



DATA FOR *PROGRESS*

THE CASE FOR NATIONALIZING RURAL HOSPITALS

BY COLIN WICK



The healthcare debate mostly focuses on how to reach universal insurance coverage, but the actual provision of healthcare carries its own unique challenges that insurance reform can't and won't solve. To ensure that doctors and nurses can provide care for those who need it most, we must fix how we manage rural hospitals. Since 2013, 103 rural hospitals have closed down.¹

Closures occur in sparsely populated counties, where the median population was thirty thousand people. Compared to the nation at large, these counties have lower median incomes, older populations, and higher proportions of residents without health insurance—the exact sort of folks for whom access to healthcare is a top concern.

Eighty-three percent of rural hospital closures took place in states that did not expand Medicaid, and 77 percent took place in the South. Nationally, 12.3 percent of rural residents are uninsured, according to the US Census Bureau.² Rural areas suffer from high concentrations of “deaths of despair”—opioid overdoses, alcohol-related liver disease, and suicide—as local resources dwindle and health providers struggle to keep up. And as the opioid epidemic has worsened, the rate of hospital closures has increased, only compounding the suffering. In fact, almost thirty million Americans live more than an hour from the nearest trauma center.³

On top of this, many rural communities face both shrinking populations⁴ and rates of chronic illness higher⁵ than urban and suburban counties. These population-level differences, even if they are small, can have devastating effects when private-equity “logic” overshadows the need to provide healthcare to our less dense areas.

This policy brief lays out the obstacles that rural hospitals face, and why our current, privatized approach is failing rural communities. If we want to stop an avoidable health catastrophe that imposes staggering costs on the families and businesses of rural America, we must nationalize rural hospitals.

Part I: The problem as it stands

DEFINING “RURAL”

Different agencies define rurality in different ways, but the most common delineation refers to the 10-point scale (1=metropolitan, 10=rural) that the Census Bureau and Department of Agriculture use to describe individual counties. The defining elements are population density and proximity to a metropolitan area, and therefore, states with larger counties—such as Nevada and Arizona—require more consideration when determining rural health policy. To compensate for this, there are subcategories within each ranking in order to precisely define the amount of “rurality.”

HOW DO HOSPITALS MAKE MONEY?

Hospital finance is complicated, so complicated that many universities offer PhDs in the subject,⁶ and it is well documented⁷ how opaque and complex hospital pricing and finance are. Still, at least a basic understanding is needed if we want to keep rural hospitals open.

There are two models of medical pricing, fee-for-service, and managed care (also called “value-based care”). Fee-for-service is the system of itemizing each medical interaction that a patient has in a hospital, from documenting each minute of a doctor's time to charging for each alcohol swab—often at completely unreasonable prices.⁸

Managed care, on the other hand, essentially charges a flat fee for the entire medical interaction. The specific details and pricing schemes are much more complicated—but

for the sake of this discussion, that complexity is exactly what matters. Much of the healthcare world is trying to move toward the managed-care model because it is ultimately simpler and it aligns provider incentives with improved health. Managed-care systems achieve sustainability and better outcomes by using data and technology to improve pricing and get a deeper understanding of their patients, but rural communities may face challenges supporting this system, due to these communities' lower volumes of patients.

If the patient has health insurance, the hospital sends the bill to the health insurance company, and prices are negotiated down from the hospital's quoted rate, based on the patient's coverage and a variety of other factors, such as the respective market powers of the hospital and insurance company. Finally, the insurance company pays their portion of the agreed-upon bill, and the patient pays their share as well (which can vary significantly).

If the patient is uninsured, the hospital still must treat them, according to the Emergency Medical Treatment and Labor Act (EMTALA), a Reagan-era law that requires hospitals to treat all patients in emergency situations. In this case, the patient must pay the bills out of pocket some way or another, often by going into debt and paying off their medical bills over a longer period.⁹ This pool of lower-income individuals is also more likely to default on this debt, and then their debt is sent to collection agencies, which is often ruinous for folks.¹⁰ This matters to rural hospitals already serving lower-density communities. Their prices must reflect these expected losses, and they either have to increase prices for their insured patients, or they must absorb the costs.

WHY DO HOSPITALS STOP MAKING MONEY?

