North Dakota Rural Health Report

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July 2018

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EXECUTIVE SUMMARY

Americans living in rural communities face unique barriers to accessing health care: they often have to travel longer distances to visit doctors and other providers, and they experience provider shortages more often. They also tend to have lower incomes than their urban counterparts, and often live in areas with higher-cost health care.

When politicians threaten to repeal rather than strengthen provisions of the Affordable Care Act, end Medicaid expansion, cut funding to outreach available to help individuals enroll and maintain insurance coverage, they put the health and health care of a significant portion of rural residents in North Dakota and elsewhere in jeopardy. Furthermore, eroding quality health coverage threatens the financial health of many rural hospitals.

The Affordable Care Act (ACA) and the opportunity it created to expand Medicaid have been crucial in supporting access to health care in rural communities. However, continuous efforts over the past year by many Members of Congress and the Administration to roll back key provisions has reversed many of these gains. Premiums have increased, affordable coverage for people with pre-existing health problems like cancer and diabetes is directly threatened and key components of the rural health care system, including financial viability of rural hospitals is compromised.

Following the implementation of the ACA, the uninsured rate in rural areas across the nation dropped from 17 percent in 2013 to 12 percent in 2015. The ACA has expanded access to health care to nearly 1.7 million rural Americans who have gained coverage through Medicaid expansion. These gains play a central role in improving rural communities' health and also support community economic well-being. Medicaid covers nearly 24 percent of rural Americans, 45 percent of rural children, 15 percent of rural seniors, and pays for 51 percent of rural births.

The uninsured rate in rural areas in states that expanded Medicaid has dropped by a median of 44 percent since expansion. In North Dakota, the uninsured rate dropped from 12.1 to 8.9 percent between 2013 and 2016. As of 2018, 26,000 additional North Dakotans were covered through Medicaid and the Children's Health Insurance Program. Also as a result of the ACA, in North Dakota over 359,000 people, most with employer sponsored coverage, obtained access to preventive health services like flu shots and cancer screenings with no out-of-pocket costs. However, much of this progress is at risk because of the Trump Administration and Congressional efforts to significantly weaken important provisions of the law.

In addition to expanding Medicaid, the Affordable Care Act paved the way for people who are self-employed or work at small businesses to purchase health insurance in the state Marketplaces, including in North Dakota. This is particularly important given rising self-employment in rural areas. Between 2013 and 2015, the number of uninsured small business employees fell from 13.9 million to 9.8 million, and the uninsured rate for small business employees fell from 27.4 percent to 19.6 percent. By 2018, 22,500 North Dakotans had enrolled in the new ACA Marketplace. Nevertheless, the Trump Administration drastically cut funding to organizations in North Dakota and other states that work with individuals and families to help them enroll in insurance coverage that best fits their budget and their health needs.

Equally at risk are rural hospitals, which rural communities often depend on for a wide range of health services. Since 2010, across the nation, 84 rural hospitals have closed.[1] The vast majority, 90 percent, were in states that refused to expand Medicaid at the time of the hospital's closure. As of 2016, 673 rural hospitals were at risk of closing. Continued efforts to dismantle insurance coverage and roll back Medicaid threaten the financial stability of these hospitals.

Since January 2017, President Trump and Republican Members of Congress have repeatedly attempted to repeal the Affordable Care Act, end Medicaid expansion, weaken states' individual insurance markets and roll back protections for individuals with pre-existing health care conditions. This report shows how the Affordable Care Act and Medicaid have

[1] The Twin Rivers Regional Medical Center ended operations on 6/11/18. At the date of publishing, this closure was not yet reflected in the Sheps Center list of hospital closures.

strengthened the landscape of rural health, how weakening Medicaid jeopardizes rural health, and what rural communities stand to lose as a result of the Congressional and Administration repeal agenda.

IMPACT OF THE AFFORDABLE CARE ACT IN NORTH DAKOTA

As Republicans in Congress continue to try to repeal and sabotage the Affordable Care Act, more people are learning that the law is working for them, which may be why the law has gotten more popular than ever.

Here is how the Affordable Care Act is working in North Dakota:

Insurers can no longer deny or drop coverage because of a pre-existing condition. Because of the ACA, insurers in the individual market could no longer drop or deny coverage, or charge you more, because of a pre-existing condition. Roughly 315,000 North Dakotans have a pre-existing health condition.

