Submitted for consideration to the May 31st hearing of the New York State Assembly Health Committee

How the New York Health Act will Improve the Health of Rural New Yorkers

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Summary

Despite recent improvement, health outcomes and life expectancy in rural areas of New York lag behind the rest of the state. While there are many reasons for this, one of the most important is lack of access to health care. Most rural counties are designated federal Health Professional Shortage Areas (HPSAs) and there are growing shortages of personal care aides for the elderly and disabled. Many hospitals, nursing homes, and clinics are under-resourced, often lacking basic medical technology available to medical centers in metropolitan areas. In addition, many rural New Yorkers face financial barriers to accessing necessary care.

The New York Health Act (NY Health) addresses the rural health crisis by reducing financial barriers to health care and by ameliorating provider and other resource shortages.

Reducing financial barriers to health care by:

- Providing comprehensive health insurance to the currently uninsured.
- Eliminating deductibles, co-pays, and out-of-network charges that create affordability barriers for those *with* health insurance.
- Providing comprehensive coverage, including dental, hearing, and optical benefits and full coverage for mental health, drugs, and medical devices.
- Providing universal coverage for long-term personal care services and supports.

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Addressing provider and other resource shortages by:

- Ensuring that all residents of rural New York will have comprehensive health care coverage, so that providers can be assured of payment for their services.
- Increasing low Medicaid and Medicare provider reimbursement rates which currently serve as a disincentive to practicing in rural areas. NY Health is committed to payment rates that shall be, according to the bill, "…related to the cost of efficiently providing the health care service and assuring an adequate and accessible supply of the health care service".
- Exercising greater control over capital planning with priority given to counties with greater facility and technology needs.
- Eliminating the county contribution to Medicaid, allowing counties to reduce property taxes or re-direct property tax receipts to meeting other local needs.
- Eliminating the government expense of providing health insurance to public employees, allowing counties, municipalities, public hospitals, school boards, and other entities to have more funds available for providing health care to the community.
- Eliminating premiums and other out of pocket health care expenses so that most families and businesses in rural New York pay less in taxes needed to support the new program than they have been spending on health care, creating a spending and investment stimulus to depressed upstate communities.

Introduction

Over 1.3 million New Yorkers live in rural areas and, despite recent improvement, their health status and life expectancy lag behind the rest of the state. While there are many reasons for this, lack of access to health care resources is one of the most important. Most counties in rural New York are considered federally-designated Health Professional Shortage Areas (HPSA), including dental and mental health professionals.[1] Most rural counties are also Medicaid Undeserved Areas (MUA).[2] In addition, many rural New Yorkers face financial barriers to accessing necessary health care. This report looks at ways the single-payer New York Health Act (NY Health)[3] will improve access to health care resources.

NY Health directs the state to provide publicly-funded health insurance for all New York residents without regard to income or immigration status. There will be no premiums (including Medicare Parts B and D), deductibles, or copays, and no restricted provider networks. Benefits will be comprehensive, including dental, optical, hearing, full mental health coverage, and full drug and medical device coverage. The 2019 version of the bill adds coverage for long-term services and supports, prioritizing personal care at home or in a community setting for any disabled New York resident, young or old, who needs assistance with activities of daily living (or care in a nursing home, if necessary).

The program will be financed by current funding for federal and state programs along with new payroll and non-payroll income taxes based on the ability to pay.

NY Health has passed the Assembly for the last four years and, following the 2018 election, has improved prospects for passing the Senate. Understanding the principles and potential impact of NY Health is therefore a matter of significant current interest to the residents of rural New York.

This report looks at Jefferson, Lewis, and St. Lawrence counties, which are included in the North Country Initiative (NCI), a government-funded health care reform program headquartered in Jefferson County. The three counties are sometimes referred to as the Tug Hill Seaway district within the greater North Country region that borders Adirondack Park to the North and Northeast. They are also called the "Tri-County" region.

With about a quarter of a million residents, the Tri-County region contains roughly one-fifth of rural New Yorkers. The area exhibits the kinds of health care access problems facing much of rural New York.