Hospitals are incorporated three ways: as a government entity, a nonprofit, or a for-profit. A 2016 study showed that the median closed rural hospital had an operating margin of -7.4 percent, while those that survived had an operating margin of 0.56 percent. For context, the median operating margin for an urban hospital hovers around 5 percent annually,¹¹ and even that is razor-thin.

This means rural hospitals are extremely sensitive to shocks, like an increase in opioid overdoses or a particularly tough flu season. Marginal demographic changes and other issues can shift profitability by a percentage point or less, and put a hospital under.

A small economic downturn that leads to marginally higher unemployment could cause a small increase in care given without the patient being able to pay. The median rural hospital has twenty-six beds, while most urban hospitals have at least 180 beds. These rural hospitals simply cannot recoup the costs on volume without a population size to support it.

Under EMTALA, these hospitals are required to treat uninsured patients in an emergency. The corresponding line item for these services are "Uncompensated Care," which falls into two main categories: "Bad Debt" and "Charity Care." The Federal Office of Rural Health Policy (FORHP) recently sponsored a study that showed rural hospitals face higher rates of uncompensated care.¹² Nearly all health-policy research underscores that rural hospitals are burdened by treating uninsured Americans.

There is some geographic concentration of this phenomenon, too. In particular, the South has much higher rates of uninsured folks, and their rural hospitals have a larger share of uncompensated care as a share of services.

The Department of Health and Human Services has a laundry list of grants and programs to support rural hospitals, such as "Medicare rural hospital designations," "Rural Grants," "Cooperative Agreements and Contracts," and "New approaches in rural health care delivery and payment."¹³

Rural hospitals are classified in three main ways: Critical Access Hospital (CAH), Sole Community Hospital (SCH), and Medicare-Dependent Hospital (MDH). CAH and SCH are ways of distinguishing that a hospital is the only source of inpatient care in a region. These hospitals receive extra public funding to make sure their communities have access to a hospital. MDHs are a special distinction that takes place when a significant portion of a hospital's revenue comes from Medicare

recipients. (However, a recent study showed that all three special rural hospital classifications are becoming less profitable over time.)¹⁴ Each designation comes with some sort of supportive funding for a rural hospital. These include but are not limited to:

- ▶ increasing the base Medicare payment for procedures, with each program having its own corresponding cliffs based on rurality, net profits, and composition of the population;
- ▶ Medicare payments for uncompensated care, which pays off the hospital's liability for treating the uninsured (while leaving said uninsured with that debt);
- ▶ a prize system for innovating care and payment structures.

One would think that with such a comprehensive payment schedule, hospitals could find a way to stay afloat, but this is not the case.

EFFECTS OF A CLOSURE

As of 2015, the median county population served by a rural hospital was 27,980.¹⁵ However, more rural hospitals closed in the past decade than the previous decade¹⁶—and there is no evidence this trend will slow, with one in three rural hospitals at risk of closure, according to a 2016 study.¹⁷ This means that without intervention this crisis will only get worse.

A working paper by the National Bureau of Economic Research showed that such closures increase the inpatient mortality rate by 0.49 percentage points (a 5.9-point increase from a closure). However, for specific diagnoses, the increase in mortality rate can be as high as three (stroke) to five (heart attack) percent¹⁸. Overall, the results of the study were mixed: mortality increased for some diagnoses and decreased for others. Nevertheless, this study focused primarily on inpatient mortality, which does not address the cases where people completely lose access to care when their local, rural hospital closes. And the mixed results of this study highlight an important factor in considering healthcare markets: The other

options in the surrounding area play an enormous role in the health outcomes of a population.

It has been shown that ambulance transportation times increase 76 percent after a rural hospital closure.¹⁹ Even a short ambulance ride can cost thousands of dollars to someone with insurance,²⁰ so even if, as we established above, the inpatient outcomes are mixed following a rural hospital closure, the increase in ambulatory costs alone are not sustainable.

A CLOSER LOOK AT OBSTETRIC CARE

Since 1987, pregnancy-related mortality has more than doubled,²¹ and a 2017 study from the Centers for Disease Control showed that rural communities have an infant mortality rate more than one percentage point higher than urban areas (6.55 percent in rural areas, compared to 5.44 percent in urban areas).²² Almost all contemporary literature on rural hospitals brings up the topic of obstetric care, i.e. medicine relating to pregnancy, childbirth, and postpartum. Often, the local hospital is the sole source of obstetric care in a rural community. As we established, a rural hospital closure will force residents to travel much longer distances for urgent care, which leaves few, if any, accessible options for pregnant women and new mothers in these areas.

