A New Day for Health Delivery: Impact of Health Reform on Rural Health in North Dakota

Alerus Center
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Connecting resources and knowledge to strengthen the health of people in rural communities.

Center for Rural Health

- Established in 1980, at The University of North Dakota (UND) School of Medicine and Health Sciences in Grand Forks, ND
- One of the country’s most experienced state rural health offices
- UND Center of Excellence in Research, Scholarship, and Creative Activity
- Focus on:
  - Education, Training, and Resource Awareness
  - Community Development and Technical Assistance
  - Native American Health
  - Rural Health Workforce
  - Rural Health Research
  - Rural Health Policy
  - Program Evaluation
- Web site: http://ruralhealth.und.edu
Why the Need for Health Reform

• U.S. health system – equity issues
• Spend the most but do not have the best health outcomes
• Growing recognition that we can no longer afford what we have, how we distribute services and benefits, how we pay for care, and how we access care
• Rural communities have unique issues
  o Access along with coverage
  o Population that is poorer, older, and sicker
  o Health care in a rural community is a community and economic resource – how we see ourselves

Why the Need for Health Reform (continued)

• Approximately 46-47 million Americans without health insurance or about 16% of population –ND about 8-16% or 50-68,000
• 12-14,000 Americans lose health insurance every day
• 2,500 file for bankruptcy everyday due to health and medical costs
• Health care spending was $2.4 trillion in 2008 and expected to grow to $4.3 trillion by 2018
• Health accounts for 17.6% of GDP (20% by 2018)
  o France spends 9.5%
  o Canada spends 9.7%
• In 2008, about $7,900 per person was spent on health care in the U.S.
• U.S. spends about twice as much per capita on health care as other countries
• Health care spending is over 4 times that spent on national defense
Why the Need for Health Reform (continued)

- **Insurance coverage**
  - 60% of Americans have insurance from their employer (down from 66% in 2000) – ND it is about 62% - 52% of ND farmers receive insurance through non-farm source
  - 28% have insurance that is government based (Medicare, Medicaid and military)
  - 9% have insurance they purchase themselves
  - 15% are uninsured

- Average premium paid by a business for a family of 4 health plan - $12,700 (2008)
- Since 1999, employment based health insurance premiums increased by 120% while inflation rose by 44% and wage growth by 29%
- In Feb. 2010, Anthem Blue Cross (of WellPoint) announces plan to increase premiums by 25%; another plan announces increases of 39%
- Premium growth for employer plans has been highest for small firms with less than 24 people
- Average employee contribution has increased more than 120% since 2000
- About 1.5 million families lose their homes every year due to unaffordable medical costs

Why the Need for Health Reform (continued)

- **Health Status**
  - U.S. ranks 28th in life expectancy (2008) in comparison to other countries*
  - 21st in age standardized mortality rate for cardiovascular disease (2008)*
  - 14th in age standardized mortality rate for cancer (2008)*
  - The Commonwealth Fund rates the U.S. last in health care system performance when compared to a group of six countries that include Australia, Canada, Germany, New Zealand and the United Kingdom. The U.S. spends twice as much as these six countries on a per-capita basis, yet it is last on dimensions of access, patient safety, efficiency and equity.*
  - Fewer physicians per capita (2.4:1000 U.S. vs. 3.1:1000 other industrialized countries)
  - 54% of U.S. patients do not seek recommended care, fill prescriptions, or visit a doctor because of health costs (7-36% in other countries)

* United Health Foundation – America’s Health Rankings 2008
Rural Health Advocacy

- **National Rural Health Association (NRHA)**
  - Coverage does not equal access
    - Rural population is older, poorer, and sicker
    - Major rural issues include basic access issues such as workforce and keeping rural hospitals and clinics open
    - We can improve coverage but risk losing access points such as hospitals, clinics, ambulances, and providers
  - **Rural focus**
    - *Workforce* – National Health Service Corps, Health professions education improvements, expand rural residency programs, expand Medical School rural training tracks, incentives for rural medicine
    - *Medicare equity for rural facilities* – improvements for Critical Access Hospitals and Prospective Payment System hospitals
    - *Improve access for vulnerable populations* – Mental health workforce, rural veterans (tele-health, contracts with local rural health providers, mental health), outreach to uninsured rural children, rural impact study for significant Medicare changes

Other Rural Health Considerations- Offered by the Center for Rural Health

- Rural health system viability important for improvement of health status
- Rural health system viability important to economic and community development
- Need for greater flexibility in health facility structures (new models of care – Frontier Extended Stay Clinic from AK)
- Need for greater flexibility to achieve better health outcomes and organizational performance (Medical Home Model)
- Need for greater awareness and emphasis of quality improvement and organizational performance
- Need for rural communities and citizens to be advocates for collaboration, networks, and regional decision making
Key Health Reform Provisions Affecting Rural Health

