Transcript
Episode 30: Plain Economics: The Main Problem With Rural Health Care
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Joe Sparks – Host
Robert Devereaux, MD – Guest

JS: 0:05
Welcome to Medicare for All Explained. This podcast will enlighten our listeners and dispel the distortions that's around Medicare for All. Medicare for All Explained is produced in collaboration with Physicians for a National Health Program and is hosted and produced by Joe Sparks. I'm your host Joe Sparks.

JS: 0:29
This is Episode 30, "Plain Economics, The Main Problem With Rural Health Care." My guest Robert Devereaux, MD, practices medicine in Pearisburg, Virginia, a rural town near the West Virginia border. He received his medical degree from the University of North Carolina at Chapel Hill School of Medicine and is certified by the American Board of Family Physicians. Dr. Devereaux has been in practice for more than 20 years. Dr. Robert Devereaux, welcome to Medicare for All Explained.

RD: 1:10
It's really a pleasure to be here be on the program today.

JS: 1:14
So, I'd like to start by asking, can you give me an example of a problem a patient would have in a rural area that they probably wouldn't have in a suburban or urban area?

RD: 1:29
Well, the thing that comes to mind first Joe is just our challenges related to our geography. I mean, we have a relatively low population spread out over a large area in our county and neighboring counties. So we, these patients are often challenged by their restrictive networks with the insurance their insurance plans. For example, they maybe work in the neighboring state of, I'm in Virginia. In the neighboring state of West Virginia and they're plan requires them to go to a hospital or get a diagnostic study in the network in the neighboring state rather than close to where they live. And we've also had issues with patients that their pharmacy benefit plan requires them to use a particular retail chain. And there may not be those pharmacies in our county, so they have to drive maybe 40-50 miles to get their prescriptions filled. And these are patients that generally aren't economically

well off, they may have transportation problems to start with. So it's those kind of things with geography that can really put big burdens on patients.

JS: 2:47
And in terms of the driving I mean, we're not talking like four-lane divided. Often we're talking two-lane roads and can be bad, it can be hard in bad weather, correct?

RD: 3:00
Right, yeah, we're in a mountainous area. And yeah, the driving conditions are often not ideal. Actually one of the hazards of living in a rural area for young people is automobile accidents. It's a public health problem that you don't really necessarily have in the city, but um, and again, these are folks with often their, their transportation isn't particularly reliable. And when we ask them to go see a specialist or have a test or be admitted somewhere, ideally we want that to be done close to home, but that's not always possible with the way their insurance plans tend to restrict the network.

JS: 3:46
And also on the driving so say they have to drive 50 miles in good weather, what would be the time it would take to drive that 50 miles on average, you think

RD: 4:00
Maybe an hour, depending on the conditions. But if you get, you know, bad weather, maybe, you know, much longer or even impossible in that kind of situation.

JS: 4:15
And you mentioned automobile accidents for young people. If they're in an accident, does it create problems for the ambulance to get there and getting them to a hospital?

RD: 4:32
Yeah, because, you know, where our county, for example, we have about 15,000 people were served by one small 25 bed hospital that's not equipped to do any kind of major trauma treatment. So, in those situations, you're always talking about at the very least, ambulance transport, oftentimes helicopter transport. And that you know, getting back to things that are unique for the patients here is these surprise medical bills related to transportation because oftentimes their insurance plans not may not cover it. And that, you know, they can get a several thousand dollar bill to get transferred to the closest facility that can provide the level of care they need.

JS: 5:22
Well, that happens in urban areas. There are stories that people will say, oh, let me call an Uber or Lyft to get to the hospital but I guess in your areas would Uber or Lyft, even be an opton?

RD: 5:39
No, there's nothing like that. We're relying on the ambulance transport which is very expensive, and even conditions that in other areas would generally be treated in a most general hospitals for example, chest pain because of, you know, our limited facilities. You're often talking about helicopter transport, which can leave somebody with a bill of several thousand dollars. It's just just a big burden to the patients in our area, but, you know, pretty unavoidable if, you know, if they need to go elsewhere for that level of medical care.

JS: 6:23
So, in terms of insurance options, are there fewer, generally fewer options in the marketplace are just to get insurance because you're in a rural area, so there's not as many companies to compete for business.

RD: 6:39
Yeah, that's my impression, you know, from my experience here, and I think our experiences similar to rural areas in the rest of the country. You have a much larger percentage of the population that's on Medicare and Medicaid and also a larger uninsured population than in the metro areas. But even those who can get insurance, the options are limited. You know, the employer provided health insurance is going to be similar to other areas. But the Affordable Care Act plans we've had periods of time where there's only one plan offered. And I know these plans, because of the pricing and rating systems that the insurance companies use, tend to be more expensive in rural areas, and with higher deductibles and copays. And I think the same is true for Medicaid [Medicare] Advantage products, which seem to be very plentiful in more urban areas, in rural areas, oftentimes very limited options. I've had patients be on a plan, and they were mainly satisfied with, but be kicked off the next year because that plan's no longer offered in our area. And I think, you know, the, the insurance companies look at the demographics look at their claims experience. And if they're not liking the kind of profit they're able to garner, they're, they're going to pull out of the market. So we've had a lot of that. I guess it's known as churning when, when the plans are changing, and the patients have to switch plans. We'd see some of that back and forth also with poor patients that go on Medicaid, and then their financial situation improves and they're thrown off Medicaid. And then they have to go to the Affordable Care Act plan, which maybe they can't afford and the coverage is different, and it just leads to coverage gaps and gaps in their health care if they're going from plan to plan.