Young adults can stay on their parents plan until age 26. Because of the ACA, roughly 7,000 young adults in North Dakota have coverage because they can stay on their parents coverage until age 26.

Helping seniors afford prescription drugs. Because of the ACA, the Medicare prescription drug donut hole is closed. As a result, 11,110 North Dakota seniors are saving $11.5 million on drugs in 2016, an average of $1,037 per beneficiary

Allowed states to expand Medicaid. Because of the ACA, states can get additional federal money to expand Medicaid. 18,000 North Dakotans have gained coverage because of this program.

Women no longer charged more than men. Because of the ACA, insurers can no longer charge women more than men for the same care.

Ended annual and lifetime limits. Because of the ACA, insurers can no longer put annual or lifetime limits on the care you receive.

Free preventive care. Because of the ACA, health plans must cover preventive services — like flu shots, cancer screenings, contraception, and mammograms – at no cost to consumers, roughly 360,000 North Dakotans, most of whom have employer coverage.

Comprehensive Coverage. Because of the ACA, insurers have to cover what are known as "essential health benefits," such as maternity care, prescription drugs, and substance and mental health.

Tax credits are available to help people afford coverage. Because of the ACA, most people getting coverage on the marketplace qualify for tax credits to help pay for coverage.

NORTH DAKOTANS AND PRE-EXISTING CONDITIONS

The Trump Administration recently announced a dramatic escalation of its attempts to roll back protections for people with pre-existing conditions, saying its Department of Justice will ask the courts to eliminate these protections. The move comes after multiple attempts by Congress to repeal the Affordable Care Act and Administration proposals to encourage short-term 'junk' plans that can discriminate against people with pre-existing conditions.

North Dakotans with a pre-existing condition by the numbers:

316,000 North Dakotans Live With A Pre-Existing Condition. About one in two North Dakotans, 50 percent, lives with a pre-existing condition.

154,000 North Dakota Women And Girls Have A Pre-Existing Condition. Approximately 154,000 women and girls in North Dakota live with a pre-existing condition.

40,800 North Dakota Children Already Have A Pre-Existing Condition. Roughly 41,000 North Dakotans below age 18 live with a pre-existing condition.

73,700 Older North Dakotans Live With A Pre-Existing Condition. 73,700 North Dakota adults between the ages of 55 and 64 live with at least one pre-existing condition, meaning attacks on these protections significantly threaten North Dakotans approaching Medicare age.

Two out of three farmers and ranchers (64%) report having a pre-existing health condition and could be priced out of the individual health insurance market without a requirement for coverage of pre-existing conditions

One in two farmers and ranchers (52%) are not confident they could pay the costs of a major illness such as a heart attack, cancer or loss of limb without going into debt.

THE AFFORDABLE CARE ACT OUTLAWED DISCRIMINATION BASED ON PRE-EXISTING CONDITIONS

Because Of The Affordable Care Act, Insurance Companies Can No Longer Deny Coverage Or Charge More Because Of Pre-Existing Conditions. "Under current law, health insurance companies can't refuse to cover you or charge you more just because you have a 'pre-existing condition' — that is, a health problem you had before the date that new health coverage starts." *[HHS]*

The ACA Outlawed Medical Underwriting, The Practice That Let Insurance Companies Charge Sick People And Women More. As the Brookings Institution summarizes, "The ACA outlawed medical underwriting, which had enabled insurance carriers to court the healthiest customers while denying coverage to people likely to need costly care. The ACA guaranteed that all applicants could buy insurance and that their premiums would not be adjusted for gender or personal characteristics other than age and smoking."

The ACA Stopped Companies From Charging Women More Than Men For The Same Plan. The Affordable Care Act eliminated "gender rating," meaning American women no longer have to pay an aggregated $1 billion more per year than men for the same coverage.

Thanks To The Affordable Care Act, Insurance Companies Can No Longer Rescind Coverage Because of Illness. Because of the ACA, insurance companies can no longer rescind or cancel someone's coverage arbitrarily if they get sick.

