Health Reform: A National Issue with Rural Implications

MPH 504 Leading & Managing Public Health Systems

Brad Gibbens, Deputy Director and Assistant Professor
Center for Rural Health

October 14, 2013

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

Home to seven national programs

Recipient of the UND Award for Departmental Excellence in Research

Focus on
- Educating and Informing
- Policy
- Research and Evaluation
- Working with Communities
- American Indians
- Health Workforce
- Hospitals and Facilities

ruralhealth.und.edu
Health Reform

Can Be

Funny

(Believe it or Not)
(Part 1) But Before Health Reform, Let’s Discuss Rural Health

Why is Rural Health Important?

Why is the Concept of Community Important?

A Guiding Principle of Rural Health

Vision is the art of seeing things Invisible

Jonathan Swift
Comparative Rural and Urban Strengths and Weaknesses

Rural | Urban
---|---
**Strengths:**
Strong informal support network | More stable economy
Fundraising | Availability of resources
Cohesive | Availability of professionals
Established interdependence | Growing and diverse population
Collaboration | Change is natural

**Weaknesses:**
Skewed population demographics | Lack of cohesiveness
Fluctuating economy | Limited informal support
Resistance to change | Competition among providers
Shortage of professionals | Competition for fundraising
Lack of resources | More contentious-fractiousized

Center for Rural Health

They’ll do ANYTHING to prevent us from stopping Obamacare!
Rural Community Health Equity Model

Environmental Conditions
- Demographics
- Economics
- Policy
- Health Status
- Workforce
- Finance
- Technology
- Health System Change
- Rural Community Culture & Dynamics

Impact on Community or Health Organization
- Threat to survival
- Growth/Decline
- Identity
- Perception toward change
- Perception toward opportunity
- How we respond

Community Action for Health Equity
- What do people think, want, or need?
  - Assessments
  - Forums-Discussions
  - Interviews
- Community Ownership (not health system ownership)
  - Collaboration
  - Inclusion
  - Participation
  - Interdependence
- Community Capacity
  - Skills and knowledge
  - Leadership development
  - Planning and advocacy
  - Manage change – non reactive

Source: Brad Gibbens, Deputy Director
UND Center for Rural Health

Why Is Community Important to Rural Health?

Rural culture – more interdependence, connectedness, cohesiveness, collaborative, and people identify with institutions and each other – community support

Relationships – things get done because of people, and sometimes don’t get done because of people – are the right people at the table?

Rural health contributes to the community – provision of health services (access), improvement of health, economic contributions (jobs), community development, civic members and leadership, health facilities are a sense of community identity and pride

Communities contribute to the rural health system – employees, purchase of health services, financing, fund raising, volunteers, ideas and vision
What is Rural Health?

• Rural health focuses on population health and improving health status but with an emphasis on access to essential health services, health equity, and health delivery systems
  - Quality of care, access to care and services, availability of care and services, cost of care, ability to afford care, health promotion and disease prevention, disease management, financing, health system viability, community viability, population change, economics – “drivers”

• Rural health relies on infrastructure: facilities, providers, services, and programs available to the public (all with quality, access, and cost implications)
  - Some are for-profit and some private or public non-profit entities
  - More and more health networks – independence with collaboration
    - Examples include: Community hospitals, clinics, public health, EMS, nursing homes/aging services, home health, behavioral/mental health, dental, pharmacy, and others

• Rural health is not simply urban health in a rural or frontier area
What is Rural Health?

**Philosophy:** rural people have the same right to expect healthy lives and access to care as do urban people – *fairness frame (health equity)*
- Access essential services locally or regionally
- Access to specialty services through network arrangements
- Quality of care on par with urban
- Availability of technology and a well trained workforce

**Rural health is very community focused – *interdependence frame***
- Integral part of what a community is and how people see themselves
- Community engagement – public input is fundamental
- Sectors: Economic/business, public/government, education, faith/church, and health/human services
- Direct services provided to the public and secondary impact for other sectors
- Major employer

---

**Rural Health Issues: Are These Important Within Health Reform?**

- Health disparities
- Access to care and availability and viability of health facilities
- Delivery system reform
- Health workforce
- Quality of care
- HIT
- Health insurance
- Networking and collaboration
- Community economics and community development/engagement
- Finance and funding
- EMS

*Source: Center for Rural Health Community and Meeting Survey of Issues, 2008-2012*
(Part 2) What is the Context for Health Reform?

