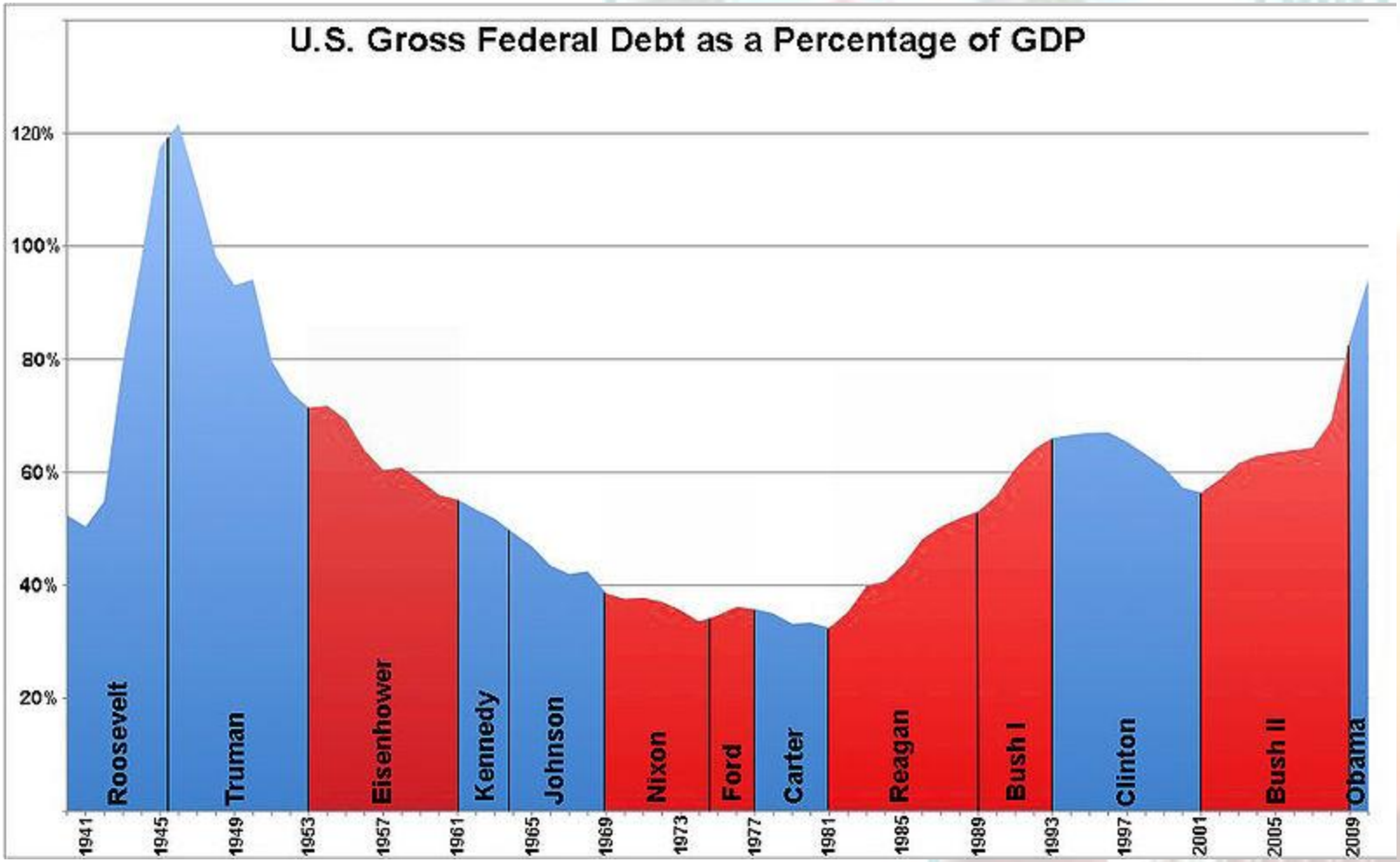
Death rate is a five year average for 1990-1994

Note: Metropolitan counties are aggregated into white areas on the map.

