

POLICY ESSAY

UNDERSTANDING RURAL HEALTH CARE NEEDS AND CHALLENGES: WHY ACCESS MATTERS TO RURAL AMERICANS

SENATOR CRAIG THOMAS*

In this Policy Essay, Senator Craig Thomas discusses the challenges currently facing rural health care, including a large uninsured population and a growing scarcity of providers. Senator Thomas examines how geographic and demographic factors impair rural health and proposes a number of practical solutions, including collaborative health care networks, greater equity between rural and urban areas for Medicare reimbursement, and direct incentives to physicians and other providers to practice in rural areas. After explaining why the Medicare Prescription Drug Modernization and Improvement Act of 2003 was an important first step toward achieving many of these solutions, Senator Thomas argues that there is still much that needs to be done to revitalize and strengthen rural health.

As I travel throughout Wyoming, almost everyone I talk to—patients, doctors, hospital administrators, and small businessmen—agrees that the health care system in the United States is broken. Health care costs continue to grow nationwide,¹ as does the number of uninsured Americans.² In rural areas, an increasingly small number of health providers³ struggle to keep up with low levels of reimbursement⁴ and the unique but varied health needs of rural citizens. It is essential for our nation, and particularly our rural

* Member, United States Senate (R-Wyo.). L.L.B., LaSalle University, 1963; B.A., University of Wyoming, 1955. Senator Thomas sits on the Senate Finance Committee, the Senate Energy and National Resources Committee, the Senate Agriculture, Nutrition and Forestry Committee, the Senate Committee on Indian Affairs, the Senate Select Committee on Ethics. He also serves as Chairman of the Finance Committee's Subcommittee on International Trade and the Energy and National Resources Committee's Subcommittee on National Parks.

¹ See U.S. DEP'T OF HEALTH AND HUMAN SERVS., EFFECTS OF HEALTH CARE SPENDING ON THE U.S. ECONOMY 1 (2005), available at <http://aspe.hhs.gov/health/costgrowth/report.pdf>.

² Data released by the Census Bureau in August of 2005 indicate that the number of uninsured Americans has risen from 39.8 million in 2000 to 45.8 million in 2004. Press Release, Ctr. on Budget and Policy Priorities, The Number of Uninsured Americans Continued to Rise in 2004 (Aug. 30, 2005), available at <http://www.cbpp.org/8-30-05health.htm>.

³ See NAT'L RURAL HEALTH ASS'N, HEALTH CARE WORKFORCE DISTRIBUTION AND SHORTAGE ISSUES IN RURAL AMERICA 1 (Mar. 2003), available at <http://www.nrharural.org/advocacy/sub/policybriefs/WorkforceBrief.pdf>.

⁴ See COMM. ON THE FUTURE OF RURAL HEALTH CARE, INST. OF MED. OF THE NAT'L ACADS., QUALITY THROUGH COLLABORATION: THE FUTURE OF RURAL HEALTH 126-42 (2005).

citizens, that we reverse these alarming trends.

After first describing the relationship between rural health and health care nationally, I will then discuss the aspects of rural health that have created its unique problems. Next I will address some of the flaws in existing health policies as they relate to the needs of rural citizens and communities. I will then outline some of the health care measures I have recently promoted in Congress. These measures will assist with the revitalization of fragile rural health networks by improving equity between rural and urban health care resources and reducing medical liability costs. Finally, I will consider some potential steps Congress might take to improve health care, both in rural areas like Wyoming and throughout the nation.

I. HEALTH CARE NATIONALLY

Health care costs continue to grow unchecked. National health expenditures rose 7.9% in 2004.⁵ While that percentage is slower than the 8.2% growth experienced in 2003,⁶ this number is still unacceptably high. The portion of the nation's Gross Domestic Product spent on health care grew to 16% in 2004—up from 14.9% only two years before.⁷ Furthermore, our health care system faces challenges beyond reining in costs.

We have one of the most advanced economies on earth,⁸ and yet there are still many Americans who lack access to quality health care.⁹ Nationwide, it is essential that we improve our underlying health care infrastructure, as rising costs affect us all.¹⁰ While our nation's hospitals struggle to collect revenues because of low public and private insurance reimbursement rates,¹¹ providers cost-shift to those with private insurance.¹²

⁵ Press Release, Ctrs. For Medicare & Medicaid Servs., Healthcare Spending Growth Rate Continues to Decline in 2004 (Jan. 10, 2006), available at <http://www.cms.hhs.gov/apps/media/press/release.asp?counter=1750>.

⁶ *Id.*

⁷ *Id.*

⁸ In 2004, the U.S. had the third highest Gross National Income ("GNI") in the world when controlling for local prices of goods and services. See WORLD BANK, GNI PER CAPITA 2004, ATLAS METHOD AND PPP 1-4 (2005), available at <http://siteresources.worldbank.org/DATASTATISTICS/Resources/GNIPC.pdf>.

⁹ See COMM. ON THE FUTURE OF RURAL HEALTH CARE, *supra* note 4, at 31-37.

¹⁰ The costs of health care for the uninsured are not only borne out of pocket by the uninsured themselves, but also by insurers, physicians, government, and taxpayers. See COMM. ON THE CONSEQUENCES OF UNINSURANCE, INST. OF MED. OF THE NAT'L ACADS., HIDDEN COSTS, VALUE LOST: UNINSURANCE IN AMERICA 38-39, 46-49, 53-58 (2003).

¹¹ See, e.g., PHILANTHROPIC COLLABORATIVE FOR A HEALTHY GEORGIA, IMPROVING RURAL HEALTH: AN ISSUE PAPER 3 (2002), available at <http://www2.gsu.edu/~wwwghp/publications/pchg/RHbriefjan02.pdf> ("It is often difficult for rural hospitals to remain open because of decreases in payments from Medicare, Medicaid, and private insurance companies.").