What Drives Health Reform?

- US Census estimate (2011) **48.6 million Americans without health insurance or 15.7% of the population** and (2010 estimate) of 49.9 million Americans without health insurance or about 16.3% of population
  - ND about 9-12% or 63,000-84,000 (various sources)
  - ND American Indian about 33% (2004 statewide survey CRH)
- 12-14,000 Americans lose health insurance every day
- 2,500 file for bankruptcy everyday due to health and medical costs
- Health accounts for **17.9% of GDP** (2010) (9% in 1980, 16.2% in 2008, and forecast to be 19.6% by 2021)
  - Netherlands spends 12.0% (2011)
  - France spends 11.6% (2011)
  - Germany 11.1% (2011)
  - Canada spends 11.2% (2011)
  - United Kingdom 9.3% (2011)
  - OECD average was 9.6% (Organization for Economic Cooperation and Development -34 countries)
- **U.S. Health care spending was $2.6 trillion** in 2010 ($1.4 Trillion in 2000, and $0.7 Billion in 1990, $256 B in 1980) and expected to grow to $4.64 Trillion by 2020
- In 2011, about $8,362 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
- U.S. health care spending averaged annual increase was 9.9% (1970-2008) or 2.5 times faster than GDP (since recession 4%, and projection is 5.7% until 2021)
Insurance coverage

- 55.1% (2010) of Americans have insurance from their employer (down from 64% in 2000) –
  - ND it is also about 55%
  - 52% of ND farmers receive insurance through non-farm source
- 64% of Americans have private health insurance
- 36% have insurance that is government based (Medicare, Medicaid and military)
  - 16.5% - Medicaid
  - 15.2% - Medicare
  - 4.4% - Military
- 15.7% (2011) are uninsured (down from 16.3% in 2010)
  - 11.1% White (non-Hispanic)
  - 19.5% African American
  - 30% Hispanic American

- **Cost of insurance** increasing at rapid rate – 120% increase since 1999 to 2010
- About **1.5 million families lose their homes** every year due to unaffordable medical costs


Health Status Indicators

- U.S. (in 2011) ranked 32nd in life expectancy (28th in 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 overall health care system performance when compared to a group of six countries that include Australia, Canada, Germany, Netherlands, 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 efficiency and equity and 6th on quality and 6.5th on access.
- 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)

Source: United Health Foundation – America’s Health Rankings 2011
Why Is U.S. Health System So Costly?

- Chronic Disease
  - Account for 75% of the over $2.6 trillion spent on health care
- Higher level of Per Capita Income (about 34% of cost differences)
  - Highest in the world, associated with higher health care costs (more money more spending)
  - Yet, not associated with medical outcomes (spend more, higher Per capita, but lower outcomes)
- Discretionary Medical Decisions (i.e. Practice Variation- Will Evidenced-based Medicine Help?)
  - Higher costing advanced care with medical specialists and availability of high tech treatment; less reliance on Primary Care – Significant regional variation (treatment process) about 21% of the cost differences may be associated with higher costing treatment decisions
  - Overall, U.S. spending on physicians is 5x higher than peer countries (accounts for about 37% of spending gap)
  - 3-6x higher costs for specialty physicians than peer countries
  - PC physician salaries roughly half specialty physicians
  - U.S. public and private payers pay more for specialty providers than other countries, and more for specialty over PC
- Higher pharmaceutical costs
- Higher administrative costs due to private health plans (ACA attempts to lower)
- Tort and Defensive Medicine (ACA does not address this)


