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A Rural Perspective/Commentary Regarding (Description of Policy Options)
"Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans"
Senate Finance Committee, May 14, 2009

Health Panel
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Section I: Insurance Market Reforms

Non-Group and Micro-Group Market Reforms

Proposed Option	Rural Commentary

• Federal rules for the non-group and micro-group (2-10 employees) market
  o Guaranteed issue and guaranteed renewal on all coverage
  o Prohibit exclusion for pre-existing conditions
  o Rates based on tobacco use (up to 1.5:1), age (up to 5:1), and family composition (up to 3:1)
  o Premiums could vary to reflect geography
• Total variation in premiums could not exceed 7.5:1
• Secretary would implement system for risk adjustment comparable to what Medicare uses for private plans; new market plans and grandfathered plans subject to "collective system of risk adjustment for a combined pool"
• Secretary could administer risk adjustment or require states to do so
	• Many individuals in rural areas are self-employed, so market reforms of the non-group market are critically important. Because it is difficult to anticipate the effect of the proposed regulations in rural areas, it would be beneficial to include a demonstration during the phase-in period, to ensure that policies work as intended.

Small Group Market Reforms

Proposed Option	Rural Commentary
• Currently HIPAA requires coverage sold to firms with 2-50 employees be sold on guaranteed issue basis and requires renewal; limits duration of pre-existing conditions • All states now require issuers to offer to firms with 2-50 workers on guaranteed issue basis with reduced time for excluding pre-existing conditions • *Proposed option:* same federal rating rules that apply to non-group and micro-group markets would apply to remainder of small group market (as defined by states) • *State option:* States would merge pooling and rating rules for non-group and small-group markets	• The final impact of regulations on the small group and individual markets, including actuarial limits, should be that persons with similar health profiles and demographic characteristics should be able to obtain comparable coverage with comparable cost in large employer groups and in the small group and individual market by using health insurance exchanges. Because of the structure of the rural economy and disproportionately high rates of chronic illness in rural areas, this should be a particular focus. o The actuarial value of plans offered in rural and urban areas should be comparable. This is currently not the case: the overall actuarial value of plans offered in nonmetropolitan counties is 79.9%, compared with a value of 83.9% in metropolitan counties.

Section I: Insurance Market Reforms

Health Insurance Exchange

Proposed Option	Rural Commentary
• All state-licensed private insurers and the public health insurance option if applicable would be required to participate in the HIE • Private insurers would also be permitted to sell directly to purchasers • Micro-groups (2-10 employees) could purchase through the HIE immediately • Other small employers could purchase through HIE once federal rating rules are fully in by their state; would have to pick only one of the four benefit levels • Tax exclusion under current law would apply when small business opts to purchase through HIE • Secretary to establish HIE that enables individual to receive state-specific information; could contract with private entity to operate HIE • State Insurance Commissioners establish procedures for review of plans and plan to decertify plans • *Option*: multiple competing exchanges, with a national exchange that enables review of state-specific information; could have multiple HIEs in same geographic area; carriers could not operate as HIE or selective participate in one or multiple HIEs	• State insurance commissioners should establish procedures to compel plans to assure access to services, defined as maintaining historical patterns of access to primary care and other local services such as emergency care and basic hospital services. • Practices used to market and sell insurance policies, both through exchanges and in direct contact between insurance agents and consumers, will need to be monitored in rural areas to assure rural residents receive relevant information in an unbiased manner, including using local groups similar to the CMS practice of enrolling "partners" to help with Medicare Part D, and regulating insurance activities similar to how that is done in Medicare Part D.

Role of State Insurance Commissioners

Proposed Option	Rural Commentary
• State insurance commissioners continue plan oversight with regard to consumer protections, rate reviews, solvency, reserve requirements, and premium taxes • Federal fallback if states do not adopt federal rating rules • Rating areas defined by State Insurance Commissioners and reviewed by the Secretary • Rating areas would allow for exceptions, be required to allow for pooling of similar cost people, and be risk adjusted across the areas	• Rating areas should not repeat the Medicare managed care experience of wide variation and volatility in rates because of using a county basis for rating. A more appropriate model would be that used by at least some insurers, creating very large regions that smooth out those differences. Analysis should precede final setting of policy to strengthen evidence-based expectations of effects on affordability of coverage in rural areas.