¹² See Michael A. Morrissey, *Cost Shifting: New Myths, Old Confusion, and Enduring Reality*, HEALTH AFFAIRS: THE POLICY JOURNAL OF THE HEALTH SPHERE, Oct. 8, 2003, W3-491, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.489v1> (follow "begin manual download" hyperlink).

Uninsured Americans increasingly visit emergency rooms for primary care services,¹³ resulting in high costs for taxpayers.¹⁴ Worldwide, Americans continue to pay the highest prices for prescription drugs¹⁵ and shoulder nearly half of global research and development costs.¹⁶ Meanwhile, doctors waste billions of dollars on unnecessary tests for fear of being sued,¹⁷ and businesses and their employees are quickly being priced out of the health insurance market.¹⁸ The public and private sectors must identify common-sense solutions to fix the system and, most importantly, individuals must take personal responsibility for their health.

II. RURAL HEALTH CARE

Rural counties are the backbone of America, consisting of a considerable number of citizens living on a large portion of the nation's land.¹⁹ Because many of those individuals without access to quality health care live in rural areas,²⁰ rural health issues are a pressing part of the nation's current health care dilemmas.

¹³ See *Emergency Room Visits Reach Record High*, MSNBC, May 26, 2005, <http://www.msnbc.msn.com/id/7995137> ("Emergency departments are a safety net and often the place of first resort for health care for America's poor and uninsured.").

¹⁴ See *id.* (stating that "Medicaid patients were four times more likely to seek treatment in an ER than people with private insurance.").

¹⁵ Gardiner Harris, *The Nation: Prescriptions Filled; If Americans Want to Pay Less for Drugs, They Will*, N.Y. TIMES, Nov. 16, 2003, at D4.

¹⁶ See Ian M. Cockburn, Professor of Finance and Economics in the School of Management at Boston University, Remarks before the Task Force on Drug Importation (Apr. 27, 2004), available at <http://www.hhs.gov/importtaskforce/session4/presentations/CockburnTestimony.doc> ("Worldwide R&D expenditures by pharmaceutical and biotechnology companies now likely exceed \$70 billion per year, over \$35 billion in the US alone.").

¹⁷ BRUCE BARTLETT, NAT'L CTR. FOR POLICY ANALYSIS, TOTAL COSTS ADD TO MANUFACTURING'S WOES (2003), available at <http://www.ncpa.org/edo/bb/2003/bb-20031215.html> ("[I]t is thought that \$50 billion to \$100 billion is wasted each year on unnecessary medical tests doctors order just to protect themselves from a lawsuit.").

¹⁸ THE KAISER FAMILY FOUNDATION, EMPLOYER HEALTH BENEFITS: 2005 SUMMARY OF FINDINGS 1 (2005), available at <http://www.kff.org/insurance/7315/sections/upload/7316.pdf>. While employer-based health care premiums rose by 13.9%, 11.2%, and 9.2% during the years of 2003 to 2005, respectively, inflation rose by only 2.2%, 2.3%, and 3.5% during those same years. Meanwhile, from 2000 to 2005, the percentage of firms offering health benefits decreased from 69% to 60%. *Id.*

¹⁹ All of the rural counties in the United States together comprise a land area equivalent to the eighteenth largest nation in the world. See Thomas C. Ricketts, *Arguing for Rural Health in Medicare: A Progressive Rhetoric for Rural America 1* (N.C. Rural Health Research and Policy Analysis Ctr., Working Paper No. 75, 2002), available at http://www.shepscenter.unc.edu/research_programs/rural_program/wp75.pdf. The U.S. Census Bureau reported in 2000 that 59 million people, or 21% of the U.S. population, live in rural areas. See U.S. Census Bureau, *Urban/Rural and Metropolitan/Nonmetropolitan Population: 2000* (2000), available at http://factfinder.census.gov/servlet/SAFFPeople?_submenuId=people_1&_sse=on (follow "Urban/Rural and Metropolitan/Nonmetropolitan Population: 2000" hyperlink).

²⁰ See THE KAISER FOUNDATION ON MEDICAID AND THE UNINSURED, *THE UNINSURED IN RURAL AMERICA 1* (2003), available at <http://www.kff.org/uninsured/upload/The-Uninsured-in-Rural-America-Update-PDF.pdf> ("Among the 41 million uninsured in the United States, nearly one in five live in rural areas.").

Despite similarities between the rural and urban poor, what works in New York City will not necessarily work in Newcastle, Wyoming. Rural populations suffer from a distinct lack of insurance,²¹ high transportation costs,²² and demographic challenges.²³ There are also significant barriers in rural health to obstetrical services,²⁴ oral health,²⁵ mental health,²⁶ substance abuse recovery services,²⁷ and many other types of care.²⁸ Furthermore, rural areas face higher rates of obesity,²⁹ depression,³⁰ and suicide.³¹

²¹ See BARBARA A. ORMAND ET AL, THE URBAN INST., RURAL/URBAN DIFFERENCE IN HEALTH CARE ARE NOT UNIFORM ACROSS STATES 2, fig.2 (2000), available at <http://www.urban.org/UploadedPDF/b11.pdf> (demonstrating that 14.3% of urban residents, 17.5% of rural residents living adjacent to urban areas, and 21.9 % of rural residents not living adjacent to urban areas are uninsured.).

²² Katherine Porter, *Going Broke the Hard Way: The Economics of Rural Failure*, WIS. L. REV. 969, 1008 (2005) (stating that “the average rural household spent nearly \$1,000 more for transportation in 2001 than the average urban household . . . because their geographic distances to jobs, schools, and services increase the need for a vehicle, and thus gas and maintenance expenses.”).