Source: National Center for Health Statistics, 1994; Alaska Bureau of Vital Statistics, 1994.

Produced by: North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, with support from the Federal Office of Rural Health Policy, HRSA, US DHHS.

The Ryan Plan, the Debt, and Federal Health Programs


U.S. Gross Federal Debt as a Percentage of GDP
120%
100%
80%
60%
40%
20%
Roosevelt
Truman
Eisenhower
Kennedy
Johnson
Nixon
Ford
Carter
Reagan
Bush I
Clinton
Bush II
Obama
1941
1945
1949
1953
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2001
2005
2009

Federal Revenues and Outlays as Percent of GDP, 1940-2011

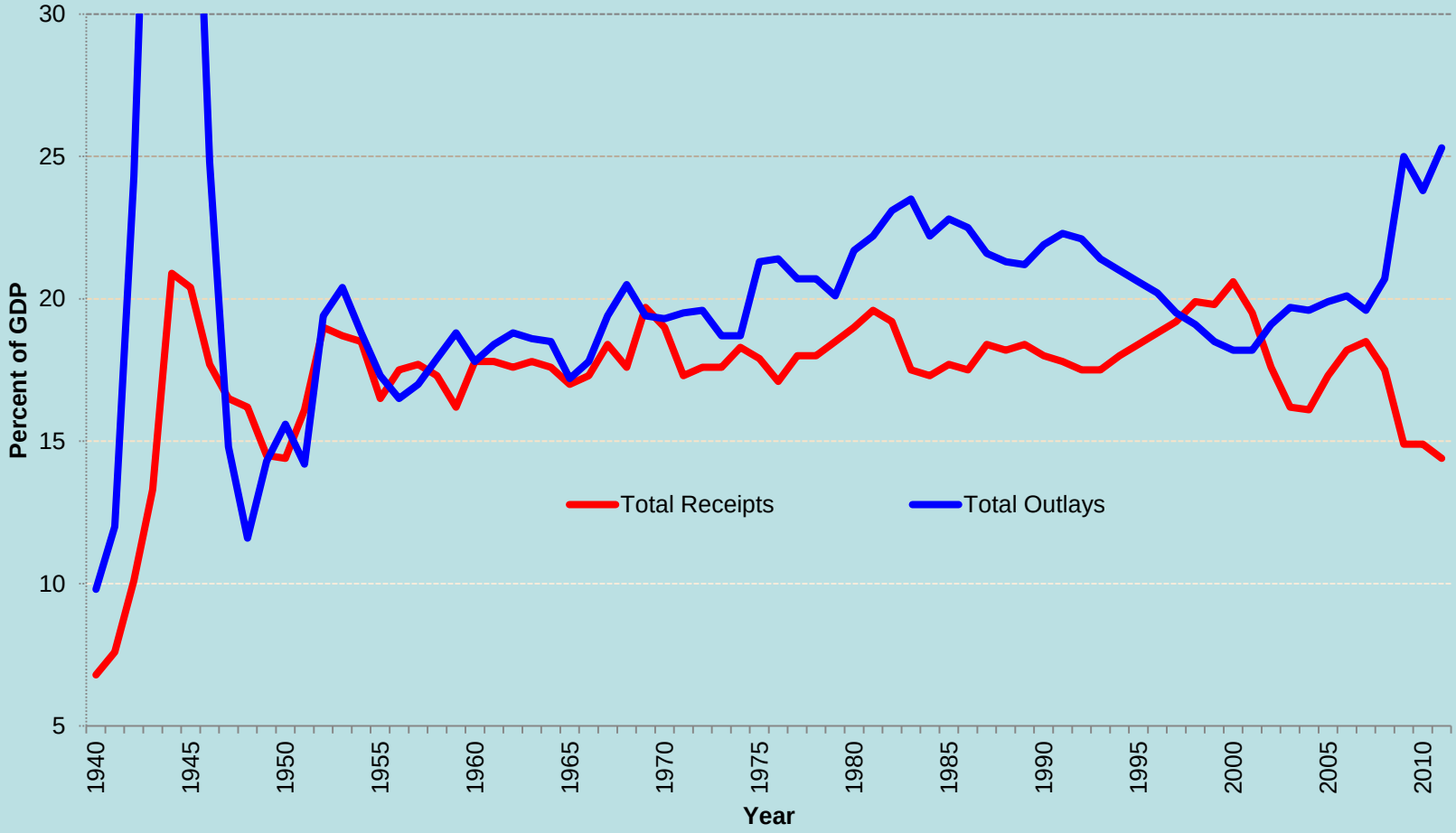


Table 1.

Federal Deficits or Surpluses and Debt

(Percentage of gross domestic product)

	Actual	Projected			
	2010	2022	2030	2040	2050
			Extended-Baseline Scenario		
Total Revenues	15	21	22¼	24¼	26
Total Spending	23¾	23¾	26¼	28¾	30¼
Deficit (-) or Surplus	-9	-2¾	-4	-4½	-4
Debt Held by the Public	62	67	74	84	90
			Alternative Fiscal Scenario		
Total Revenues	15	19¼	19¼	19¼	19¼
Total Spending	23¾	26¾	32¼	38½	45¼
Deficit (-) or Surplus	-9	-7½	-13	-19¼	-26
Debt Held by the Public	62	95	146	233	344
			Proposal		
Total Revenues	15	18½	19	19	19
Total Spending	23¾	20¼	20¾	18¾	14¾
Deficit (-) or Surplus	-9	-2	-1¾	¼	4¼
Debt Held by the Public	62	70	64	48	10

Source: Congressional Budget Office.

Notes: The proposal that CBO analyzed is as specified by Chairman Paul Ryan and his staff. The extended-baseline and alternative fiscal scenarios are as described in Congressional Budget Office, *The Long-Term Budget Outlook* (June 2010; revised August 2010).

