A Rural Perspective/Commentary Regarding
(Description of Policy Options)
“Financing Comprehensive Health Care Reform:
Proposed Health System Savings and Revenue Options”
Senate Finance Committee
May 20, 2009

Commentary provided by
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June 12, 2009
This report was funded by the Robert Wood Johnson Foundation, ID number 66036.
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This document includes commentary from the Rural Health Panel on proposed options we feel have special, significant meaning for rural areas. An appendix describes proposed options for which we are not offering commentary at this time. We are not including Section V of the Senate Finance Committee document, as it is merely a listing of proposals made by the president in the fiscal year 2010 budget proposals for raising revenues.

SECTION I: Health System Savings

I.1: Ensuring Appropriate Payment

I.1a: Adjusting Annual Market Basket Update
Proposed Options (taken from the MedPAC 2009 Report to Congress)
- Reduce or eliminate market basket updates in 2010 for provider payment
  - Adjust from MedPAC recommended levels
  - Accomplish over multiple years
- Establish differential payment updates for low and high-margin areas for fiscal year 2010 and in additional years

Rural Commentary
- Policies deriving savings from provider payment should account for differences in current and expected margins such that low margin but essential rural providers are not threatened.

I.1b: Updating Payment Rates for Home Health Services
Proposed Options
- Implement MedPAC recommendations regarding adjustments in 2010 and contemplate further adjustments given current levels of payment in the system
- Direct Secretary to “re-base” home health payments to better reflect number and mix of services and level of intensity to take into account relative margins related to specific conditions and service areas
- Establish a provider-specific annual cap on the number of allowable outlier episodes in a year

Rural Commentary
- Accounting for differences in conditions and service areas should be sensitive to special circumstances in serving sparsely populated rural areas, which often include substantial drive times for a home visit and therefore fewer visits per day.

I.1c: Updating Payment Rates for Inpatient Services
Proposed Options
- Adjust current GME and DSH payment levels to better reflect actual costs hospitals currently incur in treating low-income and uninsured patients and in training medical residents
- Adjust DSH payment levels over time as need for resources decreases as more individuals become insured as result of health care reform
- Consolidate Medicare and Medicaid payments to hospitals as way to streamline and better account for and coordinate federal funding within DSH and GME payment
Any change in DSH policy, including downward adjust over time, creates an opportunity to make all hospitals, including Critical Access Hospitals (CAHs), eligible for DSH payments. CAHs are not currently eligible for DSH because they are not paid under PPS, but if the policy purpose of these funds is to cover the costs of treating the uninsured, CAHs should be eligible for payments.

**I.1d: Adjusting Reimbursement for High-Growth, Over-Valued Physician Services**

**Proposed Options**

- Implement reforms that appropriate value services, such as MedPAC recommendation to increase utilization rate for calculating the payment for advanced diagnostic imaging services
- Establish expert panel to assist CMS in evaluating and adjusting payment for potentially misvalued physician services

**Rural Commentary**

- If income of physicians in shortage and underserved areas is reduced as a consequence of capturing savings, it could result in increased difficulty recruiting and retaining physicians in these areas.

**I.1e: More Appropriate Payment for Durable Medical Equipment**

**Proposed Option**

- Explore options to improve payment accuracy for DME items and services

**Rural Commentary**

- Exploring accuracy in payment for services in rural areas should account for increased costs of providing DME due to distance to clients and low volume.

**I.1f: Increase the Medicaid Brand-Name and Generic Drug Rebate Amounts. See appendix.**

**I.1g: Extend to and Collect Rebates on Behalf of Managed Care Organizations (MCOs). See appendix.**

**I.1h: Application of Rebates to New Formulations of Existing Drugs. See appendix.**

**I.2: Capturing Productivity Gains**

**Proposed Options**

- Include requiring annual market basket adjustments for certain fee-for-service providers be adjusted by some or all of expected productivity gains as a way to improve accuracy of Medicare payments: options could include requiring adjustments beginning fiscal year 2011 and in subsequent years or requiring change one for a set time period

**Rural Commentary**

- A single productivity adjustment should be based on verification of productivity gains across all providers regardless of size and geographic location.
I.3: Reducing Geographic Variation in Spending

Proposed Options

- Adjust Medicare Parts A and B spending per beneficiary to reflect differences in the price of inputs and health status of the local population in areas where spending is above a threshold compared with the national average
- Require spending reductions for individual providers who are above a certain threshold in spending compared to their peers in their local area
- Weigh these options against delivery system reform options under consideration which are also intended to reduce geographic variations in spending

Rural Commentary

- Current methods of assessing health status rely on claims history; typically an individual with more claims will appear to have poor health status. Adjustments based on claims history will result in lower payment in places where use is affected by lack of access to services. Therefore prior utilization is not an appropriate indicator of health status, especially in rural areas.
- A modest percentage of savings captured by these options could be dedicated to leveling payment between high-spending urban and low-spending rural areas, thereby both addressing current inequities and increasing the financial rewards for providing services in rural areas.