²³ For example, rural patients tend to be older. As of the 2000 census, approximately one in four seniors lived in a rural area. See ECON. RESEARCH SERV., U.S. DEP’T OF AGRIC., BRIEFING ROOM—RURAL POPULATION AND MIGRATION: RURAL OLDER POPULATION (2005), available at <http://www.ers.usda.gov/briefing/population/older>; see also U.S. CENSUS BUREAU, POPULATION PROJECTIONS FOR STATES BY AGE, RACE, AND HISPANIC ORIGIN 12 (1996), available at <http://www.census.gov/population/www/projections/pp147.html> (“The population 65 plus is expected to double in the top seven States with the fastest-growing elderly population. The States with the fastest growth of the elderly population in rank order are: Alaska, Utah, Idaho, Colorado, Nevada, Wyoming, and Washington.”).

²⁴ At least five Wyoming cities have already suffered the loss of OB-GYN care, and the scarcity of these services means that some pregnant women must travel distances of thirty to ninety miles to receive care or deliver their babies. See Wyo. Med. Soc’y, Will Care Be There? Wyoming’s Medical Liability Crisis Grows More Severe (May 2005), http://www.wyomed.org/pli_prob_areas.htm (last visited Apr. 30, 2006).

²⁵ See COMM. ON THE FUTURE OF RURAL HEALTH CARE, *supra* note 4, at 239 (stating that “rural areas are marked by a lack of access to dental services resulting from an inadequate supply of dentists.”).

²⁶ See Rural Assistance Center Guide to Mental Health, http://www.raconline.org/info_guides/mental_health (last visited Apr. 4, 2006) (“[I]t is well documented that rural America still lags behind its urban counterparts in mental health care.”).

²⁷ See COMM. ON THE FUTURE OF RURAL HEALTH CARE, *supra* note 4, at 53. (“Health care systems in rural areas tend to be financially fragile with some services, such as . . . substance abuse, being critically underfunded.”). Substance abuse services are of particular importance given the recent rise in methamphetamine abuse in rural areas. In 2003, 9385 methamphetamine labs were reported in rural areas nationwide, an increase from the 949 that were reported in 1998. NPR.com, *Meth a Growing Menace in Rural America*, <http://www.npr.org/templates/story/story.php?storyId=3805074> (last visited Apr. 4, 2006).

²⁸ Wyoming is now considered a “red crisis state.” Many doctors are either trimming their services or ending them all together. The most threatened and depleted resources for Wyoming residents are mental health care providers, surgical services, OB/GYN care, ophthalmology, primary care, and many more specialized medical practices. See Wyo. Med. Soc’y, *supra* note 24.

²⁹ Rural Assistance Center Guide to Obesity and Weight Control, http://www.raconline.org/info_guides/obesity (last visited Apr. 4, 2006) (“Rural communities are now experiencing higher rates of obesity . . . than urban areas.”).

³⁰ “The prevalence of mental illness, in particular depression, in rural areas is high.” Rural Assistance Center, Mental Health, http://www.raconline.org/info_guides/mental_health (last visited Apr. 4, 2006).

³¹ In 2001, Wyoming was ranked fourth in suicide rates amongst fifteen- to twenty-

Perhaps most importantly, rural areas face an unprecedented challenge in ensuring that they have an adequate number of health care professionals to serve patients.³² Physicians and other allied health professionals are retained at lower rates than ever before,³³ and our young people are not choosing careers in the health field as often as they used to.³⁴ As a result, hospital vacancy rates for registered nurses, radiology technicians, and pharmacists are each greater than 10%.³⁵ One in seven hospitals faces a severe nursing shortage and more than 20% of nursing positions remain vacant.³⁶

While many of the differences between urban and rural health are material, economic, and geographic, there are also differences of attitude as well. In rural communities, individuals are likely to define health as a person's ability to work.³⁷ For reasons related to culture, transportation difficulties, and health literacy, rural individuals are more likely to delay seeking medical treatment until a condition has become severe or until multiple conditions exist.³⁸ This mentality of the underserved exists side-by-side with those who not only have access, but arguably have too much access to medical services. Because these latter individuals are insured and have more immediate access, doctors frequently encourage them to run a gamut of expensive and repetitive testing simply because insurance covers it and there is no shared record of previous testing.³⁹ Neither of these two extremes promotes personal or professional responsibility in regard to health and both are costly in terms of health and medical costs.

four-year-olds. A Wyoming youth is twice as likely to commit suicide as the national youth average. In 2002 the rate was 20.35 per 100,000 youths in Wyoming as compared with 9.9 per 100,000 youths nationally. WYO. DEP'T OF HEALTH, MATERNAL AND CHILD HEALTH NEEDS ASSESSMENT: ISSUE PAPER 2 (2004), available at <http://wdh.state.wy.us/mcheipi/pdf/briefs/Suicidissue.pdf>.

³² See COMM. ON THE FUTURE OF RURAL HEALTH CARE, *supra* note 4, at 79 (“[F]or decades, rural and frontier communities have struggled to attract and retain an adequate supply of . . . various health care professionals.”).

³³ See NAT'L RURAL HEALTH ASS'N., *supra* note 3, at 1.

³⁴ See Press Release, U.S. Dep't of Health and Human Servs., Bush Administration Promotes Careers in Nursing: Survey Shows Critical Shortage of Nurses (Feb. 22, 2002), available at <http://newsroom.hrsa.gov/releases/2002releases/nursesevent2withpics.htm>.

³⁵ FIRST CONSULTING GROUP, THE HEALTHCARE WORKFORCE SHORTAGE AND ITS IMPLICATIONS FOR AMERICA'S HOSPITALS 4 (2001), available at http://www.hospitalconnect.com/aha/key_issues/workforce/resources/content/FcgWorkforceReport.pdf.

³⁶ *Id.*

³⁷ K. A. Long, *The Concept of Health*, 28 RURAL NURSING 123, 123–30 (1993).