As a recent study clearly stated, “In 2014, 1.8 million women between the ages of fifteen and forty-four lived in counties without obstetric services.”²³ Between 2004 and 2014, another 9 percent of these counties lost access to obstetric care, affecting another six hundred thousand women. More than half of women in rural communities have to drive at least thirty minutes for access to obstetric care. This increased travel time increases the risk of pregnancy complications, including death of the mother and/or child.²⁴

This issue has a massive socioeconomic and racial dimension as well. Black²⁵ and Native²⁶ women face infant and maternal²⁷ mortality rates two to three times higher than white women. Access to care in rural areas is only a piece of this puzzle,²⁸ but ensuring proximity to obstetric care will play an important role in the effort to reduce infant/maternal mortality in the country.

As the trend of rural hospital closure continues, there is not much evidence that the infant mortality crisis will solve itself or improve on its own.

EMERGENCY ROOMS AND ICUS

In 2018, a bill called the Rural Emergency Medical Center Act (REMC) was introduced and promptly killed in committee.²⁹ The goal of the bill was to create a special designation for critically important hospitals in areas where access to services are limited and the local population is not dense or wealthy enough to support the necessary infrastructure and services. The bill designated a variety of services that a local hospital must provide in order to be eligible for a higher payout rates from Medicare (105 percent of normal rates).

To put it bluntly, intensive care units (ICUs) and emergency rooms are simply not economical for low-density hospitals, which leave us, the public, to decide if emergency rooms are a “public good” or a “failing business.” Without the aforementioned litany of subsidy programs, there is no way that rural emergency rooms/ICUs can operate effectively.

Part II: The case for nationalizing rural hospitals

In this case, demand is not the issue. While it very well may be because some rural areas lack the population density to fill the beds of hospitals, the evidence suggests it is a matter of cost structure above all else. We must ensure the long-term existence of resources, staff, and facilities to deliver care.

Rural communities already receive outsized funding from the federal government. Exact fiscal numbers are not available, but roughly half of all hospitals are located in rural areas, an outsized share of rural hospitals’ patients are Medicare/Medicaid recipients, and the remainder is more likely to be uninsured and paid for by Medicare at increased rates. From here, it is a safe assumption that a significant portion of the \$700 billion Medicare/Medicaid budget is being spent on keeping rural hospitals afloat. This is to say, a huge amount of federal healthcare

spending is already allocated towards rural hospital subsidies.

WHAT CAN BE DONE?

There are two ways to eliminate the uncompensated costs in rural hospitals. The “budget sensible” option would be to repeal EMTALA and essentially mandate folks to disease, disability, and death. Such a move would reduce the amount of federal subsidies required to keep rural hospitals open.

The other option is for the federal government to guarantee a complete repayment of uncompensated costs. Between these two options, there is only one human option.

The first and most effective step of a complete repayment—and of stopping rural hospital closures, in general—is to expand Medicaid under the Affordable Care Act. From 2013 through 2017, 83 percent of rural hospital closures occurred in states that have not expanded Medicaid. Expanding coverage would immediately help curb the amount of uncompensated care that rural hospitals deliver, and immediately increase operating margins for hundreds of American hospitals. Medicare for All would go even further to ensure the complete repayment.

Following this, rural hospitals should not be allowed to operate under a for-profit model. The US Government Accountability Office reports that 11 percent of rural hospitals are for-profit, but over the aforementioned 2013–2017 period, for-profit hospitals accounted for 36 percent of rural hospital closures. Mandating that hospitals operate under a nonprofit model would allow for an operating margin more in line with the community’s ability to pay for care. In some cases, 40 percent of a rural hospital’s revenue comes from Medicare payments, which would be used to maintain a profit margin in these cases.

Every community is different and has different needs, but one solution to guarantee the existence of healthcare in rural communities is overhauling the Rural Health Clinic designation to provide an extra source of funding

and prevent closure of rural healthcare centers. A hospital or medical facility may apply for RHC designation if it meets certain standards,³⁰ like having a nurse practitioner or physician’s assistant on-site at least half of the clinic’s time open. Right now, these clinics may still close even with additional federal resources.