I.4: Modifying Beneficiary Contributions

1.4a: Making Beneficiary Contributions More Predictable. See appendix.

1.4b: Means Testing Part D Premiums. See appendix.

SECTION II: Options to Modify the Exclusion for Employer-Provided Health Coverage

Proposed Options

- Limit value of employer-provided health coverage excluded from gross income based on the value of the plan or the income of the insured, or a combination of both
- Limit exclusion from gross employer income based on percentage of value of the employer-provided health coverage, based on actuarial value of a benchmark plan
- Apply limit only to taxpayers whose incomes exceed a threshold income level
- Limit the exclusion based on both the value of employer-provided health insurance and the income of the taxpayer
- Limit exclusion to a percentage of the total premium for health insurance coverage obtained through the employer for all taxpayers
- Committee could discuss limits on exclusion that consider geographic variations in cost of living, including medical costs, in any option
- Could reformulate exclusion as a tax credit, a tax deduction, or a combination of the two
- Any change to exclusion could grandfather the exclusion for employer provided health insurance coverage a group plan maintained pursuant to one or more collective bargaining agreements in effect when the change is enacted
Rural Commentary
• The actuarial value of plans offered in rural and urban areas is currently not comparable; the overall actuarial value of plans offered in nonmetropolitan counties is 79.9%, compared with a value of 83.9% in metropolitan counties.¹ When considering geographic variation in setting policy the committee should consider market factors influencing premiums as well as benchmark actuarial value.

SECTION III: Other Health Care Related Revenue Raisers

III.1: Modify or Repeal the Itemized Deduction for Medical Expenses. See appendix.

III.2: Repeal or Modify the Special Deduction and Special Unearned Premium Rule for Blue Cross and Blue Shield or Other Qualifying Organizations. See appendix.

III.3: Modify Health Savings Accounts. See appendix.

III.4: Modify or Repeal the Exclusion for Employer-Provided Reimbursement of Medical Expenses Under Flexible Spending Arrangement and Health Reimbursement Arrangements. See appendix.

III.5: Limit the Qualified Medical Expense Definition. See appendix.

III.6: Modify FICA Tax Exemption. See appendix.

III.7: Modify the Requirements for Tax-Exempt Hospitals

Proposed Options
• Codify organizational and operational requirements for determining charitable organization status to include, among other things that hospitals:
  o Regularly conduct a community needs analysis
  o Provide a minimum annual level of charitable patient care
  o Not refuse service based on a patient’s inability to pay
  o Follow certain procedures before instituting collection actions against patients

• Certain hospitals critical to communities they serve or which have an independent basis for tax exemption (educational or scientific research organization) are excluded from minimum charity care requirement

• Provide for excise taxes or "intermediate sanctions" to encourage compliance with operational requirements

Rural Commentary
• The requirement for minimal level of charitable patient care should apply to all hospitals providing patient care; this should be done in tandem with changes to Medicare DSH eligibility making hospitals eligible for DSH payments.

• A requirement to conduct a community needs analysis, while appropriate, implies a cost to small charitable hospitals in rural areas; this may be met through collaboration with regional or

state organizations that can provide appropriate tools and technical assistance for analysis, if appropriately funded.

SECTION IV: LIFESTYLE RELATED REVENUE RAISERS. See appendix.
APPENDIX
This appendix describes proposed options for which we are not offering rural commentary in this document.