³⁸ Felecia G. Wood, *Health Literacy in a Rural Clinic*, 5 ONLINE JOURNAL OF RURAL NURSING AND HEALTH CARE (2005), http://www.rno.org/journal/issues/Vol-5/issue-1/Wood_article.htm.

³⁹ See, e.g., Press Release, Agency for Healthcare Research and Quality, AHRQ Awards Over \$22.3 Million in Health Information Technology Implementation Grants (Oct. 6, 2005), available at <http://www.ahrq.gov/news/press/pr2005/hitimprr.htm> (stating that some information technology grants will be used to “ensure safer patient transitions between health care settings, as well as reducing medication errors and duplicative and unnecessary testing”).

Skyrocketing medical liability premiums⁴⁰ are also crippling the rural health care system.⁴¹ Obstetrics and gynecological services have been especially impacted by medical liability premiums.⁴² Two Wyoming areas, Wheatland and Douglas, recently lost their only OB-GYNs—doctors who had previously delivered babies in three counties—as a result of rising malpractice costs.⁴³ In order to address this issue, we need to set reasonable limits on non-economic damages, provide for a quicker review of liability claims, ensure that claims are filed within a reasonable time limit, and educate people to help them understand that frivolous lawsuits only add to the overall cost of health care for everyone.

In an effort to meet these challenges, the Senate Finance Committee, of which I am a member, has been meeting regularly to discuss ways to increase health insurance access and affordability.⁴⁴ There are many competing proposals to accomplish this goal including tax credits,⁴⁵ reducing paperwork and costly regulations,⁴⁶ expanding safety net programs,⁴⁷ improving Health Savings Accounts (“HSAs”),⁴⁸ and implementing medical

⁴⁰ For example, the most substantially affected states saw premiums for specialty physicians increase between 36% and 113% in 2002. See OFFICE OF THE ASSISTANT SEC’Y FOR PLANNING AND EVALUATION, U.S. DEP’T OF HEALTH AND HUMAN SERVS., SPECIAL UPDATE ON MEDICAL LIABILITY CRISIS (2002), available at <http://aspe.hhs.gov/daltcp/reports/mlupd1.htm>.

⁴¹ See NAT’L RURAL HEALTH ASS’N, PROFESSIONAL LIABILITY REFORM 1 (2003), available at <http://www.nrharural.org/advocacy/sub/policybriefs/LiabilityReformPolicyBrief.pdf> (“In rural and underserved communities, where access to quality care is already in jeopardy, rising liability costs are creating a crisis situation.”).

⁴² See Donald J. Palmisano, Statement of the Am. Med. Ass’n to the Comm. on Small Business of the U.S. House of Rep. 3 (Feb. 17, 2005), available at <http://www.legalreforminthenews.com/Reports/AMA%20Testimony%20Congress%202-17-05.pdf> (“[P]atients’ access to care may be in jeopardy as increased medical liability costs force physicians to restrict the services they provide, especially high-risk specialists in neurosurgery, orthopedic surgery, obstetrics, and general surgery.”).

⁴³ After twenty-three years of practice, OB-GYN Willard Woods was unable to obtain liability insurance and was forced to end his obstetrics practice. See Wyo. Med. Soc’y, *supra* note 24. (providing further examples of doctors whose practices have been threatened by rising malpractice insurance costs).

⁴⁴ See, e.g., *Health Care Coverage for Small Businesses: Challenges and Opportunities: Hearing Before the S. Comm. on Finance*, 109th Cong. (2006); *Improving Quality in Medicare: The Role of Value-Based Purchasing: Hearing Before the S. Comm. on Finance*, 109th Cong. (2005).

⁴⁵ See Equity for Our Nation’s Self Employed Act of 2005, S. 663, 109th Cong. (2005) (allowing the self-employed to deduct the amount they pay for health insurance from their calculation of payroll taxes).

⁴⁶ See Healthy America Act of 2005, S. 4, 109th Cong. (2005) (proposing in section 102 to achieve increased efficiency through new technology and greater coordination among various parties); see also Better Healthcare through Information Technology Act, S. 1355, 109th Cong. (2005) (providing for increased efficiencies through application of technology).

⁴⁷ See Seniors Mental Health Access Improvement Act of 2005, S. 784, 109th Cong. (2005) (focusing on improving seniors’ access to mental health support); Medicare Rural Home Health Payment Fairness Act of 2005, S. 300, 109th Cong. (2005) (extending a rural home health bonus provision).

⁴⁸ See Personal Responsibility and Individual Development for Everyone Act, S. REP. NO. 109-051, at 266–67 (2005) (providing for the establishment of deductions for health savings plans).

liability reform.⁴⁹ Although I remain committed to working in a bipartisan manner with my Senate colleagues to find solutions to the looming health care crisis, this piecemeal approach to legislation still leaves hard working families living in rural areas without quality health care.

III. FLAWS IN THE EXISTING POLICIES

National health care policies have placed additional burdens on rural citizens and health providers beyond those that already exist due to the intrinsic characteristics of rural areas. For years, Medicare has underpaid rural providers and hospitals.⁵⁰ The underpayments include those to clinics and allied health professionals and result from the unfortunate assumption that rural health care, by nature, costs less.⁵¹ In reality, rural Americans experience escalating costs that their urban counterparts do not. This is because of factors such as the alarming 45.7% of Wyoming births paid for by Medicaid,⁵² a rapidly aging population,⁵³ high chronic illness,⁵⁴ decreasing access to providers,⁵⁵ transportation issues,⁵⁶ and low patient volumes.⁵⁷

⁴⁹ See Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2005, S. 354, 109th Cong. (2005) (seeking to reduce the burden the liability system places on health care delivery networks); see also S. 4 (proposing in sections 101–112 to “implement reasonable, comprehensive, and effective health care liability reforms.”).