Components may not add up to totals because of rounding.

Table 2.

Federal Spending Excluding Interest

(Percentage of gross domestic product)

	Actual	Projected			
	2010	2022	2030	2040	2050
Extended-Baseline Scenario					
Major Mandatory Health Care Programs[a]	5½	7¼	8¾	10¾	12¾
Social Security	4¾	5¼	6	6¼	6
Other Mandatory and Defense and Nondefense Discretionary Spending[b]	12	8¼	8	7¾	7½
Spending Excluding Interest	22½	20¾	22¾	24½	25¾
Alternative Fiscal Scenario					
Major Mandatory Health Care Programs[a]	5½	7¾	9¾	12	13¾
Social Security	4¾	5¼	6	6¼	6
Other Mandatory and Defense and Nondefense Discretionary Spending[b]	12	9¾	9½	9¼	9
Spending Excluding Interest	22½	22¾	25¼	27¼	28¾
Proposal					
Major Mandatory Health Care Programs[c]	5½	5¼	6	5¾	4¾
Social Security	4¾	5¼	6	6¼	6
Other Mandatory and Defense and Nondefense Discretionary Spending[b]	12	6	5¼	4¼	3½
Spending Excluding Interest	22½	17	17½	16¾	14

Source: Congressional Budget Office.

Notes: The proposal that CBO analyzed is as specified by Chairman Paul Ryan and his staff. The extended-baseline and alternative fiscal scenarios are as described in Congressional Budget Office, *The Long-Term Budget Outlook* (June 2010; revised August 2010).

Components may not add up to totals because of rounding.

a. Includes Medicare, Medicaid, exchange subsidies, and the Children's Health Insurance Program (CHIP).

b. Incorporates collections of premiums paid by Medicare beneficiaries.

c. Includes Medicare and Medicaid as structured under the proposal and CHIP. There are no exchange subsidies under the proposal.