• General Benefits
  o Immediate elimination (effective in 6 months) of denial of coverage to children with pre-existing conditions – 144,000 children
  o Affordable coverage options for 70,000 uninsured North Dakotans and 63,000 who purchase insurance through individual market
    ▪ Access to affordable insurance options for 8,200 uninsured North Dakotans with pre-existing conditions
  o Tax credits for up to 15,600 ND small businesses (up to 35% for businesses with 25 or fewer employees or 90% of all businesses in the state)
  o Development of High Risk Pools (effective in 3 months)
  o Medicaid expanded with first three years covered by feds, then sliding cost share
  o Close “donut hole” in Medicare prescription drug benefit – 106,000 ND
  o 106,000 Medicare beneficiaries eligible for free, annual wellness visit and no cost sharing for prevention services
  o Lower Medicare costs for 98,600 beneficiaries not enrolled in Medicare Advantage
  o Eliminates annual and lifetime limits on insurance coverage (cap on benefits) (effective in 6 months)
  o Eliminates recision on existing coverage (effective in 6 months)

• Health Workforce
  o Bonuses for PC in HPSA
  o NHSC – significant increase in funding
  o Invests in low interest loans, scholarships, and loan repayment programs
  o New competitive state health care workforce development grant program
  o Invests more in diversifying workforce – scholarships and LRP
  o Provides faculty incentives for medicine, nursing, and dental schools
  o Excludes payments made under state LRP from taxable income if serving in HPSA
  o Rural physician training grants – special rural training programs – medical schools
  o GME Improvements – new PC residency efforts – 1) target RHCs and FQHCs – demonstration and 2) grant or contract program for training residents in underserved
  o Redistribution of residency slots – increase number in rural with excess from urban
  o Undergraduate medical education – new grant programs
  o AHEC – increased funding
Key Health Reform Provisions Affecting Rural Health

• Medicare and Medicaid Improvements
  o Medicare Physician Fee Schedule – improvements via geographic adjustments (Blue Dog initiative)
    ➢ $400 million in FY 2010 and 2011 of physician payments
    ➢ $400 million in FY 10 and 11 for PPS hospitals
  o Pharmacy reimbursement – increased payments for retail pharmacies
  o MedPAC study on adequacy of Medicare payments for rural health providers
  o Adjustment in the floor for the wage index for frontier states
  o Technical correction for CAH Method II Billing reimbursement – to receive 101%
  o Medicaid payment to PC no less than Medicare rate
  o Extension of Programs Affecting Physicians and other services set to expire
    ➢ Add-ons for ambulance payments
    ➢ Add-ons for mental health fee schedule
    ➢ Payment for technical component of certain physician therapy caps

• Extension of Important Rural Medicare Protections
  ➢ Medicare Dependent Hospital Program
  ➢ Inpatient hospital payment adjustment for low volume hospitals
  ➢ Flex program
  ➢ Reasonable cost payments for clinical lab tests furnished in hospitals

• Other Improvements:
  o Quality
    ➢ Establishes a national quality strategy (development of goals, priorities, grants/contracts, collection and analysis of data support, input from stakeholders)
    ➢ Provides investments for medical home model (Accountable Care Organizations) and other advanced care coordination and disease management models
    ➢ ACO to integrate care and improve quality and then would share in savings from cost reductions (i.e., as costs decreased the ACO would receive more dollars as re-investments)
    ➢ Patient Centered Outcomes Research Institute (independent non-profit to provide for research on clinical effectiveness of different medical treatments and services)
    ➢ Authorizes contracts for public and private entities to conduct quality related research
Key Health Reform Provisions Affecting Rural Health

- **Other Improvements (Cont.):**
  - AHRQ to conduct research on health delivery system improvement and best practices
  - AHRQ to disseminate research findings from the Institute and other sources including “best practices”
  - Funding for Institute and other research secured in part from an assessment on health insurance plans
  - Creates a Medicare and Medicaid Innovation Center – CMS required to develop and test innovative payment and care delivery models that emphasize coordination of care, quality, improvement, and efficiency
  - Lowers payments to hospitals with high rates of preventable hospital acquired infections
  - Removes financial barriers to preventive care and encourages prevention
    - New grant program to states for people 55-64 to address chronic disease risk factors, help at-risk individuals receive clinical treatment, and conduct evidence-based interventions
    - Eliminates any co-pays and deductibles for recommended preventive care and screenings (cancer and mental health)
    - Provides an expanded and sustained national investment in prevention and public health

- **American Indian Impact**
  - Permanently reauthorizes the Indian Health Care Improvement Act
  - Updates and improvements to Indian Health Service Scholarship program
  - Changes in requirements for licensing (not individual states)
  - Demonstration programs for new, innovative models in health care that are tribally driven
  - Improves and expands mental and behavioral health programs
  - Authorizes comprehensive youth suicide prevention programs
  - Improves and expands cancer screening programs
  - Enhances coordination between VA and IHS for Native veterans

- **Increased funding for CHC**
- Expands 340 B medications – CAH, SCH, MDH – only inpatient; does not include RHC

NRHA forming RHC Work Group and other key focus areas as part of Post-Health Reform strategy
Contact us for more information!

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