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 viability important for improvement of health status
- Rural health 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 and Community Health Improvement Program -CHIP)
- Need for greater flexibility to achieve better health outcomes and organizational performance (Medical Home Model)
- Need for rural communities and citizens to be advocates for collaboration, networks, and regional decision making
(Part 3) The Affordable Care Act (ACA): An Enigmatic Policy in a Period of Political Transition

So Where are We Now?
Why the Need for Health Reform

- U.S. health system – access and cost create equity issues
- Spend the most but do not have the best health outcomes
- Growing recognition that we can no longer operate the way we have in the past: how we distribute services and benefits? How we pay for care? and How we access care?
- Rural communities have unique issues
  - Access – 1) system viability and workforce availability along with 2) insurance coverage
  - Population that is poorer, older, and sicker
  - Health care in a rural community is a community and economic resource – how we see ourselves, fabric of the community not just services

What are the Overarching Themes in Health Reform?

- **Changing and restructuring our health delivery system** in effort to improve quality of care to improve the public’s health and to “bend the cost curve” and “slow the rate of growth in costs”
  - Improving health via emphasis on more individual responsibility, health promotion, disease prevention and better disease management, better coordination of care, improving health workforce supply, different payment structures and delivery.
- **Improving access to care** - “universal coverage” “Shared responsibility”
  - Health Insurance Marketplace
  - Medicaid expansion
  - Tax credits for individuals and businesses
  - Individual responsibility to limit cost shifting
  - Increasing health workforce supply
- **Controlling and bending the cost curve**
  - Linking quality and outcome to reimbursement
Key Features of the ACA Being Implemented Now

- Immediate elimination (2010) of denial of coverage to **children** with **pre-existing conditions** – 11,800 children in ND have pre-existing conditions

- Elimination of denial of coverage to **adults** (non-Medicare) with **pre-existing conditions** (Jan. 2014) – 132,000 North Dakotans impacted

- Affordability of **prescription drugs for seniors**
  - Over 9,000 ND Medicare recipients saved $6 million since 2010
  - Closing the “donut hole” - by 50% in 2011 and gradually all by 2020
  - December 2010 over 4,350 Seniors received $250 check to help with donut hole
  - After 2020 standard deductible and copayment
Key Features of the ACA Being Implemented

- **Eliminates annual and lifetime limits** on insurance coverage (cap on benefits) (2010) – bankruptcy protection – about 340,000 ND

- **Affordable coverage options** for the 63-84,000 uninsured North Dakotans
  - Medicaid Expansion approved by ND Legislature -- 20-30,000 North Dakotans up to 138 percent of FPL
  - About $31,000 for a family of 4 or about $15,000 for an individual
  - 40 states, including ND, this expands Medicaid to childless adults who regardless of income were not covered previously by Medicaid
  - 30 states benefit low income parents who were not covered by Medicaid even when their children were covered
  - Health Insurance Marketplace – another 30-40,000 possible

- **Tax credits** for up to 17,700 North Dakota small businesses
  - up to 35% for businesses with 25 or fewer employees or 92% of all businesses in the state, about 95% nationally)
Key Features of the ACA Being Implemented

• **Lower Medicare costs** for 98,600 North Dakota beneficiaries not enrolled in Medicare Advantage

• Eliminates **recession** on existing coverage (being dropped by insurance company)

• In 2010 **insurers must spend at least 85% of premiums** (large group) or 80% (small group/individual) on medical costs or provide rebates to enrollees

---

Center for Rural Health

Key Features of the ACA Being Implemented

• **Senior preventive services** with no copay or deductible – over 71,000 North Dakotans

• **Preventive services for all age groups** – no copay or deductible – started in 2011 and added to in 2012 and 2013

• **Young adults** covered under parents health plan
  o Up to age 26 – over 5,000 young adults in ND

• **Health system reform** – **delivery system change**
  o Accountable Care Organizations
  o Value-based purchasing (VBP)
  o Bundled payments
  o CMS Innovation Center
Key RURAL Features of the ACA Being Implemented

• Rural payment inequities in Medicare reimbursement – IOM study
• Reauthorized Rural Hospital Flexibility program – expanded role
• Pilot program for coordinated care in rural – Medical Home demonstration
• Pay rural physicians at same rate as urban physicians
• Address health workforce supply
• Increased funding ($15 B over 5 years) to address rural health disparities in diabetes, obesity, tobacco use, and substance abuse
• Expands access to 340b drug program (CAHs to have access like CHC – did not address RHC)
• Pays CAHs for reasonable costs associated with clinical lab tests
Key Focus - Accountable Care Organizations

Definition: A group of health care providers who give coordinated care, chronic disease management, and thereby improve the quality of care patients get. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings.