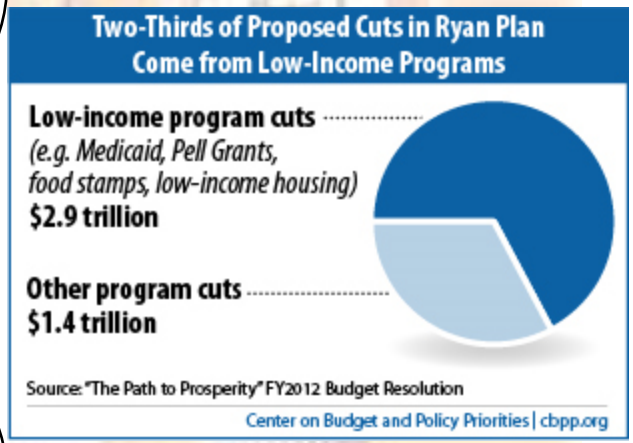
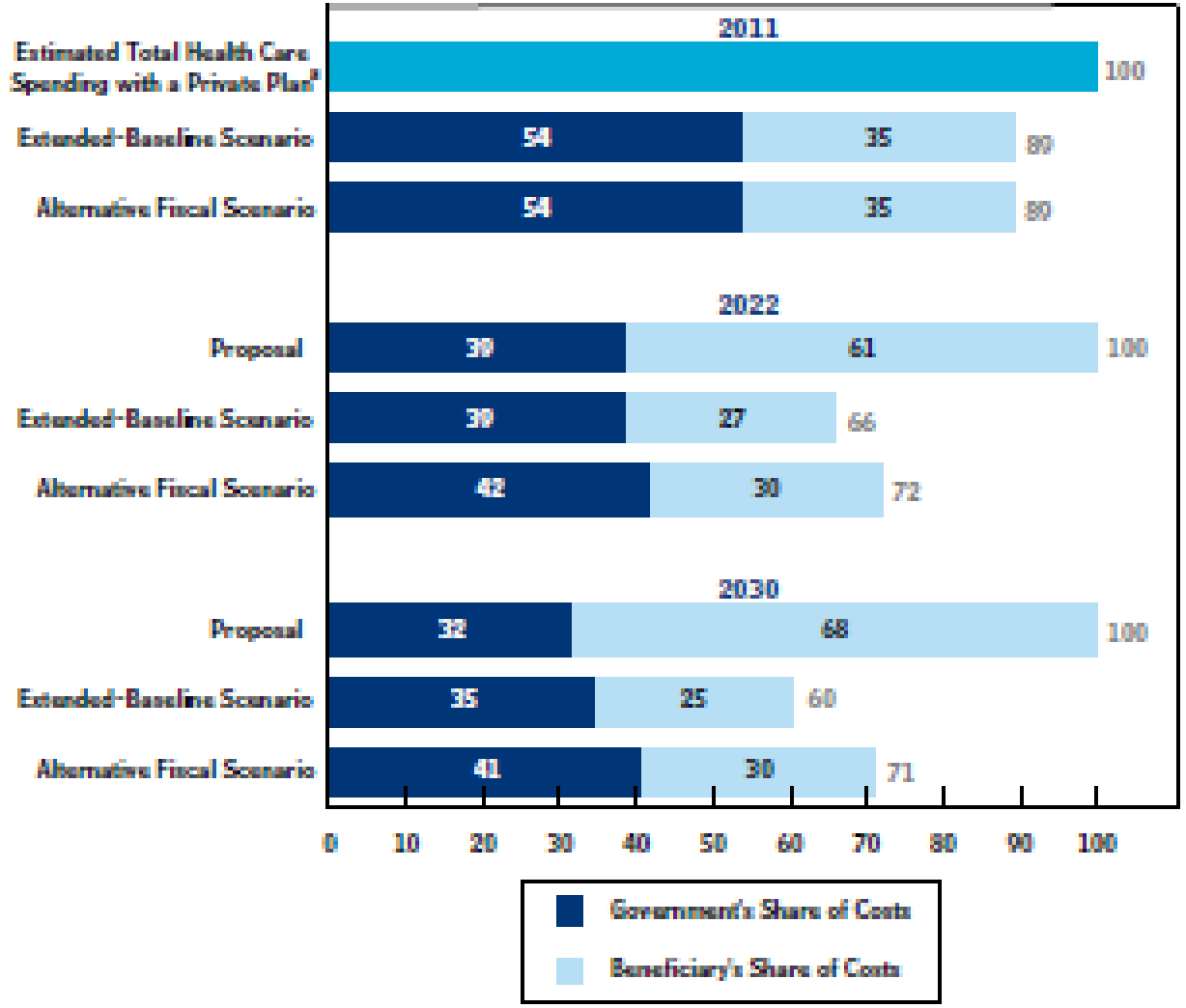


