**RURAL AMERICA IN CRISIS**  
*The Health Needs of 60 Million Rural Patients*

**The Problem:** Many provisions in the Affordable Care Act (ACA) are not working effectively in rural America. The American Health Care Act (AHCA) does nothing to address these problems and provides coverage for fewer rural Americans.

**The Details:**
The laudable goals of the ACA were not fully achieved in rural America. Lack of plan competition in rural markets, exorbitant premiums, deductibles and co-pays, the co-op collapses, devastating Medicare cuts, and the lack of Medicaid expansion have created a healthcare crisis in rural America.

Insurance companies are dropping out of rural markets and cherry-picking those who get coverage. In fact, 70% of the counties where big insurance companies have dropped out have been rural counties - - leaving rural Americans with little or no choice of plans. A January 2017 CDC study indicates that “the death rate gap between urban and rural America is getting wider” and rates of the five leading causes of death are higher among rural Americans.

Bad debt has risen among rural hospitals by 50%, leaving one in three financially vulnerable. Eighty rural hospitals have closed since the ACA went into effect. At the current rate of closure, 25% of all rural hospitals will close in less than a decade unless Congress acts. Closures of this magnitude will create a massive national crisis in access to emergency services as well as detrimentally harm rural economies.

Instead of addressing these problems, the AHCA may cause more harm to rural Americans. Rural America is, per capita, poorer and more reliant on Medicaid and the drastic cuts contained in the AHCA will leave millions of the sickness, neediest populations in our nation without coverage. According to the *Wall Street Journal*, the “GOP health plan would hit rural areas hard… Poor, older Americans would see largest increase in insurance-coverage costs.” The *LA Times* reports “Americans who swept President Trump to victory — lower-income, older voters in conservative, rural parts of the country — stand to lose the most in federal healthcare aid under a Republican plan to repeal and replace the Affordable Care Act.”

**The Solution:** Rural health care access and coverage can be dramatically and cost-effectively improved by three policy changes:

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

   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.

2. Market Reform – 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

Rural Americans are more likely to have obesity, diabetes, cancer, and traumatic injury; they 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 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.

3. Stop Bad Debt Cuts to Rural Hospitals – Rural hospitals serve more Medicare patients (46% rural vs. 40.9% urban), thus across the board Medicare cuts do not have across the board impacts. The fact that according to MedPAC “Average Medicare margins are negative, and under current law they are expected to decline in 2016” has led to 7% gains in median profit margins for urban providers while rural providers have experienced a median loss of 6%.

Congress needs to act now and stop Medicare cuts to rural hospitals, especially bad debt cuts. Current rural programs for hospitals and providers must be maintained, such as cost based reimbursement and 340B eligibility. Relief from unnecessary and burdensome regulations should be included to remove costly burdens on providers that do not improve patient safety. Rural Medicare extenders need to be made permanent including Low-Volume (LVH) and Medicare Dependent Hospital (MDH), rural and super-rural ambulance payment. The Save Rural Hospital Act should be adopted to create a new provider type for rural hospitals to ensure access Higher percentages of uninsured remain in rural America than urban areas.

¹ For 2015 ACA ‘Silver’ exchange plans.

www.RuralHealthWeb.org