Payment and quality – linking payment to outcomes, not payment to activity (value vs. volume)

Start date is January 1, 2012 (May 2012 over 220 ACO’s established; January 2013, 406 established)

Legal structure, and ability to commit for minimum of 3 years

Integrated into the Medicare system first, followed by demonstrations with Medicaid and private pay

ACO incentives originate from sharing in cost savings which are also linked to improved patient outcomes (3 yr. Medicare benchmark)

Base of 5,000 patients – hurdle for rural?

ACA calls for CMS to develop a demonstration involving CAHs
Key Focus - Value Based Purchasing

• A value-based purchasing program (VBP) is instituted by October 2012, covering five conditions in Medicare, affecting prospective payment system (PPS) hospitals, including sole community hospitals, Medicare dependent hospitals, and small rural PPS hospitals. Develop a **3 year CAH VBP demonstration** within 2 years of enactment. Pay hospitals based on performance on quality measures (VBP = P4P)

• This is another example of integrating payment and quality whereby the “buyers” of health services (employers) hold providers of health care accountable for both cost factors and quality factors.

Key Focus - Bundled Payments and CMS Innovation Center

A national, voluntary bundled payment systems (Medicare) **pilot program**, which will be developed and piloted for inpatient and outpatient hospital services, physician services, and post-acute care services (by 2013) to improve patient care and reduce spending - Sec. to consult with small rural hospitals, including CAHs.

Creation of a **Center for Medicare and Medicaid Innovation** within CMS. The purpose of the center will be to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients. Successful models could be expanded nationally. Can include medical homes, coordinated care, integrated care for dual eligible, HIT, and CDM. Rural not specifically identified, but not excluded.

**Payment penalty** applied to hospitals with high levels of readmissions and hospital-acquired conditions.
Expert Estimates of ACA Impact

Congressional Budget Office (CBO), a non-partisan Congressional research unit has estimated that the state health insurance exchanges (to purchase insurance) would ease small business insurance costs, albeit only marginally: premiums in the small-group market are forecast to fall between 1% and 4% under the exchanges, while the amount of coverage would rise by up to 3%.

CBO estimates that due to the law’s small business tax credits, the average premiums per person in the small group market will decline by up to 8-11% in 2016. The tax credit system, over those 6 years, will help small businesses and farmers to be able to provide health insurance to their employees, meet the “shared responsibility” obligation of the law, but to do so without a mandate or a federal requirement to do so, and without fear of fines and penalties.

CBO estimates that the CMS Center for Innovation provision will lead to an additional savings of $1.3 billion over 10 years.
Expert Estimates of ACA Impact

**Business Roundtable** estimated that provisions in the legislation could save $3,000 per person in health costs.

**Rand Corporation** (published in NE Journal of Medicine) estimates that the proportion of U.S. workers who will have access to health insurance through their jobs will jump from 84.6% to 94.6%. That works out to 13.6 million additional workers having the option to buy affordable health plans. Most of this will be in the 50 and less employer category.

**Commonwealth Fund** state that prior to the passage of the ACA, family premiums were expected to increase from $13,305 in 2010 to $21,458 in 2019.36 Under reform, premiums will increase only three-quarters as much. By 2019, it is estimated that family premiums will be nearly $2,000 lower as a result of the ACA.