Instead, the federal government could fund and manage RHCs, SCHs, and CAHs, guaranteeing that they stay open regardless of profitability. Once they are designated as such, public funding can ensure that these important medical facilities are kept open regardless of their community’s ability to pay. A regime like this sets up an obvious issue, where medical facilities could take advantage of a federally guaranteed minimum revenue in a variety of ways.

To circumvent this, a nationalized network of public healthcare providers would be able to provide care to communities that otherwise cannot afford it. Either by nationalizing the existing infrastructure or by establishing new institutions, building out a public network of healthcare providers would eliminate the existential threat posed by the uninsured on the existing healthcare system. This is the most efficient way to ensure that public dollars are spent on healthcare itself.

VOTERS SUPPORT AN EMERGENCY FUND FOR HOSPITALS

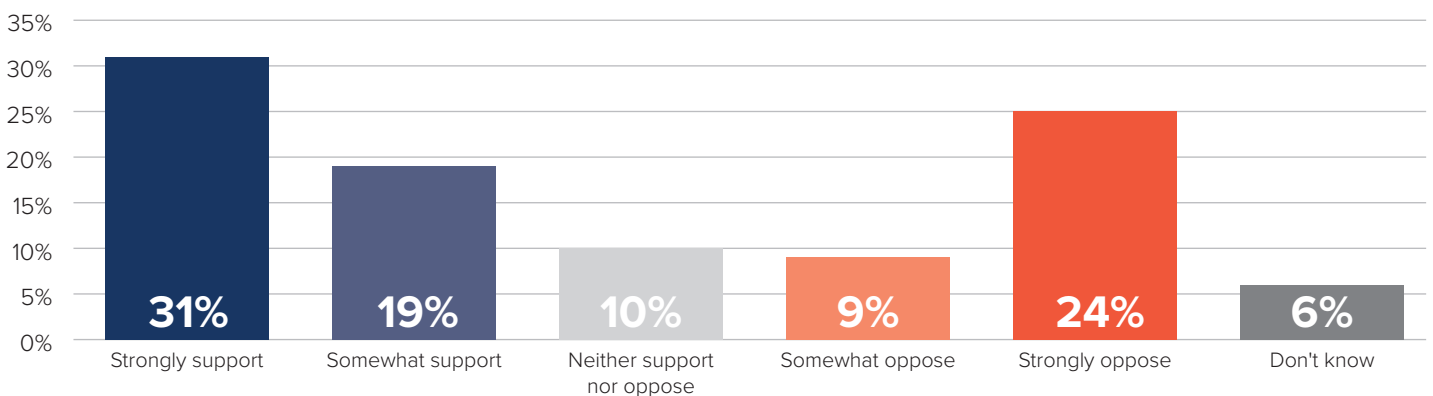
In an August 2019 poll,³¹ Data for Progress asked registered voters in the US:

Some Democrats have proposed spending \$30 billion per year to create publicly owned and managed urgent care facilities and walk-in clinics, where patients can receive routine medical services such as treatment of minor injuries and diagnosis and treatment for illnesses such as a cold or the flu. The clinics would be free to use and would be funded by raising taxes on individuals with incomes over \$200,000 per year by 1.5 percent. Democrats say that the clinics would allow people who cannot afford to go to a privately run clinic to get quality care,

and would reduce the burden on hospitals caused by people seeking treatment in the emergency room in non-emergency situations. Republicans say the clinics would be a government takeover of healthcare and would be a waste of taxpayer money. Would you (support or oppose) this proposal?

- <1> Strongly support
- <2> Somewhat support
- <3> Neither support nor oppose
- <4> Somewhat oppose
- <5> Strongly oppose
- <6> Don’t know

PUBLIC URGENT CARE



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From this, we found that voters support the creating publicly owned and managed healthcare centers, 51 percent to 33 percent. Independent voters support the policy by 6 percentage points.

In a September poll,³² we asked registered voters:³³

Democrats have proposed setting up a \$20 billion emergency trust fund to help states and local governments purchase hospitals that are in financial distress and run them as non-profit public entities. The fund would be financed by a tax of 1 percent on people with incomes over \$200,000 per year. Democrats say this will prevent hospitals from closing and from leaving communities without sufficient access to health services. Republicans

say that taxpayer money should not be used to prop up failing businesses and that the private sector could run hospitals more efficiently. Do you support or oppose this proposal?