⁵⁰ See COMM. ON THE FUTURE OF RURAL HEALTH CARE, *supra* note 4, at 12 (“Although significant steps have been taken to correct historical underpayment of rural providers under Medicare, the operating margins of many rural hospitals are still low, and concerns about the equity of physician payments persist.”).

⁵¹ *Finding the Funds for Rural Health*, RURAL HEALTH NEWS (Rural Info. Ctr. Health Serv.) Spring 2001, at 1, available at http://www.raconline.org/newsletter/pdf/spring01_vol8-1.pdf (“Medicare reimbursement policies . . . pay rural providers lower rates than urban providers for the same services, based on the arguably incorrect assumption that everything costs less in rural areas.”).

⁵² BRENT SHERARD, WYO. DEP’T OF HEALTH, COMPREHENSIVE ASSESSMENT OF MATERNAL AND CHILD HEALTH NEEDS 2006–2010, at 12 (2005), available at <http://wdh.state.wy.us/mch/pdf/Final Needs Assessment.pdf>.

⁵³ See *supra* note 23 and accompanying text.

⁵⁴ A recent study found that 30.5% of Wyoming’s adult population reported being diagnosed with high blood cholesterol; 37% were overweight; 4.5% reported being diagnosed with diabetes; and 24.6% were smokers. CTRS. FOR DISEASE CONTROL AND PREVENTION, PROFILING THE LEADING CAUSES OF DEATH IN THE UNITED STATES: WYOMING 4 (2005), available at <http://www.cdc.gov/nccdphp/publications/factsheets/chronicdisease/pdfs/wyoming.pdf>. The numbers were even higher for Wyoming’s Native American Population, whose death rates from both diabetes and liver disease both exceeded national Native American averages. They were also, on average, more overweight (41%) and more likely to smoke (39%) than their Caucasian counterparts. *Id.*

⁵⁵ See *supra* notes 32–36 and accompanying text.

⁵⁶ See Porter *supra* note 22 and accompanying text.

⁵⁷ See, e.g., COMM. ON THE FUTURE OF RURAL HEALTH CARE, *supra* note 4, at 98 (“[L]ow volume of patients make it difficult for rural hospitals to hire specialists in emergency medicine and muster the financial resources to adequately support an EMS system.”).

An additional problem is the lack of statistical data to support rural health programs as well as policy changes.⁵⁸ While some states have compiled their own statistics to support their rural health needs,⁵⁹ the U.S. Department of Health and Human Services' ("HHS") Office of Rural Health Policy ("ORHP")⁶⁰ is under tight budget constraints for its rural health priorities.⁶¹ While the ORHP has produced some good data for rural areas given its limited funding,⁶² HHS needs to look more closely at rural populations' specific health care concerns and respond in concrete, fiscal terms to the rural health crisis.

Another complication is the very definition of the term "rural population." Currently, there are several definitions for rural, frontier, and rural-urban populations—each with different criteria.⁶³ The lack of clarity and cohesiveness created by these overlapping definitions serves to neglect particular rural areas.⁶⁴ It also simultaneously oversimplifies the continuum of rural and urban areas by overlooking the existence of neighboring urban and rural counties into consideration.⁶⁵ This is likely to result in the wasteful distribution of resources to areas without truly rural needs.

IV. RURAL HEALTH NETWORKS

One reason for the lack of health care professionals willing to work full time in rural areas,⁶⁶ and hence for the resulting shortage of medical

⁵⁸ See, e.g., *id.*, at 111 ("Current workforce programs are hampered by a lack of data and information to target resources effectively."); *id.* at 226 ("Efforts to evaluate the quality, status, and utilization of emergency services in specific terms have been hampered by the overall lack of data.").

⁵⁹ See, e.g., The Colorado Rural Health Ctr. Library, <http://www.coruralhealth.org/crhc/resources/library.php> (last visited Apr. 16, 2006); Idaho Dep't of Health & Welfare Health Statistics Webpage, <http://healthandwelfare.idaho.gov/site/3457/default.aspx> (last visited Apr. 16, 2006); JOHN PACKHAM, NEVADA OFFICE OF RURAL HEALTH, NEVADA RURAL AND FRONTIER HEALTH DATA BOOK—2004 EDITION (2004), available at <http://www.unr.edu/med/dept/CEHSO/Documents/DataBook2004.pdf>.

⁶⁰ The ORHP is part of the Health Resource Services Administration ("HRSA"). Rural Health Policy Homepage, <http://ruralhealth.hrsa.gov> (last visited Feb. 23, 2006).

⁶¹ The President requested only \$27 million for rural health in the proposed 2007 HRSA budget, down from the \$145 million earmarked for rural health programs in 2005. See U.S. DEP'T OF HEALTH AND HUMAN SERVS., BUDGET IN BRIEF: FISCAL YEAR 2007, at 20 (2006) available at <http://www.hhs.gov/budget/07budget/2007BudgetInBrief.pdf>.

⁶² See generally, e.g., VICTORIA FREEMAN ET AL., INTENSIVE CARE IN CRITICAL ACCESS HOSPITALS (2005), available at http://www.shepscenter.unc.edu/research_programs/rural_program/WP81.pdf; ERIKA C. ZILLER & ANDREW F. COBURN, HEALTH INSURANCE COVERAGE OF THE RURAL AND URBAN NEAR ELDERLY (Maine Rural Health Research Center, Working Paper No. 27, 2003), available at <http://muskie.usm.maine.edu/Publications/rural/wp27.pdf>.

⁶³ See COMM. ON THE FUTURE OF RURAL HEALTH CARE, *supra* note 4, at 200–04.

⁶⁴ See THOMAS C. RICKETS ET AL., DEFINITIONS OF RURAL: A HANDBOOK FOR HEALTH POLICY MAKERS AND RESEARCHERS 6 (1998), available at http://www.schsf.unc.edu/research_programs/rural_program/ruralit.pdf.

