The Impact of Health Reform on Rural; or >1,000 Pages of Legislation in <50 Minutes

Rural Health Development Council

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Kevin Jacobson

The Rural Situation

- A greater proportion of rural residents than urban residents are uninsured or covered through public sources (23% cf.19%)
- Fewer rural Americans receive insurance through their employer than their urban counterparts (64% cf. 71%)

The Rural Situation

- A higher number of self-employed are in rural America
- Rural workers pay higher costs for health insurance plans than their urban workers

But, coverage does not equal access…

- Changes to Medicare/Medicaid
- Workforce Provisions
- Individual, Insurer and Employer Mandates
- Other Features

Patient Protection and Affordable Care Act

- Reduce uninsured from 15% to 5% (32 million)
- Leaves 23 million uninsured
- Individual mandate
- Health insurance exchanges
- Employer penalties
- $ for workforce, demonstration projects, wellness…

Changes to Medicare: Provider Payment Improvements

- 10% incentive payment for primary care providers:
  - All physicians, nurse practitioners, clinical nurse specialists and physician assistants
  - Will receive bonus if at least 60 percent of their Medicare charges in a prior period were for primary care services
  - Effective 2011-2015

Provider Payment Improvements

- 10% bonus payment to general surgeons
  - Must perform major procedure in a health professional shortage area
  - Effective 2011-2015
- Incentive payments for mental health services
  - 5 % increase for psychotherapy services in 2010

Provider Payment Improvements

Increases Medic*aid* reimbursement rates for primary care practitioners to Medi*care* rates for 2013 and 2014

Changes to Medicare: Hospital Payment Improvements

- Currently, some rural, low-volume hospitals (25 miles from another facility and fewer than 800 annual discharges) receive supplemental reimbursements

- These may increase up to 25%

Hospital Payment Improvements

For FY 2011 and 2012:

- Drops mileage requirement from 25 to 15
- Increases discharge threshold from 800 to 1500
- Tiered:
  - Hospitals with fewer discharges will receive the full 25%
  - Hospitals closer to or exceeding 1500 discharges receive lower or no extra payment

Changes to Medicare: Drug Benefit

Phases in coverage of Medicare Part D drug benefit coverage gap (the “donut hole”):

- 2010 – enrollees with any spending in donut hole will receive $250 rebate
- 2011 – enrollees with spending in gap will receive 50% discount on brand-named drugs
- 2020 – enrollees responsible for 25% of gap instead of current 100%

Changes to Medicare: EMS

- 2010: 3% percent bonus for ambulance services in rural areas (a one percent increase from previous bonus payment; 2% for urban)
- 2010: “Super rural” bonus payment up to 22.6% for certain transports in certain rural areas

Additional Medicare/aid Changes

- Home Health: 3% bonus for rural home health providers between April 2010 and December 2015
- Coverage for annual comprehensive wellness visits and personal prevention plans effective 2011
- ***Individuals*** at 133% of poverty eligible for Medicaid effective 2014

How/Who Will Pay?

- Medicare payroll tax increases beginning in 2013
- Rate increases from 1.45% to 2.35%

And….

Tanning Beds – 10% tax on indoor tanning

Workforce Improvements

- Significant expansion of NHSC
- Graduate medical education
- Primary care training grants
- Health Care Workforce Commission

Rural Workforce

- Increased number of rural residency slots
- 900 slots reassigned; 30% reserved for rural hospitals
- Rural physician training grants

Rural Workforce

- PAs permitted to order skilled nursing care including home health
- Funding for Public Health Sciences programs; graduate over 700 providers/year
  - Priority placement to rural and minority students

Workforce Funding

- Funding to states for health care workforce assessment, analysis and planning
- Primary care extension program; $120 million annually 2010-12
- See Association of State and Territorial Health Officials: http://www.astho.org/Programs/Health-Reform/

HPSAs and National Health Service Corps

- Target for final HPSA rule: July 2011
- New providers: pediatric surgery and mental health
- Funding increased from $610 million in 2011 to $1.46 billion in 2015 with formula-based increases thereafter