OVERVIEW: KEY HEALTH AND ECONOMIC CHALLENGES FACING RURAL COMMUNITIES

LOWER-INCOME AND FEWER JOB OPPORTUNITIES

The 2008 recession hit rural communities especially hard. Today, the rural job market remains more than four percent smaller than it was in 2008 while the urban job market is four percent larger. Among those in rural areas who are working, a higher percentage of workers live near or below the poverty line. In 2015, 18.4 percent of rural working households lived in families with incomes less than 150 percent of the federal poverty line. In comparison, 13.5 percent of urban working households lived with incomes less than 150 percent of the federal poverty line. The average per capita income in counties served by rural hospitals is $32,781, while the average per capita income in counties served by urban hospitals is $41,003.

HEALTH INSURANCE COVERAGE

The percent of people with health insurance tends to be lower in rural communities than urban communities. Because rural communities tend to have higher employment in fields such as agriculture that do not typically provide employer-sponsored health care, people living in rural communities are less likely to have private health coverage. 61 percent of Americans living in rural areas are covered by private health insurance, versus 64 percent in urban areas and 66 percent in other non-rural areas. It can also be difficult for some rural people to afford coverage on the individual market, especially if they do not receive tax credits through the ACA.

ACCESS TO CARE

People living in rural areas are typically further away from health care providers and have access to a smaller supply of providers than people in urban areas. In rural communities, there are on average 39.8 physicians per 100,000 people, compared to 53.3 physicians per 100,000 people in urban settings. Difficulty accessing hospitals has a negative impact on people's health. The Centers for Disease Control and Prevention found that between 1999 and 2015, the rate of accidental death was almost 50 percent higher in rural areas than urban areas. As a partial explanation, the CDC cited the distance between hospital facilities in rural areas: "because of the distance between healthcare facilities and trauma centers, rapid access to specialized care can be more challenging for people injured in rural areas."

Similarly, it is also harder to access basic services like maternity care in rural areas. A 2017 study found that fewer than half of all rural counties in the United States had hospital-based obstetric care as of 2014. When hospitals face financial hardship, obstetric services are among the first to be cut.

OPIOID EPIDEMIC

The opioid epidemic is taking a significant toll on rural communities. According to the Centers for Disease Control and Prevention (CDC), the rate of drug overdoses in rural communities is about 17 per 100,000 residents. Agricultural workers have been hit especially hard by the epidemic. According to a 2017 study by the National Farmers Union and the American Farm Bureau Federation, three in four farmers have misused opioids or know someone who has. Consequently, ensuring the availability of affordable health insurance plans that cover treatment for opioid and other substance use disorders is critical for rural communities. The prevalence of substance use disorder in rural communities is and another reason why the ACA requirement that insurance companies cover essential health benefits, including prescription drugs, clinic visits and hospital stays for these and other health problems is particularly important.

RURAL HOSPITALS: SOURCE OF HEALTH CARE AND JOBS

Since 2010, 84 rural hospitals across the United States have closed, the vast majority of them in states that did not expand Medicaid. States that have chosen to expand Medicaid have had vastly different experiences compared to states that chose not to expand. A 2018 Health Affairs study found that states that refuse to expand Medicaid experienced a large increase in the rate of hospital closures from 2008-12 to 2015-16. States that expanded Medicaid encountered the opposite — their rates of hospital closures decreased after expanding Medicaid. Overall, hospitals in expansion states were six times less likely to close than hospitals in non-expansion states.

Also, because of the mix of demographic trends such as an aging population, economic difficulty in rural areas, aging facilities, and challenges for hospitals in adapting to changing payment models and delivery systems, many more rural hospitals (nearly 673) are financially fragile and vulnerable to policies that compromise their bottom lines.

Because of the long distance between hospitals and trauma centers in rural areas, communities can lose access to specialty health services, primary care, and other forms of care when hospitals close. In a study of rural hospital closures, the Kaiser Family Foundation found that some specialty services - like obstetric care, diagnostic testing, and mental health care - were entirely based in rural hospitals. When the hospitals closed, rural residents were no longer able to access these services. Similarly, in each rural hospital studied by Kaiser, the emergency department functioned as a major source of primary care for the community.

Rural areas also have difficulty recruiting and retaining providers, which results in systemic health workforce shortages. These shortages get worse when hospitals close. As Kaiser highlighted, "When the hospital closed, many physicians relocated to another hospital in the owner's system or left the area. As a result, communities were often left without key providers."