Tri-County health profile

The Tri-County region has a poor health profile as indicated by the high prevalence of important physical and mental health conditions and the high prevalence of avoidable hospital admissions.

Physical health indicators

According to a 2016 needs assessment, the region has the highest, or among the highest, rates in the state of the following important primary health indicators[4]:

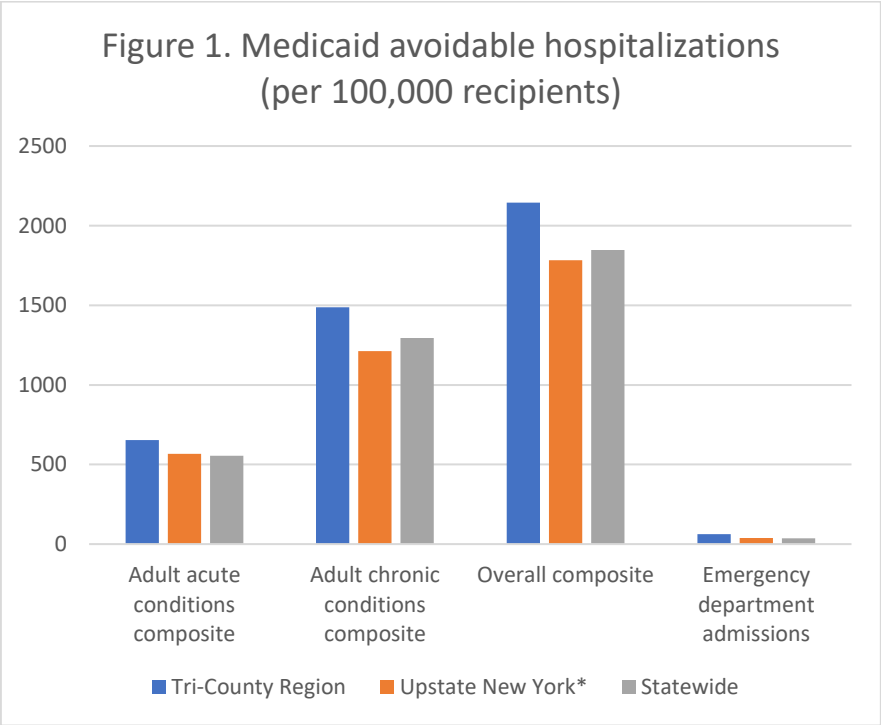
- Adults of all ages who are overweight or obese.
- Adults of all ages with hypertension (high blood pressure).
- Diabetes.
- Premature death from stroke.
- Death from liver cirrhosis.
- Death from diabetes.

The region is also well above the state average (and national average) in age-adjusted mortality rates for several major disease categories, including cardiovascular disease, cancer, and lung disease.[5] Years of potential life lost for these conditions, and the number of premature deaths, are consequently also higher.

Avoidable hospital admissions

Health care access problems correlate with the prevalence of avoidable hospitalizations, admissions that could have been prevented by early detection and intervention through routine

primary care. Data from the Medicaid program show that rates of avoidable admission for some of the most important medical conditions are well-above both the upstate New York average as well as the overall state average, despite patients having Medicaid insurance coverage[6]. These include pediatric acute conditions, adult diabetes, adult respiratory conditions, COPD, pneumonia, dehydration, diabetes complications, heart failure, and uncontrolled diabetes. The composite numbers for all conditions, as shown in **Figure 1**, indicate the scale of the problem:



*excluding New York City

Of further note are ER visits for untreated tooth decay. In 2005 the region had 62% more such visits than the statewide average. By 2015 the excess grew to 105% (Lewis County), 148% (Jefferson County), and 161% (St. Lawrence county) while the state-wide average increased by only 25%. St. Lawrence ranked 60th of 62 counties in this statistic[8]. It is well known that poor dental health makes a person more susceptible to a number of serious medical conditions[9].

Mental and behavioral health indicators

The Tri-County area also has the highest, or among the highest, rates in the state of the following[10].

- Percentage reporting binge drinking.
- Suicide.
- Medicaid in-patient admission for alcohol abuse.