<1> Strongly support

<2> Somewhat support

<3> Somewhat oppose

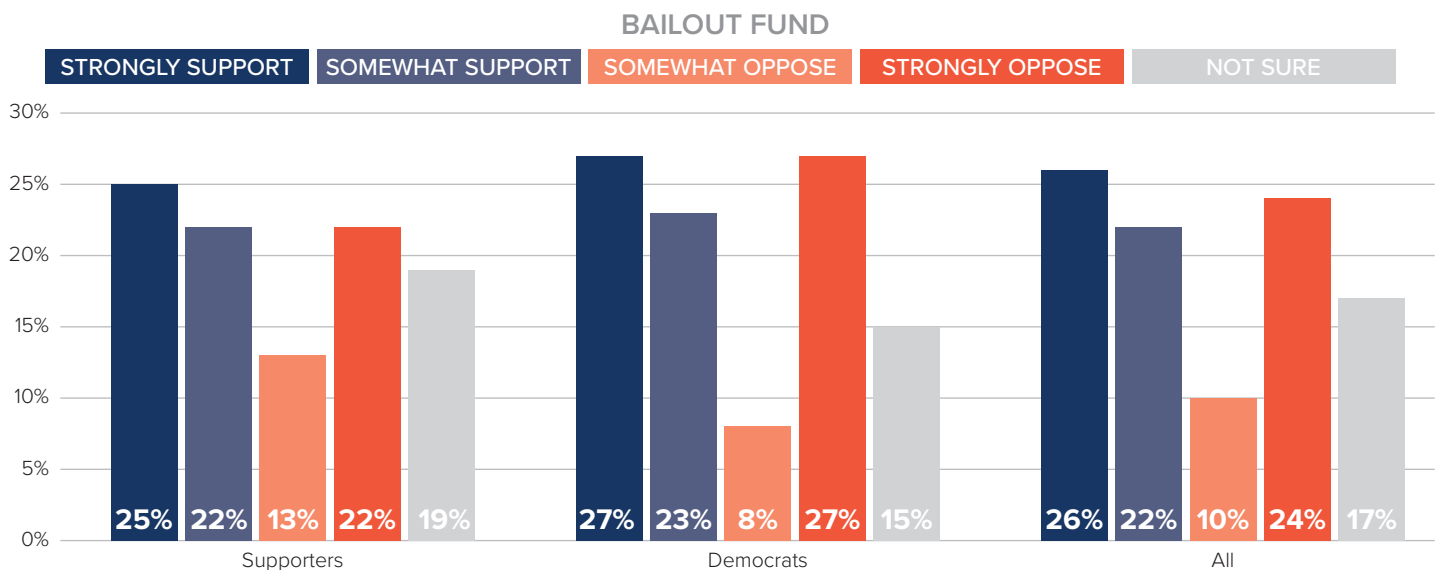
<4> Strongly oppose

<5> Not sure

This poll included a split sample, in which half of respondents were given a partisan cue and the other half were not. Without a partisan cue, 47 percent of registered voters supported the bailout fund and 34 percent opposed it. With a partisan cue, 50 percent were in support and 35 percent were opposed. Because the margins of support is not statistically significant whether a partisan cue is included, it shows that such a policy would likely remain popular even in American's broader, hyperpartisan environment. Furthermore, voters know the fiscal cost, and they believe it's worth it.

TIME TO NATIONALIZE

Public healthcare systems—federal, state, and local—should consider bailing out and running rural hospitals that go bankrupt or close. A rural health network could begin to resemble the VA—but with a focus on treating the entire rural community. The VA is extremely popular among veterans,³⁴ and many of the traditional talking points about VA care have been shown to be untrue.³⁵ This program of nationalizing rural hospitals need



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not apply to the hospitals that are still afloat and/or profitable; instead, it should focus only on maintaining a continuity of care for areas that would completely lose access in the case of a closure.

The key issue in actually running these hospitals would be staffing. Introducing a state-run healthcare system, especially in rural communities, could lead to issues with finding nurses, doctors, and administrators in remote areas of the country. In some sense, this would not be unique to the rural health system; the US has been facing a shortage of healthcare workers for years, both in the private sector and the VA.³⁶ These are important considerations if we are to nationalize rural hospitals, and they will need to be tackled.