⁶⁵ See *id.* at 8.

⁶⁶ See *supra* notes 32–36 and accompanying text.

care, is the isolation that many rural physicians face.⁶⁷ An innovative solution to some rural health problems, including that of physician isolation, is rural health networks.⁶⁸ By using the information technologies to create a network of co-worker collaboration between sparsely located hospitals and rural care providers within which communication about care plans for specific patients can occur, we can improve the effectiveness of rural care and reduce the isolation faced by rural providers. Furthermore, because shared information about patients reduces the need for repetitive tests, the care can also be less expensive for both the provider and the patient.⁶⁹ Existing networks need to stretch federal dollars to serve as many people as possible. Communities need the tools and resources to build meaningful and collaborative health networks to support rural communities on a regional level.

Another complication in addressing rural health care is the lack of data to support rural health networks and similar collaborative programs.⁷⁰ Under its 2002 Rural Initiative, HHS established the Rural Assistance Center (“RAC”) as a rural health and human services information portal.⁷¹ The RAC “helps rural communities and other rural stakeholders access the full range of available programs, funding, and research that can enable them to provide quality health and human services to rural residents.”⁷² The ORHP also assists in promoting rural health networks by “maintaining a national information clearinghouse.”⁷³

Although the efforts of the RAC and ORHP have brought some improvements to rural health,⁷⁴ there is much that remains to be done. We can start by improving upon the existing communication and collaborative capabilities of rural health clinic systems already in place in Wyoming

⁶⁷ See AM. MED. STUDENT ASS’N, HEALTH CARE DELIVERY: RURAL VS. URBAN COMMUNITIES (2006), <http://www.amsa.org/programs/gpit/ruralurban.cfm>.

⁶⁸ A rural health network is defined as “[a] formal organizational arrangement among rural health care providers (and possibly insurers and social service providers) that uses the resources of more than one existing organization and specifies the objectives and methods by which various collaborative functions are achieved.” AGENCY FOR HEALTH CARE POLICY AND RESEARCH, STRENGTHENING THE RURAL HEALTH INFRASTRUCTURE: NETWORKING DEVELOPMENT AND MANAGED CARE STRATEGIES (1997), available at <http://www.ahrq.gov/news/ulp/ulpstren.htm>.

⁶⁹ See MICHAEL E. SAMUELS & SHELLY TEN NAPEL, NAT’L RURAL HEALTH ASS’N, COLLABORATION: MODERN RELATIONSHIPS BETWEEN RURAL COMMUNITY HEALTH CENTERS AND HOSPITALS 2–8 (2005), available at <http://www.nrharural.org/quality/collaboration.pdf>.

⁷⁰ See *supra* notes 58–61 and accompanying text.

⁷¹ See generally Rural Assistance Center Homepage, <http://www.raconline.org> (last visited Apr. 14, 2006).

⁷² What is the Rural Assistance Center?, <http://www.raconline.org/about> (last visited Apr. 14, 2006).

⁷³ Rural Health Policy Homepage, *supra* note 60.

⁷⁴ See generally OFFICE OF RURAL HEALTH POLICY, DEP’T OF HEALTH AND HUMAN SERVS., A HISTORY OF THE RURAL HEALTH CARE SERVICES OUTREACH PROGRAM (2004), available at <http://ruralhealth.hrsa.gov/funding/outreachhistory.asp> (providing a history of the Department’s efforts to improve rural health and discussing some of the ORHP’s recent success stories).

and other rural states. This effort must begin by increasing funding for critical access hospitals, community hospitals, community health centers, and tribal health services. It should also involve improvements in resource equity for rural programs and providers⁷⁵ and reductions in liability for rural health providers.⁷⁶

V. THE MMA AND RURAL PROVIDER EQUITY ACT

Rural health was not on the radar screen in the 1980s. But the growing concerns about the status of rural health prompted key senators from rural states to begin working in a bipartisan fashion to effect change. During the late 1990s, Congress enacted rural-friendly health legislation in response to data indicating the inadequacies of payment systems and poor health status of rural Americans. Some of those pieces of legislation include the Balanced Budget Act of 1997 (“BBA”),⁷⁷ the Balanced Budget Refinement Act of 1999 (“BBRA”),⁷⁸ the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (“BIPA”),⁷⁹ and the Medicare Prescription Drug Modernization and Improvement Act of 2003 (“MMA”).⁸⁰

The MMA⁸¹ in particular includes many provisions that begin to address rural health concerns, the most important of which relate to Medicare equity.⁸² Medicare should prioritize rural health,⁸³ not only because

⁷⁵ See *supra* notes 50–51 and accompanying text.

⁷⁶ See *supra* notes 40–43 and accompanying text.

⁷⁷ Balanced Budget Act of 1997, Pub. L. No. 105-33, §§ 4201–4207, 111 Stat. 251, 369–81 (1997) (codified as amended in scattered sections of U.S.C.). This Act attempted to reduce Medicare spending by \$116.4 billion between 1998 and 2002. JENNIFER O’SULLIVAN ET AL., CONG. RESEARCH SERV., RL30347—MEDICARE, MEDICAID, AND STATE CHILDREN’S HEALTH INSURANCE PROGRAM (SCHIP): CHANGES TO BALANCED BUDGET ACT OF 1997 (BBA 97, P.L. 105-33) PROVISIONS I (1999), available at <http://www.house.gov/moore/rl30347.pdf>.

⁷⁸ Balanced Budget Refinement Act of 1999, Pub. L. No. 106-113, §§ 401–413, 113 Stat. 1501, 1501A-369 to -378 (1999) (codified as amended in scattered sections of U.S.C.). This legislation was intended to mitigate the impact of the BBA on Medicare payments and access to care. See O’SULLIVAN ET AL., *supra* note 77, at 1–2, 4–5.