- Medicaid in-patient treatment for drug abuse.
- Medicaid ER visits for substance use disorders.
- Public mental health system patients with depression.
- Public mental health system patients with anxiety disorders.
- Public mental health system patients with neurodevelopmental disorders.

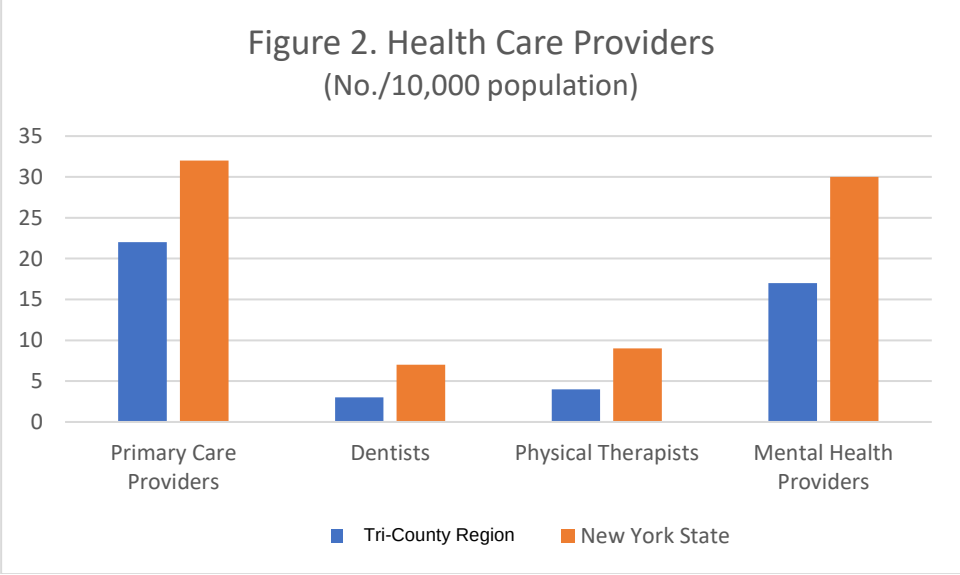
The area also has the lowest rate of follow-up care following hospitalization for mental illness[11].

Of special note is that mental health patients in the Medicaid system have the highest rates of smoking in the state, at all ages[12]. This suggests that those being treated for mental health conditions are also likely to be in poor health. It is well established that, even beyond smoking, poor mental and physical health tend to co-exist and reinforce each other.

It should also be noted in this regard that opioid addiction has risen over the last decade in the Tri-County area, consistent with national and statewide trends. Emergency department admissions for opiate poisoning more than doubled between 2010 and 2014, from 197 to 518 and admissions for heroin poisoning nearly tripled, from 55 to 142 over the same span[13]. While the state and federal governments have recently mobilized to address the problem, as of 2016 the region had no opioid addiction treatment centers[14].

Health care provider shortages

As federally-designated Health Professional Shortage Areas (HPSAs) and Medicaid Underserved Areas (MUAs), the three counties have significant provider shortages, as indicated in **Figure 2**.



The area also has shortages of substance use disorder (SUD) crisis facilities (1), in-patient facilities (2), residential facilities (6), and opioid treatment facilities (0)[15].

The number of nurse practitioners and physician assistants per capita is also less than a quarter of the state average[16]. This is particularly important because NPs and PAs are trained to perform routine medical procedures and can prescribe medications, reducing the burden on primary care physicians and helping to reduce shortfalls in primary care.

Of special note is the persistent shortage of personal care aides for older and younger adults with disabilities and chronic health conditions throughout rural New York[17]. According to the state's federally-approved Medicaid long-term care plan, personal care in the home or community, is guaranteed for all who need assistance with activities of daily living, without waiting lists. However, the home care worker shortage has created a situation where thousands of rural residents needing assistance have been living unsafely at home, or have been forced into hospitals, nursing homes, and other institutions while waiting for home care services. Others do not receive the needed number of care hours.