Expert Estimates of ACA Impact

**Commonwealth Fund** finds that the small business tax credit is estimated to provide new coverage or stabilize existing coverage for about 3.4 million workers and family members employed in small firms by 2013. Small firms eligible to offer their employees health insurance through the insurance exchanges will provide new coverage or stabilize existing coverage for about 5 million workers and their families by 2019. The combination of the individual requirement to health insurance and the employer penalties for not offering coverage are expected to provide employer-based health insurance to 6 million to 7 million people who are currently without employer health insurance.
Expert Estimates of ACA Impact

Robert Wood Johnson Foundation in analysis performed by the Urban Institute (simulation model), issued December 2010:

- Number of uninsured to decline by 28 million to 8.3% (Rural Policy Research Institute or RUPRI estimate is higher with a decline of about 31 m)
- Costs of uncompensated care to uninsured to decline from $70 billion to $27 billion
- 30% of uninsured covered by Medicaid and S-CHIP (RUPRI – 30% adults and 24% children)
- 20% of uninsured covered through exchanges
- 10% of uninsured covered through other changes for private market access to insurance
- Of remaining uninsured about 40% would be eligible for Medicaid or S-CHIP but refuse to enroll
- Spending for non-elderly acute services would increase by 4.5%
ACA Direct Impact on Health Delivery System

- Change or Restructuring of the U.S. Health Delivery System – Fundamental Focus of the Affordable Care Act
  - Renewed focus on Wellness, Health Promotion, Disease Prevention, Disease Management (Population Health/Health Status)
  - But with a significant re-focus on the relationship of these factors to organizational performance, health outcomes and payment, cost factors (“lowering the cost curve”)
  - “Marry the two”
    - health behavior/health outcome
    - organizational performance/cost/payment/finance

Myths and Facts

- Myth # 1: It hasn’t helped anyone.
  - FACT: Insurance now covers:
    - About 5 million children nation-wide with pre-existing conditions,
    - Over 6 million young adults through age 26 who can now stay on their parents’ plans,
    - About 60-129 million adults with pre-existing conditions (Jan. 2014),
    - No more insurance company caps on how much they will spend on your health care over the life time
    - Ends insurance practice of rescission
    - Closing the donut hole – 5.5 m Seniors saved money in 2012 ($4.5B in 2 yrs)
    - 19 million seniors received preventive services in 2012
    - CMS Center on Innovation and health system reforms

MYTH # 2: It is a government take-over of health care; it is “socialized medicine”

  - FACT: Relies heavily on private insurance market and actually adds millions of new participants to the insurance market
  - People still choose their physician and providers
  - Tax credits available to build access
  - The Exchanges are portals to acceptable health plans
Myths and Facts

• MYTH #3: It’s increasing premiums and costs for families.
  o FACT: Private employer-based health premiums were skyrocketing before the law, and it will help change that.
  o FACT: Insurance companies now have to explain why they are raising rates on a public website.
  o FACT: If insurance companies don’t spend enough of your premium dollars on health care, they are now required to send you a rebate at the end of the year. (We received notices from BCBSND)

MYTH #4: It hurts Medicare and seniors.
  o FACT: No reductions are made to Medicare benefits; it actually prohibits cuts
  o FACT: Seniors get help affording prescription drugs (Closing the Doughnut Hole by 2020)
  o FACT: Eliminates cost-sharing for most preventive services - Seniors get annual checkups with no copays for preventive services for diseases such as diabetes, heart disease, and cancer
  o FACT: It cuts the excess profits of private Medicare Advantage Plans (but mandates that MA Plans cannot cut benefits to be less than current Medicare benefits)
    - Overpayments to private health plans for MA costs $1,000 per person each year more than regular Medicare and raises Part B premiums for seniors including those not on MA plans by about $90 per year.
Myths and Facts

• MYTH # 5 Starting in 2014 everyone must either have health insurance or pay a penalty with no exceptions.
  o FACT: Individual mandate does require people who can afford to buy health insurance to do so, or there is a penalty; however, this is anticipated to affect about 2% or so of people – vast majority of Americans already have insurance – also exempt people who are not required to file taxes, people with legitimate religious objections, member of Indian tribes, and people who cannot afford to purchase coverage