Figure 1.

Shares of Spending on Health Care for a Typical 65-Year-Old with a Standardized Health Insurance Benefit

(Percentage of total spending with a private plan)



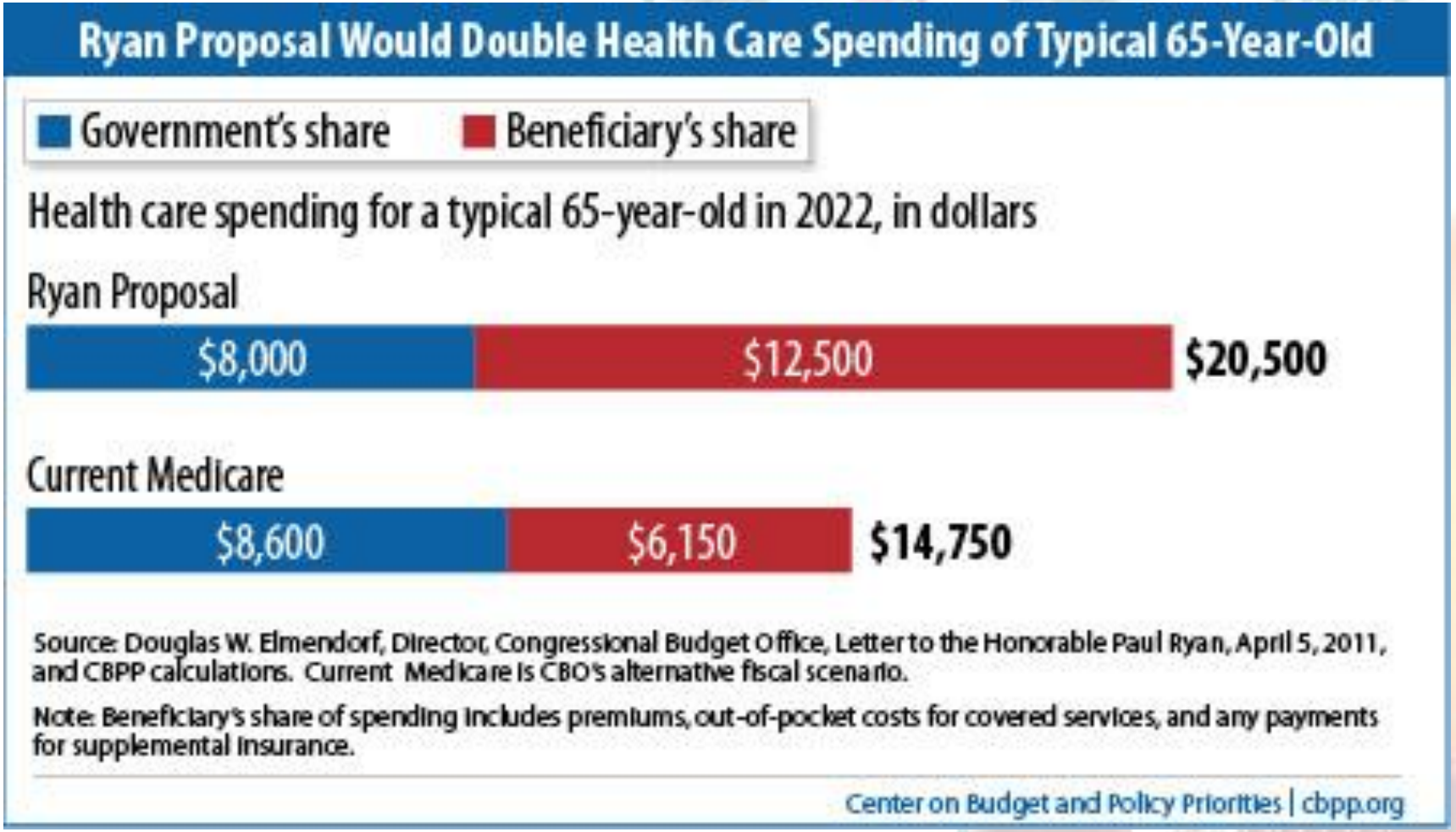
Source: Congressional Budget Office.