Personal care aides experience high rates of burnout and turnover due to poor pay and working conditions[18]. Dealing with long travel distances and poor weather in upstate New York makes the situation particularly difficult for aides who are often not compensated for travel time and expense. Low Medicaid reimbursement rates to home care agencies make it difficult to improve salaries, even as the state moves to increase the minimum wage.

The shortage has reached crisis levels and the state has had to use emergency funds to ameliorate a situation that continues to this day[19]. It will only grow worse as rural New York continues to lose younger residents at a rate higher than the state average[20]. The physical, emotional, and financial burden on family caregivers is consequently increasing.

New York Health Act: Reducing financial barriers to health care in rural New York

Some of the reasons for the poor health profile relate to poor socioeconomic conditions, including poverty, income insecurity, low education levels, and other social determinants of health. The Tri-County area has has levels of educational attainment lower than the state average[21], the second highest poverty rate of any region in the state health reform program[22], a median income much lower than the state average[23], and more unemployment than the statewide average[24]. 35% of residents reported housing insecurity[25] and 23% experienced food insecurity[26] within a recent 12-month period.

Such conditions, however, make access to health care services, especially primary, preventive, and mental health care, that much more important. NY Health addresses the problem of access to health care in two ways. The first is by reducing financial barriers to access. The second is to reduce provider and resource shortages.

With respect to reducing financial barriers to care, NY Health will help by:

- Covering the uninsured.
- Ending cost sharing (deductibles, copays, and coinsurance)
- Providing more comprehensive medical coverage, including dental, hearing, optical, mental health, drugs, and medical devices.
- Providing universal coverage for long-term personal care services.

Covering the uninsured.

NY Health guarantees health insurance for all New Yorkers regardless of income or immigration status.

Since the enactment of the Affordable Care Act, the number of uninsured in New York has dropped considerably. This has been largely due to the expansion of Medicaid, the introduction of the Essential Plan, which effectively increased the Medicaid eligibility threshold, and the availability of subsidies for those unable to afford to purchase private plans on the ACA exchange. It has also been due to enhanced efforts to get eligible people to enroll in available programs. Unfortunately, the elimination of the ACA insurance mandate has slowed the improvement.

In 2016, the uninsured rate in the Tri-County area stood at 6.1%[27]. Most of the uninsured reported affordability as the main reason for not having insurance, especially those who were unemployed[28].

Lack of health insurance is responsible for avoidable deaths and for the avoidable development of chronic conditions and disabilities due to failure to receive preventive services or address medical conditions at early stages. Researchers have shown that there are over 30,000 preventable deaths each year in the U.S. due to lack of insurance[29]. Studies have shown that 20% of uninsured individuals go without needed care during a given year, while only 3% of those with private insurance and 8% of those with public insurance avoid care during the same time period[30]. A study showed that uninsured individuals were three times more likely than those with private coverage to postpone or not get a needed prescription, due to cost[31].

Ending cost sharing (deductibles, copays, coinsurance)

NY Health eliminates financial barriers to care for those who have insurance, including deductibles, copays, coinsurance, and out-of-network charges.

Research shows that cost-sharing at the point of health care service in the form of having to meet requirements for deductibles, copays, out-of-network charges, and other out-of-pocket expenses, increases the likelihood of avoiding necessary care. 23% of U.S. households that *have* insurance report someone going without needed care, and 29% of the insured are considered underinsured. 41% of underinsured put off care and 49% have trouble paying medical bills[32]. The significance of underinsurance is made clear by looking at the rate of

growth of deductibles for employer plans in New York, as shown in **Table 1**. The large increases dwarf the 15% rate of inflation over the same period.

Table 1. Increase in employer health insurance plan deductibles in New York, 2008-2017[33].

	2008	2017	Percent increase
Percent of employees with deductibles	46.6%	75.2%	61.4%
Average deductible for individuals	732	1,687	130.5%
Average deductible for families	1,524	3,226	111.7%

In 2017, 58% of the insured in the Tri-County region used employer-based commercial insurance or the military's Tricare program. 24% used Medicare which also has substantial cost-sharing as shown in **Table 2**[34].