• MYTH # 6 If you have insurance from your employer, the ACA will not help you.
  o FACT: ACA provides many new protections, provides employers with incentives for better coverage
    ➢ No annual or lifetime limits on dollar amounts paid by your plan for health care
    ➢ Access to preventive health services with no cost sharing
    ➢ Coverage for dependents 26 and younger
    ➢ Right to choose your doctor
    ➢ Right to appeal coverage denials to an independent reviewer outside of your plan
    ➢ Elimination of denial for pre-existing conditions
    ➢ Rebates to your or employer if health plan spends less than 80% of premium dollars on health services

Myths and Facts

• MYTH # 7 All businesses will be required to provide health insurance coverage to their employees. It will hurt small businesses.
  o FACT: Not true. “Shared Responsibility” requirements of ACA apply to large business that may have to pay a penalty if they don’t offer coverage
  o FACT: Small employers (which account for 96% of all businesses or about 5.8 million) are not required to provide insurance but encouraged to do so through tax incentives of 25%, and 35%, (in 2014 goes to 50% in some cases)
  o FACT: Small employers can identify approved health plans through the Exchange (plans that meet benefit and cost standards). Small businesses have their own access area the Small Business Health Options Program (SHOP) Exchange for small businesses up to 100 employees
    ➢ CBO estimate that SHOP will lower small business premiums by 4% (small business premiums tend to be higher than large businesses, as much as 18% higher)
  o FACT: Businesses with employees 55-64 can now access the Early Retiree Reinsurance Program under the ACA
  o FACT: Currently, over 96% of all small firms offer insurance


Myths and Facts

• MYTH # 8 the ACA will bankrupt Medicare
  - FACT: Medicare actuaries estimate that the ACA actually extends Medicare by 7 years, from becoming insolvent in 2017 to 2024
  - FACT: ACA has not increased Medicare premiums
  - FACT: Medicare Advantage is improved by forcing costs (administrative costs and profits) into line
  - FACT: The “$716 billion cut to Medicare” charge made in the Presidential campaign has some truth. It is not a cut in benefits; however, it is a cut in provider payments and a correction of overpayments to insurance companies offering private Medicare plans. Biggest savings used to pay for closing the “doughnut hole” gap for seniors, paying for the free preventive care services for seniors, and increasing coverage for the uninsured.
  - FACT: USDHHS estimates that from 2010-2022, the average Medicare recipient with traditional Medicare will save $5,000
Myths and Facts

• Myth # 9 The ACA will bankrupt the country
  o FACT: The SCOTUS ruling that stated that mandated Medicaid expansion is unconstitutional will, as a negative, likely leave about 3 million more American uninsured; however, it will save the federal government about $84 billion by 2022
  o CBO estimate is the ACA will reduce the budget deficit by $143 billion from 2010-2019 and about $1 trillion from 2020-2030
  o Hospitals agreed to a cut in their annual Medicare update (about $155 b) because they expect to make it up in patients with insurance (about $170 billion)
  o MA savings of about $136 billion
  o Higher fees to drug companies for doughnut hole will add $107 billion
  o People making more than $250,000 year will have a higher Medicare tax rate on income and capital gains – about $210 billion
  o Large employer fines if they do not provide health insurance - $65 billion
  o CBO estimate is repealing the ACA will increase the deficit by $109 billion
  o Significant increase in the number of people with private insurance will add revenue and income to the private sector
  o ACA lessens the cost transfer in the system today where people with insurance pay for individuals and businesses not covered

Myths and Facts

• Myth # 10 is lessening my choice; Government decides
  o FACT: People still choose their doctor and where they go for care
  o FACT: “Death Panels” were a fabrication.
  o FACT: State or federal exchange will increase competition from private plans for millions of additional users
  o FACT: More incentives to get healthy and stay healthy – private plans and Medicare use incentives to give us more choices
Brad Gibbens, Deputy Director
501 North Columbia Road, Stop 9037
Grand Forks, North Dakota 58202-9037

701.777.3848 (office)
701.777.2569 (desk)
• Brad.gibbens@med.und.edu
• ruralhealth.und.edu

Contact us for more information!