NOTE: Two things occur:

Total benefits offered drop: to 89% of baseline in 2011 then 60-71% in 2030.

But also **government's contribution drops** for a typical 65-year-old's total health care spending drops as well: from 54% in 2011 to between 35-41% in 2030.

So beneficiary pays more for less


Ryan Proposal Would Double Health Care Spending of Typical 65-Year-Old
Government's share
Beneficiary's share
Health care spending for a typical 65-year-old in 2022, in dollars
Ryan Proposal
$8,000
$12,500
$20,500
Current Medicare
$8,600
$6,150
$14,750
Source: Douglas W. Elmendorf, Director, Congressional Budget Office, Letter to the Honorable Paul Ryan, April 5, 2011, and CBPP calculations. Current Medicare is CBO's alternative fiscal scenario.
Note: Beneficiary's share of spending includes premiums, out-of-pocket costs for covered services, and any payments for supplemental insurance.
Center on Budget and Policy Priorities | cbpp.org

Ryan Plan and Medicare:
Devil in the Details

- Starting in 2022, convert Medicare system to a system of premium support payments to help them purchase private health insurance.
  - Premium support payments would vary with the health status of the beneficiary.
  - The payment for 65-year-olds in 2022 is specified to be $8,000, on average (based on projected Medicare spending in 2022); after 2022 indexed for inflation (CPI)
  - Premium support payments would also vary with the income of the beneficiary (top 2% would receive 30% of benefits, next 6% would receive 50% of benefits; rest would receive 92% of benefits)
- Increase the age of eligibility for Medicare by two months each year starting in 2022 until it reached 67 in 2033.

The "Social Contract”

- Social contract:
  - workers support non-workers with the understanding that future workers will do the same for them should they require transfers.
  - Blinder discusses social contract as part of *"filialism"*:
    - *“any generation that abrogates the social compact when young will lose not only the benefits it derives from the consumption of the old, but also its own future claims to benefits." (page 31)*
  - Kingson: understanding the common stake in intergenerational transfers rests on the "life course perspective" not a “cross-sectional perspective”

Summary sources and Resources

- National Advisory Committee on Rural Health to HHS ruralcommittee.hrsa.gov/
- Institute of Medicine report www.iom.edu
- Federal Office of Rural Health Policy: www.ruralhealth.hrsa.gov
  - Rural Health Research Centers ruralhealth.hrsa.gov/policy/rhrccoop.htm
- Rural Assistance Center: www.raconline.org
- Flex Monitoring Team www.flexomonitoring.org
- RUPRI www.rupri.org
  - Community Informatics Resource Center: www.circ.rupri.org
- Medicare: www.cms.gov

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