Table 2. Cost-sharing for Traditional Medicare in 2019[35].

Cost-sharing for	Cost to Medicare recipients
Medicare Part A	$1,364 per hospitalization benefit period plus $341 daily co-insurance for days 61 through 90. $682 thereafter up to lifetime reserve limit. ($170.50 daily co-insurance for skilled nursing facility after 20 days up to 100-day limit; Recipient responsible for full coverage thereafter)
Medicare Part B	Monthly premium & $185 annually. 20% co-pay per service
Medicare Part D	Varies based on plan and income level; Standard plan has up to $415 annual deductible with 25% co-insurance thereafter, plus co-pays for higher-tier drugs; and no coverage after $3,820 limit ("donut hole").

Providing more comprehensive medical coverage, including dental, hearing, optical, mental health, drugs, and medical devices.

NY Health offers comprehensive benefits and includes any service covered by Medicare, Medicaid, the Child Health Insurance Program, or New York public employee health insurance plans.

Out-of-pocket costs for dental services can be significant and lead many to neglect this important area of health care. Unfortunately, this kind of neglect can turn a minor dental problem into a major one, leading to far more expensive dental procedures as well as serious medical problems that commonly arise from dental infections, gum disease, and other conditions. Medicaid covers essential dental services, but only for the very poor. NY Health will cover dental care for all, with no cost-sharing and no restricted provider networks.

NY Health will also cover essential hearing and optical services, and any drug listed in the New York State Preferred Drug Program, with no copays. Despite parity laws, many commercial insurance plans still limit mental health and addiction coverage through restricted networks

and extensive prior authorization requirements. NY Health will cover all essential services with minimal prior authorization requirements.

Providing universal coverage for long-term personal care services.

NY Health includes coverage for long-term services and supports based on the current New York Medicaid long-term care plan. The program prioritizes a personal care aide in a home or community setting for any state resident needing assistance with activities of daily living, up to and including, round-the-clock care. Those who cannot be managed at home are guaranteed a bed in an appropriate nursing or other facility.

It is well-known that quality person-centered long-term care can have positive health benefits, including fewer falls, fewer nutritional deficits, better medication compliance, better infection control, and fewer acute care hospital admissions. Going without care, having inadequate hours of care, or having poor care can worsen health in many ways.

Access to long-term services and supports in New York is currently restricted to either the very poor, through Medicaid, or the wealthy who can afford long-term care insurance or can pay out-of-pocket for a nursing home or a personal care aide. The average annual cost of a semi-private room in a New York nursing home was $132,000 in 2015 and the cost of an aide at home for 6 hours daily was over $45,000[36]. A round-the-clock aide could reach $100,000 annually.

Although long-term care costs in rural New York are lower than the state average, low income residents face serious affordability problems. The majority of working and middle- class families in the Tri-County area are not poor enough for government help or rich enough to pay for care directly. Those in need of care must either live unsafely at home or seek help from family members and friends. While caregiving can be a rewarding experience, the burden can be heavy for families when caregivers must quit jobs or reduce working hours. It can also be emotionally burdensome when dealing with complex medical conditions or conditions that involve behavioral disturbance, such as Alzheimer's disease and other dementias. Caregivers often sacrifice their own physical health and suffer high rates of anxiety disorders and depression.

NY Health extends to all New Yorkers full access to the state's long-term personal care plan benefit now available only to Medicaid recipients. Based on an objective assessment of care need, New Yorkers will be entitled to a personal care aide at home or in a community setting for assistance with activities of daily living. Nursing home beds will be available, with no cost-sharing, should a disabled individual require more intensive care.

New York Health Act: Reducing provider and resource shortages

The second way that NY Health will improve access to health care services is through ameliorating provider and other resource shortages.

This will be accomplished by:

- Improving payment to health care providers.
- Increasing spending on facilities.
- Providing savings for counties and municipalities.
- Improving the rural economy.

Improving payment to health care providers

The NY Health legislation commits the state to fair negotiations over reimbursements to health care providers. The legislation mandates that payment rates "shall be reasonable and reasonably related to the cost of efficiently providing the health care service and assuring an adequate and accessible supply of the health care service."