JS: 9:05
So, you mentioned hospitals. Is there a situation where the closest hospital even though it's far away could not be in network? And then you have to go to an even farther hospital?

RD: 9:20
Yeah, absolutely. I think for routine care elective surgical procedures, for example, or diagnostic tests. Oftentimes, the local hospital is not in this in the particular network. So the patients could end up driving another hour, another hour and a half at the facility that that

gives them the best coverage. Of course, in an emergency situation, that's not necessarily going to be possible. So then yeah, the patient ending up in an out-of-network hospital with a bigger bill they're responsible for,

RD: 10:04
You know, in those situations it's not, you know, not necessarily safe or prudent to try to transfer the patient to the in-network facility. There's an acute medical problem.

JS: 10:18
So I don't know if we've been covering it, but what do you think is the biggest problem faced by people in rural areas and getting health care?

RD: 10:30
Well, by far what I see is just plain old economics. Our patients in this area, like other rural areas, tend to have lower incomes. I think it's probably two-thirds of the national median income for our area, which is similar for other rural areas. And when that's the case, if you've got an insurance product that doesn't provide very good coverage, with high copays and deductibles, it's just gonna hurt those families harder in rural areas just because of the economics. You know, I had a problem with my foot the other day. I had to get an MRI. I work for health care company. My out of pocket for the MRI was 500 bucks. You know, I paid it. I'm a physician. I could afford it, but you know, for I'd say the vast majority of my patients that's a huge hardship. That's you know, they may not even have a credit card to put that on and it's just plain old economics, and then you add the burden of having to travel pay for gas to get their specialty care or drive to a neighboring county to get a prescription filled. It, just, just just adds to the burden these, these just have to carry.

JS: 11:50
And do you have a problem getting doctors to come work in your area?

RD: 11:58
We do, and I think nationally there's a shortage of primary care doctors. And that's what we really need because we don't have the population necessarily to support specialty care in every specialty. For example, our county has about 15,000 people. Up until recently, we had four primary care physicians which is way under where we should be. And we went had a two year period with two vacancies in our clinic and didn't even get a single application and it's very hard to attract primary care docs when most health care systems, you know, they're gonna put their emphasis on where where can they get the most profit and most of the profit of health care company is going to come from specialty services, usually, a centralized facility where they do advanced surgery and have specialty care. I mean you need that primary care network, but it's not where your profit margins are for a system. But yeah, we've we've had a heck of a time recruiting in and retaining docs, and it's not just what docs docs get paid or what the emphasis is of the healthcare system. A lot of it is just the nature of life in rural areas or for some doctors. It's not particularly attractive to them

for a number of reasons. That's why we really need stronger incentives to get new graduates to come to areas where there is a high need.

JS: 13:42
And what do you think would be the solution to these problems?

RD: 13:48
Well for us, you know, it's a complicated issue, but I think from a single-payer health care perspective, I mean, the whole idea is having a system where you try to match the need of a region or community rather than making the incentive all about profit. So I mean it if you have a rural hospital that can under a single-payer system where their budgetary needs could be met through global budgeting, extra money could be allocated for recruiting physicians, helping with pay back of student loans. Making sure their compensation is is adequate to provide, you know, there's an adequate incentive to get them to move to to the rural area. I'm in a worker rural health clinic and that is a model. It's a federal designation that that allows an extra facility to get extra reimbursement for seeing Medicare patients, and that incentive, where you can improve the finances is really, really important. It's a way to kind of keep the doors open and make sure there is enough funding to support retaining physicians.

JS: 15:17
So it sounds like, in terms of implementing single-payer Medicare for All, that that would solve many of the economic problems that you have, and may also address the problems of getting facilities in the right places. Is that a fair assessment?

RD: 15:39
Yeah, I think so. And one thing you know, if you if you look at physicians working in rural areas, if their payer mix, currently is lots of Medicaid, and some Medicare, uninsured and not so much commercial insurance, the the whole mix together is going to be less, you know. You have a less of an economic incentive than in a system where everybody's on Medicare. The rates are the same for the services provided, whether they're in a rural or urban area. Kind of levels the playing field and takes away the incentive, necessarily to work in an area where, where your patients are on commercial insurance that tends to provide better reimbursement.

JS: 16:30
Are your patients, are they excited when they get on Medicare?