The Individual Mandate

- The “centerpiece” of the Act: All individuals must be covered by an employer-provided health plan or individual health insurance policy that provides “minimum essential coverage”
- Insurance exchanges to help individuals find coverage and tax credits to help pay insurance premiums

Individuals

- Individual Mandate effective 2014: must have MEC or pay a penalty
- Penalties starting at $95 or 1% of income, increasing to $695 or 2.5%

Not applicable if incarcerated

Insurer Mandates

- Lifetime limits prohibited
- Coverage of children to age 26
- Annual limits prohibited as of 2014
- No restriction on pre-existing conditions for children under 19 as of 2011

Insurer Mandates

- No discrimination against providers, e.g., MDs and DOs
- Emergency Coverage:
  - – Can’t require pre-authorization
  - – Must pay out of network providers at in network rates
- Flexible spending accounts: no non-prescription drugs as of Sept. 2010
  - $2,500 cap as of 2013

Employer Mandates Effective 2014

- Waiting period for new employees no more than 90 days
- 50+ FTE employers must provide “qualifying and affordable” coverage, i.e., <9.5% of household income
  - $2,000 penalty per employee

Employer Mandates Effective 2014

- Automatic enrollment unless opt out for 200+ FTE employers
- Employers may provide cash vouchers for employees to purchase coverage in HIEs
  - May keep the difference

Additional Employment Related Mandates

- Cadillac Tax: effective 2018, 40% tax on ***health*** benefits valued >$10,200 for individuals, >$27,500 for families
- Beginning 2010, small business (<25 employees) tax credits for providing coverage; must pay at least 50% of premium

Employment Related Mandates

- Health plan values reported on W-2 effective 2011
- Four page health plan summaries in 2012

New 501(c)(3) Hospital Requirements

- Financial Assistance Policies
  - Written policy, clear basis for calculating fees, eligibility criteria, must be publicized
- Community Health Needs Assessment
  - Once every 3 years, broad community input

501(c)(3) Hospital Requirements

- Limitations on Charges
  - For emergency and necessary care to those qualifying for financial assistance
- Billing and Collection Practices
  - Limitations on extraordinary collection practices

Hospital Mandates

To reduce fraud and abuse:

- New, physician-owned specialty hospitals will be banned from participating in Medicare
- Medicare claims submitted 1 year after service

Based on RHQDAPU, the HHS Secretary shall determine quality measures

FQHCs and Other Clinics

- FQHC grants will increase from $2.98 billion in 2010 to $8.33 billion in 2015
- May contract with CAHs for delivery of primary care services
- School based health centers: $50 million annually, 2010-14
- $50 million for advance practice nurse-managed clinics

CLASS Act

Voluntary insurance plan:

- Community Living Assistance Services and Supports
- Minimum $50/month for assistance with daily activities

Pilot Programs

- Regionalized emergency care systems
- Independence at home
- Oral health care prevention
- Alternative dental care providers
- NP training programs
- Childhood obesity
- Individualized wellness plans
- IT use in long term care facilities

What's Missing

- CAH HIT
- 340B drug plan for RHCs
- Medicare payment/cap increase for RHCs
- Improve rural workforce development
- Ensure proper rural representation on all health commissions

Additional Sources

- Rural Assistance Center: http://www.raconline.org/info_guides/hot_topics/health_reform/
- HealthReform.gov
- Library of Congress: http://thomas.loc.gov/cgi-bin/bdquery/z?d111:HR03590:
- Alliance for Health Reform: http://www.allhealth.org/
- Kaiser Family Foundation: http://healthreform.kff.org/

What Questions Do You Have?

Kevin Jacobson

WI Office of Rural Health

kmjacobson2@wisc.edu

608-261-1888

With thanks to: Maggie Elehwany, Alan Morgan, & Brock Slabach, National Rural Health Association

David Snow & Todd Nova, Hall Render Killian Heath & Lyman