NY Health will radically improve the health care situation in rural areas by providing reasonable payment for services based on health care need and not insurance source. Low Medicare and Medicaid reimbursement rates to physicians, dentists and other primary care providers will be replaced by rates that will attract providers to rural areas and provide them with adequate support staff including RNs, LPNs, medical assistants, dental assistants and hygienists, physical therapists, radiology technicians and many others.

NY Health will also assure that providers get paid. In the current system, there are many who cannot afford to pay their cost-sharing bills forcing providers to engage staff or agencies for collections or to write off unpaid bills as bad debt.

Past efforts to overcome provider shortages have been stopgap and piecemeal, involving government grants, emergency funding, telehealth, and a variety of incentive programs. None represents a long-term solution, however, because they do not assure continuity of services, including care coordination. Programs experimenting with more sustained and integrative approaches have needed access to substantial federal demonstration project funding and have been addressing only Medicaid patients.

Some graduates of U.S. medical schools have an interest in working in underserved areas and many recent graduates of foreign medical schools see these areas as a good way to start a career. However, both groups have shown high levels of turnover, seeking opportunities in non-rural areas within 1-2 years[37]. To improve the situation in the North Country and other rural parts of the state, health professionals should reside in their communities and anchor stable, integrated health care organizations that can coordinate care and work effectively with social service agencies and public health officials.

Studies show that health care professionals from rural areas are more interested in serving their communities upon graduation. Stronger efforts will be needed to encourage local residents to enter medical schools[38]. NY Health requires that payment methodologies and rates include a distinct component for graduate medical education.

Increasing resources for facilities

NY Health centralizes planning for health care facilities with the state and will direct facility spending based on community need.

In the current health care financing system, private institutions direct their own facility planning. Rich hospitals will build new facilities or acquire additional technology in an effort to compete effectively with other institutions and attract wealthier clients. Hospitals and nursing homes with high numbers of Medicaid patients or dual-eligible (Medicare and Medicaid) older adults, are chronically under-resourced. NY Health's mandate to assure access to health care for every New Yorker will ameliorate this situation by having the state assume direct responsibility for allocating facility funding and basing it on need. A hospital in an underserved area will get its first MRI machine before a wealthy suburban chain gets its fifth. Rural areas will get needed outpatient and urgent care clinics in underserved communities.

Savings for counties and municipalities

The county contribution to Medicaid, based on local property taxes, will no longer be required in the NY Health financing plan. Counties with limited financial resources, such as those comprising the Tri-County region, could use the freed-up resources to expand essential services. Further resources will become available as county and local governments will be relieved of the burden of providing health insurance to employees.

Counties currently contribute to the financing of Medicaid through local property taxes. In addition, health insurance for public employees makes up a significant portion of the budget for counties, municipalities, school boards, public hospitals and nursing homes, and other public agencies and departments. These expenses place significant pressure on the budgets of rural counties and municipalities, compromising essential services and needed infrastructure improvements.

NY Health eliminates the county share of Medicaid financing, shifting the burden to the new state taxes. Savings in this area can be used to relieve property owners of burdensome property taxes, expand essential services, including health care services, or engage in important infrastructure projects.

NY Health also reduces the cost to public entities for employee health insurance coverage, usually a large share of their operating budgets. While these entities will still pay the employer share of payroll taxes, this should be significantly less than current premiums and administrative expense. This will be especially important for under-resourced public hospitals

and nursing homes. **Table 3** shows the county savings through the combined Medicaid and county employee health insurance cost reductions for Jefferson, St. Lawrence, and Lewis counties. (based on the tax schedule shown in **Table 4**).

