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May 28, 2015

Chairman Orrin Hatch
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Ranking Member Ron Wyden
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Senator Johnny Isakson
131 Russell Senate Office Building
Washington, DC 20510

Senator Mark Warner
131 Russell Senate Office Building
Washington, DC 20510

Dear Senators,

The National Rural Health Association (NRHA) appreciates the opportunity to discuss the impact of chronic disease in rural America in response to the Senate Finance Committee Hearing on Chronic Care held on May 15, 2015 and the request for input from stakeholders.

Rural Americans are older, poorer, and sicker than their urban counterparts; placing them at much higher risk of chronic disease. Additionally, characteristics of rural American make treating these patients more challenging including longer distances to see health care professionals and professional shortages.

The National Rural Health Association (NRHA), a non-profit membership organization with more than 21,000 members in rural America. NRHA membership is made up of a diverse collection of individuals and organizations, all of whom share the common bond of ensuring all rural communities have access to quality, affordable health care.

Rural Americans are on average older than their urban counterparts and therefore, are disproportionately represented in the Medicare population. Though rural Americans make up around approximately 18 percent of the national population, in 2010, 23 percent of Medicare beneficiaries resided in rural areas.¹ Failing to consider rural populations unique needs would hinder the committee's attempts to deal with the issue of chronic disease.

As you know, dually eligible Medicare and Medicaid beneficiaries are one of the most vulnerable and costly populations. Rural beneficiaries are more likely to be dual eligible than urban beneficiaries (17.9% rural vs. 15.8% urban; $p < .0001$).² However, a focus on primary as opposed to specialty care in rural settings, results in rural beneficiaries having a lower median

¹ "Chart 2-5: Characteristics of the Medicare population, 2010", *A Data Book: Health care spending and the Medicare Program*. MedPAC. June 2014.

<http://medpac.gov/documents/publications/jun14databookentirereport.pdf>

² Bennett, K. J. et al. Characteristics, Utilization Patterns, and Expenditures of Rural Dual Eligible Medicare Beneficiaries. November 2014. http://rhr.sph.sc.edu/report/%2813-1%29RuralDualEligible_MedicareBeneficiaries.pdf

total expenses than urban beneficiaries (\$3,002 rural vs. \$3,439 urban; p<.001).² This population of poor beneficiaries are more likely to be sicker than non dual eligible populations, and more importantly is likely to have multiple chronic conditions.

Rural Americans are also sicker than their urban counterparts. For example, rural Americans experienced a greater incidence of diabetes than their urban counterparts (9.0 % non-metro vs. 7.0 % metro).³ Additionally, rural Americans are more likely to experience adverse events as a result of their disease state. 18% of non-metro population experience limitations of activity caused by chronic health conditions vs. 13% of the metro population⁴. More concerning, the non-metro population experiences higher mortality rates from ischemic heart disease (non-metro 201/100,000 population vs. metro 181/100,000 population) and COPD (non-metro 81/100,000 vs. metro 63/100,000).³

Partially, this greater incidence and severity stems from the fact that rural Americans are more likely to engage in behavior that increases the chance of chronic disease such as smoking (For individuals 18 and older: 27% smoking rate in non-metro areas vs. 18% metro). Rural Americans are additionally much more likely to be obese than Americans living in urban areas (For individuals 18 and older: non-metro 34% of men and 37% of women vs. metro 28% of men and 30% of women).³

Rural Americans also face health care challenges that make them less likely to receive preventive care and screenings which could catch prevent or catch chronic disease early. Ninety-seven percent of the nation's 2,041 rural counties are Health Professional Shortage Areas. And when rural patients require more advanced care, more than 40% of rural patients have to travel 20+ miles to receive specialty care compared to 3% of metropolitan patients. Six hundred and forty counties across the country are without quick access to an acute-care hospital, a statistic likely to become as 51 hospitals have closed since 2010 with 283 more on the brink of closure. Without local access to care rural Americans are less likely to receive preventive care, early screening, or receive sufficient follow-up care.

NRHA believes these are solutions to the chronic disease burden, however, for these solutions to make the greatest impact on those most in need of them, these solutions must take into account the unique challenges faced by rural America.

We appreciate your leadership on the issue of chronic disease and look forward to working with you as a stakeholder moving forward. Please feel free to contact Diane Calmus on my Government Affairs staff at (202) 639-0550 or dcalmus@nrharural.org with any questions.

Sincerely,



Alan Morgan
Chief Executive Officer

³ Hale, N., Bennett, K.J., and Probst, J.C. "Diabetes Care and Outcomes: Disparities Across Rural America" J Community Health. 2010;35(4):365-374. <http://www.medscape.com/viewarticle/729003> 3

⁴ Meit, M. et al. *The 2014 Update of the Rural-Urban Chartbook*. October 2014.

<https://ruralhealth.und.edu/projects/health-reform-policy-research-center/pdf/2014-rural-urban-chartbook-update.pdf>