Rural hospitals contribute significantly to local economies by employing large numbers of people with relatively high-paying jobs. When rural hospitals close, communities can lose a staggering number of jobs. Beyond being a source of jobs, hospitals tend to pay higher wages than other rural industries. As the House of Representatives Minority Staff report on rural hospitals

highlights, "The average pay of hospital employees in rural counties is 43 percent higher than the average pay of other workers in the same counties."

As the director of the Rural Health Research Program at the University of North Carolina, emphasizes, "Losing an employer of 150 people with good jobs is like losing a manufacturing plant…Hospitals are usually the largest, or the second-largest, employer in a rural community. That's something that's easy to lose sight of because we think of this from a health standpoint. But the effects are wide-ranging when a hospital closes" (M. Holmes).

THE AFFORDABLE CARE ACT AND MEDICAID: LIFELINES FOR CARE IN RURAL COMMUNITIES

Medicaid is critical to ensuring that individuals and families in rural communities have health coverage, which generally have lower rates of employer-sponsored coverage than other areas. Nearly one in four rural Americans have health coverage through Medicaid. The rates of Medicaid coverage are generally higher in rural areas than in other areas of the country (Kaiser Family Foundation).

Medicaid plays an especially important role in covering rural seniors and children. Nationally, nearly 15 percent of seniors living in rural areas have health coverage through Medicaid and Medicaid pays for more than 50 percent of long-term care, including nursing home care. Similarly, Medicaid provides health care for 45 percent of children in rural areas, and pays for 51 percent of rural births.

By opening the doors to Medicaid expansion, the ACA significantly expanded access to health care in rural communities, reduced rural hospitals' uncompensated care costs, and helped rural health providers keep their doors open by allowing states to expand Medicaid coverage for adults up to 138 percent of the federal poverty line. Medicaid expansion allowed 1.7 million rural Americans to gain coverage who had not previously been eligible. Following Medicaid expansion, the uninsured rate in rural parts of expansion states decreased by a median of 44 percent. In rural states that expanded Medicaid, uninsured rates dropped significantly after the ACA became law. In North Dakota, the uninsured rate dropped from 12.1 to 8.9 percent between 2013 and 2016.

Underscoring the difference in health that Medicaid expansion makes, a study published in 2017 in the American Public Health Association journal indicated that individuals residing in states that expanded Medicaid were diagnosed with cancer much earlier than individuals with cancer diagnoses in non-expansion states. Time of diagnosis has real impact on the ability to effectively treat many patients with cancer.

By increasing access to health care, Medicaid expansion also drastically reduced the amount of costs that a hospital absorbs for any treatment or service not paid for by an insurer or patient, known as uncompensated care. The Center on Budget and Policy Priorities found that "states that expanded Medicaid to low-income adults under the ACA saw both larger coverage gains and larger drops in uncompensated care: a 47 percent decrease in uncompensated care costs on average compared to an 11 percent decrease in states that did not expand Medicaid."

A Commonwealth Fund study yielded similar findings: uncompensated care costs decreased substantially in states that expanded Medicaid. On average, uncompensated care costs in Medicaid expansion states decreased from 3.9 percentage points to 2.3 percentage points between 2013 and 2015. Medicaid coverage gains have the economic benefit of reducing the amount of uncompensated care costs hospitals incur. RWJF and Urban calculate that if all states were to fully expand Medicaid, hospitals' uncompensated care would decline by $8 billion.

COMMUNITY HEALTH CENTERS FARE BETTER IN STATES THAT EXPANDED MEDICAID

Just as rural hospitals fare better in states that expanded Medicaid, so too do community health centers (CHCs). Community health centers in North Dakota and elsewhere provide comprehensive primary health services to underserved areas. They are particularly important in rural areas where people face increased barriers to care. A recent study in Health Affairs highlighted

how Medicaid expansion strengthens community health centers in rural areas by reducing the number of uninsured patients they see, and improving their quality of care.

The study revealed that Medicaid expansion decreased the percentage of uninsured patients seen by community health centers. Expansion was associated with an 11.4 percentage point decrease in the proportion of uninsured patients a community health center received, and a 13.2 percent increase in patients with health coverage through Medicaid.