Table 3. County savings under the New York Health Act[39]

County	Property taxes	Medicaid Costs	Health Insurance costs	New York Health taxes	County savings**	Savings as a percent of property taxes
Jefferson	$54,883,326	$19,242,350	$8,127,102	$3,935,776	**$23,433,676**	42.7%
Lewis	$15,463,412	$13,385,559	$16,300,644	$3,324,529	**$26,361,674**	170.5%
St. Lawrence	$42,900,103	$18,832,211	$12,285,000	$3,218,232	**$27,898,979**	65.0%

** *County savings = Medicaid costs + Health insurance costs – NY Health Taxes*

Improving the rural economy

NY Health will finance its program using progressive payroll taxes and taxes on non-payroll (investment) income based on the ability to pay. Studies have estimated that up to 90% of New Yorkers will spend less on taxes than they currently spend on out-of-pocket health care expenses. Most small and mid-sized businesses that provide insurance for their employees will also see savings. These savings will have a stimulus effect on local economies.

The median income in the Tri-County area is the lowest in the state[40]. With NY Health's progressive tax plan based on the ability to pay, over 90% of Tri-County residents can expect to have taxes lower than what they currently spend for health care. Some will be far lower. These savings will occur even as benefits are expanded to include dental, long-term care, and other services. Only those few with very high incomes will end up paying more in taxes to support NY Health than they spend now on health care. The payroll tax component is paid 80% by employers and 20% by employees.

Most businesses will also save relative to the current cost of providing insurance to their employees. **Table 4** shows estimated tax rates for individuals and families and the savings that can be expected at different levels of income. It is based on a model progressive tax schedule.

Table 4. **New York Health tax schedule**[41]

Annual Income	Employee tax	Effective rate	Employer tax	Effective rate
$25,000	$0	0%	$0	0%
$50,000	$900	1.8%	$4,500	9%
$75,000	$1,800	2.4%	$9,000	12%
$100,000	$2,700	2.7%	$13,500	13.5%

The economy of the Tri-County area and rural New York generally is based on small to mid-sized businesses. Those employers who offer health insurance to employees have seen their premiums rise dramatically over the last decade. Some have responded by offering plans with limited coverage, restricted provider networks, and higher deductibles. Others are asking employees to pick up a greater share of the cost of the plan or have dropped insurance coverage altogether, forcing employees to seek coverage on the ACA insurance exchange. Still others have been forced to cut back on wages and raises in order to keep an insurance plan in place. Unions have limited negotiating power when health insurance costs rise. **Table 1** above showed the dramatic increase in deductibles over the past decade. **Table 5** shows the average increase in private-sector employer-based health insurance premiums in New York over the last ten years. Inflation over that period was only 15%.

Table 5. Private-sector employer-based premium increase, 2008-2017. [42]

	2008	**2017**	**Percent increase**
Average premium			
Single coverage	$4,638	$7,309	57.6%
Family coverage	$12,824	$21,317	66.2%
Average employee share of premium			
Single coverage	$947	$1,568	65.6%
Family coverage	$3,376	$5,878	74.1%

Economic studies have shown that savings to individuals, families, and businesses will have a stimulus effect on the state economy, creating new jobs and opportunities for investment and entrepreneurship[43]. This will be very important for rural New York where the economy has been depressed in the face of an ageing population.

Conclusion

Rural New York faces barriers to accessing quality health care resulting in poor health status. Some of these barriers are financial, as residents forgo necessary care due to lack of affordability. There are still many who lack insurance or who have insurance plans with high levels of cost sharing. Many working and middle-class families cannot access important services, including dental and long-term care, because they are not poor enough for Medicaid eligibility or rich enough to pay out of pocket.

Other barriers are due to chronic shortages of health care providers, including primary care physicians, dentists, and home care workers. These shortages are due, in part, to low payment rates by Medicaid and Medicare which serve as a disincentive to setting up a practice in a rural setting. They are also due to chronic budget shortfalls in rural counties and municipalities that create resource shortages in public hospitals, clinics, and nursing homes.

The New York Health program is designed to address financial barriers to care by providing comprehensive coverage to all New York residents with no cost-sharing. The program will use progressive taxes based on the ability to pay to ensure that all New Yorkers can afford care. The program is also designed to address the sources of provider and resource shortages by assuring payments to all providers, setting payment levels that are sufficient to ensure an adequate supply of providers in rural areas, and directing facility spending to areas of need.

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