I.1f: Increase the Medicaid Brand-Name and Generic Drug Rebate Amounts
Proposed Options
- Increase Medicaid’s flat rebate from 15.1% to as much as 23.1%
- Increase the base Medicaid rebate from non-innovator, multisource drugs from 11% to 13% of average manufacturer price

I.1g: Extend to and Collect Rebates on Behalf of Managed Care Organizations (MCOs)
Proposed Options
- Require that prescription drug manufacturers pay a rebate on drugs purchased for beneficiaries enrolled in Medicaid MCOs
- Require that drug manufacturers pay Medicaid FFS rebate directly to the states

I.1h: Application of Rebates to New Formulations of Existing Drugs
Proposed Option
- When a new, extended-release version of an existing drug is introduced, additional rebate obligation for the new drug would be either the AMP percentage owed under current law or AMP percentage owed for original drug, whichever is greater

1.4a: Making Beneficiary Contributions More Predictable
Proposed Options
- Consider proposals to simplify Medicare beneficiary cost-sharing obligations to make them more consistent with benefits available in the private sector
- Make changes in Medicare cost-sharing requirements while placing restrictions on Medigap policies
- Proposals could include the following:
  - Out-of-pocket maximum for all Part A and B services
  - Replace complicated mix of cost-sharing provisions with consistent cost-sharing and combined annual deductible for all of Part A and Part B
  - Modify Medigap to require some cost sharing for services along with catastrophic protection
  - Impose nominal cost sharing in Medigap for primary care visits and copayment for specialists
  - Index all cost sharing to the growth rate in average Medicare costs

1.4b: Means Testing Part D Premiums
Proposed Options
- Require beneficiaries above a certain income threshold to pay higher premiums for Part D drug coverage; could apply only to basic coverage and be set as same manner as under Part B
- Could consider raising premiums for higher income enrollees in conjunction with options to allow more beneficiaries with low income to be eligible for reduced Part D premiums and cost sharing through the low income subsidy program
• Could consider raising premiums for income enrollees in conjunction with reducing size and
effect of coverage gap or donut hole

III.1: Modify or Repeal the Itemized Deduction for Medical Expenses
Proposed Options
• Consider raising the 7.5% adjusted gross income threshold for itemized deduction for medical
expenses, or eliminate the deduction

III.2: Repeal or Modify the Special Deduction and Special Unearned Premium Rule for Blue Cross and
Blue Shield or Other Qualifying Organizations
Proposed Options
• Could repeal the special deduction for 25%of claims and expenses and the exception from the
reduction of deductible unearned premiums in the case of Blue Cross and Blue Shield and other
qualifying organizations
• Could reduce the percentage of the special deduction and exception from the reduction of
deductible of unearned premiums

III.3: Modify Health Savings Accounts
Proposed Options
• Health Savings Account contributions could be limited to lesser of individual’s deductible or the
dollar amount of the maximum allowable aggregate HAS contributions
• Additional tax on distributions from an HAS not used for qualified medical expenses would be
increased to 20%
• Distributions excludible from gross income for qualified medical expenses only if expenses
substantiated by employer or independent third party

III.4: Modify or Repeal the Exclusion for Employer-Provided Reimbursement of Medical Expenses
Under Flexible Spending Arrangement and Health Reimbursement Arrangements.
Proposed Options
• Consider an option to place a limit on amount of salary reduction contributions to health flexible
spending arrangement (FSA) that would be excludible from gross income
• Eliminate the exclusion from salary for FSA contributions
• Consider similar options being applied to health reimbursement arrangements

III.5: Limit the Qualified Medical Expense Definition
Proposed Options
• Definition of medical expense for purposes of employer plans and HSAs set to conform to
definition for purposes of itemized deduction for medical expenses; example of cost of
nonprescription medicines not being reimbursed through an FSA

III.6: Modify FICA Tax Exemption
Proposed Options
• Amend student exception so it does not apply to individuals whose earnings subject to the
exception exceed an annual dollar limit
• Codify regulations related to definition of “school, college, or university” as applied to the student exception

• Extend Medicare coverage on a mandatory basis to all employees of state and local governments without regard to dates of hire or participation in a retirement system

SECTION IV: LIFESTYLE RELATED REVENUE RAISERS

IV. 1: Impose a Uniform Alcohol Excise Tax

Proposed Options

• Impose a uniform tax based on the alcohol content contained in a product at the rate of $16 per proof gallon on all alcoholic beverages

• Wineries having aggregate annual production not exceeding 250,000 gallons entitled to tax credit on first 100,000 gallons

• Domestic brewers producing less than two million barrels during calendar year have reduced rate of tax on first 60,000 barrels

IV.2: Enact a Sugar-Sweetened Beverage Excise Tax

Proposed Option

• Federal excise tax per 12 ounces of sugar-sweetened beverage

• Tax applies to beverages sweetened with sugar, high-fructose corn syrup, or other similar sweeteners, not to beverages sweetened with non-caloric sweeteners
**RUPRI Health Panel**

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