The report also found that expansion was associated with improved quality of care in rural areas. For instance, in rural areas that expanded Medicaid, patients with asthma were 3.5 percent more likely to receive appropriate pharmacologic treatment and patients with high blood pressure were 2.1 percent more likely to achieve blood pressure control.

DISMANTLING QUALITY HEALTH COVERAGE HURTS RURAL AREAS

The Trump Administration and many Republican Members in Congress have spent the past year pushing an agenda designed to reduce enrollment in Affordable Care Act Marketplaces, limit low income Americans' access to health care, erode Medicaid, weaken insurance coverage and put the financial and physical health of individuals with pre-existing health conditions like asthma and diabetes at serious risk. These policies hit rural areas particularly hard, because of higher rates of chronic health problems in rural versus urban areas, lower average incomes and fewer people with access to employer-sponsored insurance.

By cutting funding to Medicaid, allowing states to adopt policies that make it more difficult for their residents to obtain health coverage, and working to dismantle consumer protections that support access to care for individuals with pre-existing conditions, President Trump and many Republicans in Congress make it harder for people living in rural areas to get health coverage and care.

RECENT CONGRESSIONAL ACTION TO SLASH MEDICAID

Since taking office, the Trump Administration and Republicans in Congress have repeatedly tried to repeal key provisions supporting programs and policies important to rural Americans. Consumer and health care provider organizations ranging from the American Medical Association, American Nurses Association, the Catholic Health Association to AARP and the American Cancer Society, have spoken out in opposition to some or all of these efforts because of their impact on health and health care, including opposing:

- President Trump's FY 2019 budget: $1.4 trillion in cuts to Medicaid
- September 2017 - Graham-Cassidy: more than $1 trillion in cuts over 20 years
- July 2017 - Senate's repeal, "Better Care Reconciliation Act": $842 billion cut by 2026
- May 2017 - House repeal bill, "American Health Care Act": $834 billion in cuts to Medicaid over 10 years **People in Rural Areas Would Be Hit Hard Hard Because the House Repeal Bill Doesn't Take Income or Location into Account.** Premiums for individuals in marketplaces in rural areas were 6.6 percent higher than the national average in 2016 because insurance pools tend to be smaller making the costs for services in those areas higher. The Affordable Care Act bases its tax credits on age, income and geographic location, but the House repeal bill (AHCA) only takes age into account. Therefore, not only would the House repeal bill cut the amount of tax credits available for many people, but because it did not take into account income or location - people in rural areas would have been even more adversely impacted by the House repeal bill and find coverage further out of reach.
- **30 Million Would Have Been Subject to Penalty - Particularly in Rural Areas.** The Commonwealth Fund estimated that if the House repeal bill had been in effect for the 2016 coverage year, 30 million people would have been subject to the 30 percent premium surcharge because they experienced a gap in coverage longer than 63 days. A 30-year-old would be forced to pay roughly $1,000 more while a 50-year-old would face a $2,100 penalty. As the

Commonwealth Fund points out, "People who live in rural and other areas of the country where health care costs and premiums are higher also would face higher premium surcharges if they had a gap in coverage."

- **Under The House Repeal Bill, A 45 Year Old Earning $18,000 Per Year Living In Rural Area Would Pay $2,291 More Per Year. A 62 Year Old Earning The Same Would Pay $9,075 More.** The Wall Street Journal reported, "The House Republican effort to overhaul the Affordable Care Act could hit many rural areas particularly hard, according to a new analysis, sharply increasing the cost for some residents buying their own insurance...The Oliver Wyman analysis, which used data from states and the federal Department of Health and Human Services, projected the cost of a benchmark plan at the "silver" level in 2020 in each county in the U.S....Countrywide, a rural 45-year-old making around $18,000 a year would pay about $2,291 a year more on average from his own wallet under the Republican bill than under the ACA, according to the analysis — compared with a $1,588 increase for a 45-year-old urban resident. For 62-year-olds earning about $18,000, the average increases in cost under the Republican bill's setup were far greater: $9,075 for rural and $6,954 for urban consumers."

- June 2018 – President Trump's Department of Justice chooses not to defend ACA provisions that protect access to affordable health insurance for people with pre-existing health conditions

Following these and other attempts to dismantle health care coverage, The Trump Administration and Congressional Republicans passed a $1.5 trillion tax cut last fall. To pay for these tax cuts, a number of Congressional Republicans have suggested they will need to cut funding for important public health programs, like Medicaid.

