NATIONAL RURAL HEALTH ASSOCIATION

Three Critical Amendments Needed in Rural Health Care Reform

Congress has long recognized the importance of the rural health care safety net and has steadfastly worked to protect it. And now, much of the protections created to maintain access to care for the 62 million who live in rural America are in jeopardy. **We implore Congress to continue its fight to protect rural patients' access to care. At minimum, three amendments are critical for rural patients and providers:**

Amendment 1 - Medicaid – Though most rural residents are in non-expansion states, a higher proportion of rural residents are covered by Medicaid (21 percent vs. 16 percent).

Congress and the states have long recognized that rural is different and thus requires different programs to succeed. Rural payment programs for hospitals and providers are not 'bonus' payments, but rather alternative, cost-effective and targeted payment formulas that maintain access to care for millions of rural patients and financial stability for thousands of rural providers across the country. Any federal health care reform must protect a state's ability to protect its rural safety net providers. The federal government must not abdicate its moral, legal, and financial responsibilities to rural, Medicaid eligible populations by ensuring access to care.

Any federal health care reform proposal must protect access to care in Rural America, and must provide an option to a state to receive an enhanced reimbursement included in a matching rate or a per capita cap, specifically targeted to create stability among rural providers to maintain access to care for rural communities. Enhancements must be equivalent to the cost of providing care for rural safety net providers, a safeguard that ensures the enhanced reimbursement is provided to the safety net provider to allow for continued access to care. Rural safety net providers include, but not limited to, Critical Access Hospitals, Rural Prospective Payment Hospitals, Rural Health Clinics, Indian Health Service providers, and individual rural providers.

Amendment 2 - Market Reform – In 2017, Forty-one percent of rural marketplace enrollees have only a single option of insurer, representing 70 percent of counties that have only one option. This lack of competition in the marketplace means higher premiums. Rural residents average per month cost exceeds urban ($569.34 for small town rural vs. $415.85 for metropolitan).[1] Based on what we already know, the situation is far worse for 2018 with many counties having no insurers in the marketplace and dramatically increased premiums.

Rural Americans are more likely to have obesity, diabetes, cancer, and traumatic injury; they are more likely to participate in high risk health behaviors including smoking, poor diet, physical inactivity, and substance abuse. Rural Americans are more likely to be uninsured or underinsured and

[1] For 2015 ACA 'Silver' exchange plans.

less likely to receive employer sponsored health insurance. Rural communities have fewer health care providers for insurers to contract with to provide an adequate network to serve the community.

Any federal health care reform proposal must address the fact that insurance providers are withdrawing from rural markets. Despite record profit levels, insurance companies are permitted to cherry pick profitable markets for participation and are currently not obliged to provide service to markets with less advantageous risk pools. Demographic realities of the rural population make the market less profitable, and thus less desirable for an insurance company with no incentive to take on such exposure. In the same way that financial service institutions are required to provide services to underserved neighborhoods, profitable insurance companies should be required to provide services in underserved communities.

Amendment 3 - Stop Bad Debt Cuts to Rural Hospitals – Rural hospitals serve more Medicare patients (46 percent rural vs. 40.9 percent urban), thus across-the-board Medicare cuts do not have across the board impacts. A goal of the ACA was to have hospital bad debt decrease significantly.

However, because of unaffordable health plans in rural areas, rural patients still cannot afford health care. Bad debt among rural hospitals has increased 50 percent since the ACA was passed. According to MedPAC "Average Medicare margins are negative, and under current law they are expected to decline in 2016" has led to 7 percent gains in median profit margins for urban providers while rural providers have experienced a median loss of 6 percent.

If Congress does not act, all the decades of efforts to protect rural patients' access to care, could rapidly be undone. The National Rural Health Association implores Congress to act now to protect rural health care across the nation.

Hospital Revenue Loss due to Medicare Bad Debt Reductions

State	Revenue Loss *in millions*
AL	34.7
AK	3.7
AR	19.7
AZ	6.7
CA	78.4
CO	13.6
CT	2.3
DE	2.0
FL	18.0
GA	74.1
HI	1.6
ID	3.2

State	Revenue Loss *in millions*
IL	60.8
IN	74.5
IA	8.6
KS	34.1
KY	70.2
LA	27.5
ME	25.0
MD	0.2
MA	5.7
MI	84.5
MN	6.3
MS	25.0
MO	46.4

State	Revenue Loss *in millions*
MT	5.4
NE	4.8
NV	7.6
NH	9.2
NJ	–
NM	9.6
NY	24.0
NC	73.5
ND	2.2
OH	60.6
OK	37.2
OR	19.5
PA	48.3

State	Revenue Loss *in millions*
RI	–
SC	19.2
SD	2.3
TN	77.0
TX	93.3
UT	1.9
VT	8.5
VA	26.1
WA	23.3
WV	18.0
WI	52.4
WY	2.0