⁷⁹ Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), Pub. L. No. 106-554, § 1(a)(6), 114 Stat. 2763 (2000) (codified as amended in scattered sections of 42 U.S.C.). See generally HINDA CHAIKIN ET AL., CONG. RESEARCH SERV., RL30707—MEDICARE PROVISIONS IN THE MEDICARE, MEDICAID, AND SCHIP BENEFITS IMPROVEMENT AND PROTECTION ACT OF 2000 (2001), available at http://digital.library.unt.edu/govdocs/crs/data/2001/upl-meta-crs-1363/RL30707__2001May24.pdf (discussing the legislation’s effects on Medicare).

⁸⁰ Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (2003) (codified as amended in scattered sections of 26 & 42 U.S.C.).

⁸¹ Medicare Prescription Drug, Improvement and Modernization Act, 42 U.S.C.A. § 1395 (West Supp. 2005).

⁸² See *infra* notes 90–95, 99–99, 101–104 and accompanying text.

⁸³ Medicare is essential to rural health, since it may account for up to 70% of the total revenue for many rural providers. See Keith Mueller, Ph.D., Nat’l Rural Health Ass’n, Testimony before the Nat’l Bipartisan Comm’n on the Future of Medicare (Sept. 8, 1998),

of the unique needs and characteristics of rural populations,⁸⁴ but also because Medicare's complex funding formula currently favors urban providers.⁸⁵ The Senate Rural Health Caucus has worked long and hard to address the current rural inequities of the Medicare program.⁸⁶ The fact that the MMA contains the largest rural health package to date—approximately \$25 billion for rural providers, including \$40 million for Wyoming providers over the next ten years⁸⁷—is an indication that the Caucus has begun to succeed in that endeavor.

The package makes the equalization of the standardized base payment amount permanent in all states and territories.⁸⁸ The MMA addressed the payment disparities in Medicare between rural and urban health providers for hospitals, physicians, ambulances, and home health agencies.⁸⁹

For hospitals, the MMA extends the equalization of in-patient base payments,⁹⁰ making permanent what would have otherwise been a temporary elimination of disparities between hospitals in large urban areas and hospitals in rural and small urban areas.⁹¹ In addition, the MMA equalizes Medicare disproportionate share payments⁹² to Disproportionate Share Hospitals (DSHs), rural hospitals, rural referral centers, and Sole Community Hospitals (SCHs).⁹³ These payments are meant to improve services for a large number of uninsured, poverty-stricken, and indigent patients. The MMA package also creates a ceiling of 62% for the labor-related share of

available at <http://thomas.loc.gov/medicare/muellertest.html>.

⁸⁴ See *supra* Part II.

⁸⁵ See *supra* notes 50–51 and accompanying text.

⁸⁶ See, e.g., Letter from Senate Rural Health Caucus to Senate Finance Comm. and House Comm. on Ways and Means (July 15, 2005), available at <http://hospitalconnect.com/aha/advocacy-grassroots/advocacy/hillletters/content/030725senruralhlthlet.pdf>.

⁸⁷ See Fact Sheet, U.S. Dep't of Health and Human Servs., HHS Programs to Protect and Enhance Rural Health (Jan. 13, 2006) available at <http://www.hhs.gov/news/factsheet/rural.html>; Press Release, Craig Thomas, U.S. Senator (R-Wyo.), Thomas Attends Medical Bill Signing (Dec. 9, 2003), available at http://thomas.senate.gov/index.cfm?FuseAction=PressReleases.Detail&PressRelease_id=165&Month=12&Year=2003.

⁸⁸ As of April 1, 2004, urban and rural standardized amounts (under PPS) were permanently equalized through a single base payment for all hospitals. *MMA—Medicare Prescription Drug, Improvement and Modernization Act of 2003: Information for Medicare Rural Health Providers, Suppliers, and Physicians*, MEDLEARN MATTERS: INFO. FOR MEDICARE PROVIDERS. (Ctrs. for Medicare & Medicaid Servs., Baltimore, Md), Dec. 14, 2004, at 1, available at <http://www.cms.hhs.gov/medlearnmattersarticles/downloads/SE0450.pdf> [hereinafter *Information for Providers*].

⁸⁹ See *infra* notes 90–95, 99–99, 101–104 and accompanying text.

⁹⁰ Medicare Prescription Drug, Improvement and Modernization Act, § 401, 42 U.S.C.A. § 1395ww(d)(3)(A) (West Supp. 2005).

⁹¹ See *id.*; JENNIFER O'SULLIVAN ET AL., CONG. RESERACH SERV., RL31966—OVERVIEW OF THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003, at 18 (2003), available at <http://www.nachc.com/advocacy/files/CRSMedicareRxSummary.pdf>.

⁹² Disproportionate share payments are payments made to providers that “serve[] a significantly disproportionate number of low-income patients.” 42 U.S.C.A. § 1395ww(d)(5)(F)(i) (I).

⁹³ 42 U.S.C.A. § 1395ww(d)(5)(F).

the wage index in low-wage areas,⁹⁴ which will further boost payments to rural hospitals.⁹⁵

The effort also extends the current “hold harmless” provisions for rural hospitals from the Outpatient Prospective Payment System.⁹⁶ This assures that isolated rural hospitals with less than 100 beds are protected from payment decreases.⁹⁷ Hospitals with fewer than 800 annual discharges will receive up to a 25% increase in inpatient payments.⁹⁸ This creates a new low-volume payment system to recognize the different economies of scale of rural hospitals. Finally, the MMA provided a 5% bonus payment for rural home health agencies⁹⁹ as well as an increase in payments for ground and air ambulance transportation.¹⁰⁰