We must also consider that healthcare staff help stimulate the economies of rural communities. Healthcare staff in a state-run hospital is easily preferable to the local hospital closing and the accompanying job loss in an already shrinking rural job market.³⁷ Staffing such medical facilities ties in neatly with a federal jobs guarantee³⁸ and retraining programs for medical professions. With the federal government guaranteeing that rural hospitals stay open, we can also help keep rural economies afloat.

But in the immediate term, rural hospitals are closing and this problem shows no signs of slowing. We need a bold solution to meet the gravity of the problem. We need to nationalize rural hospitals.

Edited by Andrew Mangan, Senior Editor at Data for Progress

ENDNOTES

1. <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>
2. <https://www.census.gov/library/stories/2019/04/health-insurance-rural-america.html>
3. <https://www.ncbi.nlm.nih.gov/pubmed/28069138>
4. <https://www.unh.edu/unhtoday/news/release/2019/02/06/unh-research-finds-shrinking-population-more-third-rural-counties>
5. <https://www.cdc.gov/media/releases/2017/p0112-rural-death-risk.html> and <https://www.cdc.gov/chronicdisease/resources/publications/factsheets/rural-health.htm>
6. For example, Harvard: <https://www.hsph.harvard.edu/health-care-financing/>
7. <https://www.vox.com/2018/2/27/16936638/er-bills-emergency-room-hospital-fees-health-care-costs>
8. Hospital bills are so commonly unreasonable that NPR runs a “Bill of the Month” series: <https://www.npr.org/series/651784144/bill-of-the-month>. Vox also has an article on this: <https://www.vox.com/health-care/2018/12/18/18134825/emergency-room-bills-health-care-costs-america>.
9. https://files.consumerfinance.gov/f/201412_cfpb_reports_consumer-credit-medical-and-non-medical-collections.pdf
10. <https://www.nytimes.com/2019/11/08/us/hospitals-lawsuits-medical-debt.html> and <https://www.theatlantic.com/health/archive/2019/08/medical-bill-debt-collection/596914/> and <https://www.cnbc.com/2019/11/10/americans-are-drowning-in-medical-debt-what-to-know-if-you-need-help.html>
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25. <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=23>
26. <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=38>
27. https://www.cdc.gov/mmwr/volumes/68/wr/mm6818e1.htm?s_cid=mm6818e1_w
28. For instance, racism itself likely increases these rates of mortality: <https://www.npr.org/sections/health-shots/2017/12/20/570777510/how-racism-may-cause-black-mothers-to-suffer-the-death-of-their-infants>
29. <https://www.billtrack50.com/BillDetail/981290>
30. <https://www.ruralhealthinfo.org/topics/rural-health-clinics#certified>
31. This survey was fielded by YouGov Blue, on behalf of Data for Progress, from August 16 throughth, 2019 - August 18th, 2019. This survey is based on 1,002 interviews with self-identified voters, conducted by YouGov on the internet of self-identified voters. The sample was weighted according to gender, age, race, education, US Census re-gion, and by 2016 Ppresidential vote choice. Respondents were selected from YouGov’s panel to be representative of registered voters in the US.
32. This survey was fielded by YouGov Blue on behalf of Data for Progress from September 11th, 2019 - September 13th, 2019. This survey is based on 1,280 interviews conducted by YouGov on the internet of self-identified voters. The sample was weighted according to gender, age, race, education, US Census region, and by 2016 Presidential vote choice. Respondents were selected from YouGov’s panel to be representative of registered voters.
33. This question was a split sample, wherein half of respondents saw the question framed as “Republicans and Democrats” and the other half saw it as “opponents and supporters.” The supporters/opponents question wording was as follows: Some have proposed setting up a \$20 billion emergency trust fund to help states and local governments purchase hospitals that are in financial distress and run them as non-profit public entities. The fund would be financed by a tax of 1 percent on people with incomes over \$200,000 per year. Supporters say this will prevent hospitals from closing and from leaving communities without sufficient access to health services. Opponents say that taxpayer money should not be used to prop up failing businesses and that the private sector could run hospitals more efficiently. Do you support or oppose this proposal?
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37. On the shrinking job market in rural America: <https://www.marketwatch.com/story/much-of-rural-america-is-fated-to-just-keep-dwindling-2019-05-07>
38. More on this can be found here: <https://www.dataforprogress.org/green-new-deal> and <https://www.dataforprogress.org/green-jobs>

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COVER PHOTO
Charles/Unsplash