IMPOSING ADMINISTRATIVE HURDLES TO COVERAGE

Beyond trying to cut Medicaid funding, the Trump Administration is also working to change the fundamental structure of the program by preventing people from accessing coverage through Medicaid if they fail to document working a certain number of hours each month, adding a significant barrier between individuals and their health care providers. Experts warn that imposing such requirements could significantly reduce Medicaid enrollment by imposing administrative hurdles that make it significantly harder for people to access care. In order to establish these new requirements, significant administrative capacity will need to be built into state government infrastructure, often with substantial costs, even though the vast majority of people receiving Medicaid are employed or in a family with one or more family members working.

Comparable paperwork requirements have a history of reducing enrollment. In 2003, Washington State required people enrolled in Medicaid to submit documentation proving they were still eligible for the program twice a year, instead of the previous annual requirement, and enrollment in the program fell by 40,000. The Tennessee Justice Center estimated more than 480,000 Tennesseans would lose coverage because of bureaucratic red tape if the state were to impose such requirements.

After Indiana adopted such a policy, more than half of people covered by Medicaid who had incomes below the federal poverty line, 287,000 people, missed premium payments. As a result, they were involuntarily moved from comprehensive plans to plans with a more limited benefit package. Individuals without access to needed health care services can be more likely to miss days from work or fall behind in job training and educational programs.

NEW ACTIONS BURDEN RURAL HOSPITALS AND JEOPARDIZE RURAL AMERICANS' ACCESS TO CARE

Trump Administration actions also undermine health care for Americans living in rural areas by encouraging the proliferation of association health plans and short-term health plans, and repealing the requirement that most Americans carry health insurance.

Association Health Plans

The Trump Administration has introduced new regulations that expand access to skimpy health plans, known as "association health plans", that are allowed to skirt some of the Affordable Care Act's core consumer protections**.** In May of 2018, the House of Representatives included in its annual farm bill a $65 million fund to set up association health plans (AHPs). These plans, designed for small businesses and associations, let small employers purchase cheaper health insurance. However, AHPs do not provide the same type of comprehensive quality health care coverage ordinarily offered through employer-sponsored care or the ACA marketplaces.

Instead, AHPs offer plans that are allowed to exclude or limit basic services such as prescription drug coverage, mental health care, and hospital care. AHPs allow plans that do not require coverage of people with pre-existing health conditions. Subpar coverage and the lack of consumer protections are especially dangerous for those working in the agricultural sector, where the injury rate is 40 percent higher than the national workplace average. Beyond just offering subpar coverage, association health plans also have a history of fraud and unpaid claims. Experts, such as the National Association of Insurance Commissioners, warn that association health plans may destroy the small-group market and make health insurance on the ACA Marketplace more expensive.

In rural communities, association health plans can make it even more difficult for people to afford comprehensive health care, and instead leave people with subpar plans that provide minimal coverage.

Short-Term Health Plans

The Trump Administration is encouraging states to sell short-term plans, often referred to as junk plans, that are exempt from key Affordable Care Act requirements. Like association health plans, short-term health plans do not have to cover essential health benefits such as cancer treatment, substance use treatment, or maternity care. They can deny coverage altogether for those with pre-existing conditions, and leave people with hundreds of thousands of dollars in unpaid medical bills should they fall sick.

Overwhelmingly opposed by groups representing patients, physicians, nurses, and hospitals, short-term plans would draw consumers out of the ACA marketplaces because of their lower prices only to leave them in financial ruin should they fall sick. For people living in rural areas, these plans would offer subpar coverage and make comprehensive coverage even more expensive.

Repealing the Individual Mandate

In December 2017, Republicans in Congress passed a tax bill that repealed the requirement that most people have insurance. Repealing this requirement is expected to drive healthy people out of the health care markets, ultimately causing premiums to increase. The Kaiser Family Foundation, warns that this change will pose a particular burden to rural areas: "Repealing the individual mandate will affect insurance markets everywhere, but markets where there is already little choice and high premiums are especially vulnerable...Rural areas could be especially hard hit."