For physicians, the MMA establishes a floor for the downward adjustment of payments based upon geographical regions and their relative cost differences so that the value of rural physicians’ time and effort is not minimized in comparison to their urban counterparts.¹⁰¹ The MMA also increases payments for all physicians by turning planned cuts in Medicare physician fees into 1.5% pay increases in 2004 and 2005.¹⁰² Furthermore, the MMA improves the Medicare Incentive Payment Program (MIPP) by creating a new 5% bonus payment program based upon physician scarcity.¹⁰³ These provisions create incentives for doctors to practice in areas where there are physician shortages, many of which are rural.¹⁰⁴

Finally, the MMA strengthens the Critical Access Hospital (CAH) program through provisions to increase the qualifying bed limit from 15 to 25, to provide flexibility within the 25-bed limit for acute care,¹⁰⁵ as well as to increase reimbursement by basing its calculation on 80% of 101% instead of 80% of 100% of reasonable costs for CAHs.¹⁰⁶ The MMA also provides additional funding and flexibility by authorizing periodic interim payments;¹⁰⁷ paying the costs of more emergency room on-call

⁹⁴ 42 U.S.C.A. § 1395ww(d)(3)(E).

⁹⁵ See H.R. REP. NO. 108-391, at 610 (2003) (Conf. Rep.) (“Decreasing [the] labor-related share . . . increase[s] Medicare payments to hospitals in areas with wage indices below one.”); Kathleen Dalton et al., *Rural Hospital Wages and the Area Wage Index*, 24 HEALTH CARE FINANCING REVIEW 164, fig.3 (2002) (demonstrating a correlation between rural areas and lower relative wages).

⁹⁶ 42 U.S.C.A. § 1395l(t)(7)(D).

⁹⁷ See O’SULLIVAN ET AL., *supra* note 91, at 18.

⁹⁸ 42 U.S.C.A. § 1395ww(d)(12).

⁹⁹ 42 U.S.C.A. § 1395fff (“[T]he Secretary shall increase the payment amount . . . for [home health] services by 5 percent.”).

¹⁰⁰ 42 U.S.C.A. § 1395m(l).

¹⁰¹ 42 U.S.C.A. § 1395l(u).

¹⁰² 42 U.S.C.A. § 1395w-4(d)(5).

¹⁰³ 42 U.S.C.A. § 1395(u)(B).

¹⁰⁴ See *supra* notes 32–36 and accompanying text.

¹⁰⁵ 42 U.S.C.A. § 1395i-4(c)(2)(B).

¹⁰⁶ 42 U.S.C.A. §§ 1395f(1), m(g)(1), tt(a)(3).

¹⁰⁷ 42 U.S.C.A. § 1395g(e)(2).

providers;¹⁰⁸ permitting distinct units for psychiatric and rehabilitation;¹⁰⁹ and providing four additional years of special grant funding.¹¹⁰ The CAH program has been essential to keeping some Wyoming hospitals open, and there are now at least fourteen CAHs in the state, including those in Basin, Worland, Thermopolis, Newcastle, Douglas, Wheatland, and Torrington.¹¹¹

The substantive changes in CAH and other rural health programs are a reasonable short-term solution for rural health needs. In the long-term, however, either reimbursement policies need to change or the entire system must become market-driven and lose its basis in an artificially overpriced insurance-reimbursement system that does not adequately inform buyers of what they are purchasing. If we are to improve upon the efforts that the Senate Rural Health Caucus has begun over the past decade, then Congress must place the tremendous needs of rural health care at the top of its agenda.

VI. CONCLUSION

We must continue the fight for rural health care access and affordability. The task before Congress may be Herculean, but it is important to focus on the steps we can take for the greater good of rural health. There is momentum in 2006 for efforts involving Health Savings Accounts.¹¹² With so many Americans changing jobs,¹¹³ we need to give some “portability” to our health care system. This may also help us develop a system where we “shop” for our health care needs, knowing that we have a finite amount of money to use. While the creation of a more market-driven health care system should control costs, it would not fully address rural health needs.

I will continue efforts to shore up rural health networks through collaboration and fair and equitable payment policies. I will also work to provide more access to mental health and substance abuse programs, which are desperately needed in many rural areas and have become a growing concern in Wyoming.¹¹⁴ Another focus must be the needs of rural America’s

¹⁰⁸ 42 U.S.C.A. § 1395m(g)(5).

¹⁰⁹ 42 U.S.C.A. § 1395i-4(c)(2).

¹¹⁰ 42 U.S.C.A. § 1395i-4(j).

¹¹¹ See Flex Monitoring Team, A Complete List of Critical Access Hospitals (Feb. 28, 2006), http://flexmonitoring.org/documents/CAHlist_current.xls.

¹¹² See Personal Responsibility and Individual Development For Everyone Act, S. REP. NO. 109-051, at § 223 (2005) (providing for the establishment of deductions for health savings plans).

¹¹³ See Ronald Bird, Chief Economist, Employment Policy Foundation, Testimony to U.S. Senate Comm. on Appropriations (May 4, 2004), *available at* <http://appropriations.senate.gov/hearings/record.cfm?id=221090> (“In 1938, most workers expected to stay with a single employer for his or her working life. Today, average job tenure is under five years and declining.”).

¹¹⁴ Press Release, University of Wyoming, College of Health Sciences, UW Program to Improve Access to Wyoming Primary Mental Health Care (Aug. 9, 2005), *available at* <http://>

aging population.¹¹⁵ We must also remain steadfast in encouraging providers to practice in designated physician-shortage areas. Finally, throughout this looming health care debate, we need to remember to be creative and to help Americans help themselves. As we shape health policy for all Americans, we need to work collaboratively with federal, state, and private interests and in concert with associations and providers, to find common-sense solutions to rural health care needs.

uwadmnweb.uwyo.edu/hs/showrelease.asp?id=961 (“[Wyoming] has the second highest rate of suicide per 100,000 people in the nation. . . . Wyoming also has the fourth highest rate of substance abuse.”).

¹¹⁵ See ECON. RESEARCH SERV., *supra* note 23.