RD: 16:35
You know, they really are. It's the and we joke about it. Patients, especially in their early 60s, late 50s that are looking forward to retiring. And we talked about that a lot. And many of them say, I would retire right now. I've been working for this factory for a number of years. But I can't afford to because my premium will be X dollars, often over $1,000 a

month, which would eat into their pension. And they're like, I can't wait till I turn 65 and I can go on Medicare and, you know really afford health care. I think so many are pleasantly surprised when they're on Medicare. All of a sudden they're leaving an environment where they had that really high deductible and 20-30% of coinsurance for procedures, you know that they were use to spending upwards in the thousands of dollars a year out-of-pocket, all of a sudden they're on Medicare with a good supplemental plan, and they're amazed. They'll say, “Gee, I didn't pay anything last year.” Or, “You know, I was in the hospital three weeks, and I didn't get a bill.” And the lessening of anxiety is tremendous when people get a reliable insurance product that covers their costs.

JS: 18:04
So, do you think that people understand what Medicare for All is?

RD: 18:11
We've got a long ways to go on that. I think especially in areas where people are less educated, less informed. They hear that term, and they have some have a knee jerk reaction that would represent unwanted government control. And, but I'm also amazed with a little bit of explanation about the economics of the proposals and the benefits to patients and the increase, not decrease in choice, that they would get. and the fact that the doc doctors and hospitals remain as private independent entities, not government employees. There kind of surprised at the simplicity of that approach and the benefits that they could see. Yeah, we definitely got a ways to go as far as I think educating the population about the benefits of this. And I really think the only way we're going to see movement towards a system like this is to have buy in from the patients. They've got to be pushing, talking about their providers with there government officials, and really, we need that kind of grassroots support for this ever become a reality.

JS: 19:40
It always amazes me. And I think it's kind of both ironic and funny that they say well, I'm very concerned about having this government run health care program, even though it's not really government run health care, its government finance, and yet at the same time, they can't wait to get on Medicare. There's...

RD: 20:03
Right, and I, you know, I'll point that out. There's Oh, gosh, we don't want the government running our healthcare system so well, right now you add up Medicare, Medicaid, the armed forces, health care plans, the VA, state health care plans. I mean, the government is already paying, I think over 60% of the bill.

JS: 20:27
Yea.

RD: 20:27

So it's just talking about that remaining 40%, that, that is causing so much aggravation for patients and providers that we need to change.

JS: 20:43
It sounds to me like with a little education, that if we started pushing Medicare for All, there would be strong support for that, even in rural areas, and that could be a winning issue. Do you agree, disagree, don't know?

RD: 21:01
Yeah, I really agree. You know, it's kind of ironic that the places with the greatest need, oftentimes, rural areas, the states with big rural populations have often had the most resistance to Medicaid expansion, which of course is, you know, a government sponsored insurance program. And, you know, I've had several patients over the years that have become disabled, couldn't work anymore, had to quit their jobs, apply for disability. And they feel like okay, I'm getting some security, and then I've had to explain to them that they won't qualify for Medicare for two years. And up until last year in Virginia, they wouldn't qualify for Medicaid because there was no Medicaid expansion here. And the look on their face, just feeling like, my gosh, my government's letting me down. And but, again, many states are very large rural populations have resisted Medicaid expansion, which, you know, gosh, these patients, so oftentimes are desperate for health care. And until we can all agree that this is something that's a universal, right. It is hard to move forward.

JS: 22:28
Before we end, is there anything that you would like to add?

RD: 22:33
Yeah, I think we've pretty much covered the issues that I've seen in my practice and that are important to me. I've really enjoyed talking with you about these issues. In my career, I've always been interested in the idea of getting value from our healthcare dollar and making sure patients are treated fairly in an equitable manner. And you know, over the years, as I see more and more spent on health care more and more technology, emphasis on specialty care. And yet at the same time, we have so many people with very limited access to care. It's just frustrating as a primary care doc, because I know we have the resources and healthcare in this country. And it's just, I mean, the money's there. We have the specialists. We have the infrastructure, but just the economics is keeping people from getting the care they need, which is really frustrating for me to see.

JS: 23:40
So, Bob, you are saying that you don't like the fact that we're spending more and more for our healthcare system and getting less and less.

RD: 23:53
Yeah, that's right. You know, as you know, Joe, we, I mean, in this country, we're spending

upwards of twice as much as what any other developed country spends on health care per person, yet, somehow those other countries can still manage to cover all their citizens and provide them with decent care. And it's discouraging with with that much money in the system that, you know, our health care outcomes are also slipping. We're just nowhere near the top of the developed world on a number of measures, from our mortality rates to infant mortality, maternal mortality, and it's just frustrating to see how resources aren't really going towards were needed. And I think single-payer is the answer. It's, it's a way to, to really put some planning in the system and, you know, make it fair and give everybody access to care.

JS: 24:54
Yep, we spend more and our average health outcomes are worse and that's really horrible.

RD: 25:03
Yeah, it is. Yeah! Yeah, and it's it's something we can we can work on. We can make a difference.

JS: 25:10
Dr. Devereaux, thank you so much for being on Medicare for All Explained.

RD: 25:16
Thank you Joe. It's been my pleasure.

JS: 25:19
You have been listening to Medicare for All Explained. Information about this podcast can be found at our website, MedicareForAllExplained.org. The music for this show is “Super Bubbly” by Jesse Spillane. The logo was created by Lilly sparks. Thank you for listening.

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