According to a Los Angeles Times analysis based on data from the Kaiser Family Foundation, there are 454 counties in which only one insurance company will be selling marketplace plans in 2018, and where the cheapest plan for a 40-year-old consumer will cost more than $500 a month. Of these at-risk counties, 86 percent have fewer than 50,000 residents. They are largely concentrated in rural states. By increasing premiums, the repeal of the individual mandate could put health care out of reach for Americans living in these rural counties.

CONCLUSION

Rural Americans face unique challenges in accessing health care. In addition to facing economic barriers such as lower average incomes, and lower levels of access to employer-sponsored health care, they also face geographic barriers, such as longer distances between health care providers and fewer providers to choose from.

The Affordable Care Act has improved access to health care in rural areas, particularly in states that expanded Medicaid. Medicaid expansion, in particular, has helped to dramatically reduce the uninsured rate of people living in rural areas, and has been instrumental in supporting rural hospitals and community health centers.

Instead of building on the Affordable Care Act's progress, recent federal level policies walk back recent progress in rural health. The Republican-led Congressional health care agenda erodes comprehensive health coverage for Americans and markedly limits Medicaid. These measures disproportionately impact rural areas, increase barriers in access to health care, lead to coverage losses, increase the likelihood that rural hospitals will close, threaten major sources of jobs in rural communities, and jeopardize access to health services. Simply put, instead of strengthening access to affordable quality health care, and building on what works in the Affordable Care Act, the proposed health care agenda severely compromises health care access for rural Americans, including rural North Dakotans.

APPENDIX A: BY THE NUMBERS — RURAL HEALTH IN NORTH DAKOTA

- In North Dakota, the uninsured rate dropped from 12.1 to 8.9 percent between 2013 and 2016
- **11 percent of North Dakotans living in rural areas have health coverage through Medicaid.**
- **The Affordable Care Act led to a $46 million reduction in North Dakota uncompensated care costs.** Between 2013 and 2015, North Dakota hospitals' uncompensated care costs decreased by $46 million, or roughly 38 percent.
- **In North Dakota, where lawmakers expanded Medicaid, no rural hospitals have closed since 2010.**

FURTHER READING

Center on Budget and Policy Priorities, "Medicaid Works for People in Rural Communities." 1/19/18.

Center on Budget and Policy Priorities, "Uncompensated Care Costs Fell in Nearly Every State as ACA's Major Coverage Provisions Took Effect." 5/23/18.

Commonwealth Fund, "Impact of the ACA's Medicaid Expansion on Hospitals' Uncompensated Care Burden and the Potential Effects of Repeal." 5/3/17.

Georgetown University Health Policy institute Center for Children and Families. "Medicaid in Small Towns and Rural America: A Lifeline for Children, Families, and Communities." *Rural Health Policy Project.* June 2017.

Georgetown University Health Policy institute Center for Children and Families. "Medicaid's Role for Seniors Living in Small Towns and Rural America." *Rural Health Policy Project.* June 2017.

Health Affairs, "Understanding The Relationship Between Medicaid Expansions and Hospital Closures." January 2018.

Health Affairs, "Medicaid Expansion and Community Health Centers: Care Quality And Service Use Increased For Rural Patients." June 2018.

Kaiser Family Foundation, "The Role of Medicaid In Rural America." 4/25/17.

Kaiser Family Foundation, "Changes in Insurance Coverage in Rural Areas under the ACA: A Focus on Medicaid Expansion States." 5/4/17.

Kaiser Family Foundation, "Digging Into the Data: What Can We Learn from the State Evaluation of Healthy Indiana (HIP 2.0) Premiums." 3/8/18.

Kaiser Family Foundation, "Medicaid and Work Requirements: New Guidance, State Waiver Details and Key Issues." 1/16/18.

National Rural Health Association, "Birth volume and the quality of obstetric care in rural hospitals." *Journal of Rural Health.* Fall 2014.

Protect Our Care, "Health Care Sabotage Tracker." June 2018.

Protect Our Care, "Fact Sheet: Association Health Plans." 5/17/18.

Protect Our Care, "Fact Sheet: Short-Term Junk Plans." 2/20/18.

Robert Wood Johnson Foundation and the Urban Institute. "The Implications of Medicaid Expansion in the Remaining States: 2018 Update." May 2018.

University of North Carolina Sheps Center For Health Services Research. "83 Rural Hospital Closures: January 2010 - Present." June 2018.