Section II: Making Coverage Affordable

Benefit Options

Proposed Option	Rural Commentary
• All plans in non-group and small group market required to provide a broad range of benefits including but not limited to: o Preventive and primary care o Emergency services o Hospitalization o Physician series o Outpatient services o Day surgery and related anesthesia o Diagnostic imaging and screenings, including x-rays o Maternity and newborn care o Medical/surgical care o Prescription drugs o Radiation and chemotherapy o Mental health and substance abuse services • Plans could not include lifetime limits on coverage or annual limits on any benefits and cannot charge cost-sharing for preventive care services • Insurers required to offer all four options: o High option with actuarial value (health care expenses paid by plan) of 93% o Medium at 87% (approximately equal to FEHBP Blue Cross/Blue Shield standard option, as estimated by the Congressional Research Service) o Low at 82% o Lowest at 76% • Plan design required to apply parity for cost-sharing conditions within these categories of benefits: o Inpatient hospital o Outpatient hospital o Physician services o Other items and service, including mental health • Each plan design required to meet the class and category of drug coverage requirements specified in Medicare Part D o Insurers in the HIE required to charge the same price for the same products in entire service area as defined by the state regardless of how an individual purchase the policy	• Exclusion of a dental benefit from the basic package could exacerbate access problems in rural areas. Given the strong evidence linking oral health and medical conditions, dental benefits should be included in any comprehensive health care reform. • Definition of the service area is an important rural consideration and requires assessment to be sure there is not an adverse affect on affordability.

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Section II: Making Coverage Affordable

Low-Income Tax Credits

Proposed Option	Rural Commentary
• Tax credit for low income taxpayers who purchase through HIE, refundable and paid in advance in form of premium subsidy • Level of coverage: high benefit between 100 and 200 percent of federal poverty level; medium between 200 and 300 percent; low benefit option between 300 and 400 percent • *Option:* calculate premium credit based on enrollment-weighted average premium of qualified low coverage option offered in service area, with cost sharing assistance up to valuation of high coverage option for lowest income, medium coverage between 200 and 300 percent of poverty	• Low-income tax credits are important for access to insurance in rural because of higher presence of low-income households in rural and higher likelihood of purchasing insurance through individual plans. • Congress should consider prohibiting cost sharing for certain services based on income level of the insured to encourage prevention and not discourage utilization of needed services; for example many plans using health savings accounts have discontinued cost sharing for preventive services. • A sliding scale should be considered as income increases so there is no sudden loss of subsidy.

Small Business Tax Credits

Proposed Option	Rural Commentary
• Tax credit for certain small employers for each full time (30 hours) employee covered, equal to 50% of the average total premium • Full amount of the credit would be available to employer with 10 or fewer full time employees with average annual wages from employer of less than $20,000; phase out above 10 employees to 25; and for incomes between $20,000 and $40,000 • Credit not payable in advance	• Will need to include seasonal employees for maximum impact in rural areas.

Section III: Public Health Insurance Option

Proposed Option A *(Public Health Insurance Option)*

Issues to be Resolved	Rural Commentary
• How providers will be reimbursed for services • Whether or not public option will be required to establish provider networks or be able to compel providers to participate • Whether public option required to have reserve funds • Whether or not premiums collected by public option will be required cover costs or if shortfall will be subsidized • Administration by federal agency or by third party	• Many rural areas have persistent provider shortages. Adequate provider reimbursement and provider participation/contracting issues under a public plan need to be carefully considered so as not to exacerbate current workforce shortages. • The answers to critical rural questions about private plans will determine whether there is a need for a public plan option: o Will rural areas be included within the service area of at least one private plan? Currently there are rural areas in which one carrier dominates the market. Should that carrier decide to reduce its service area access to insurance, coverage could suffer. Presence of affordable coverage is more than access to nationally advertised plans in the individual market; equity concerns would demand that there be active agents for the plan. o Will private plans marketed in rural areas contract with local primary care providers? Evidence from the Federal Employee Health Benefits Program indicates that plans may be available that do not use local providers. o Will private plans remain active in rural areas, or will there be market turnover that threatens access to affordable plans? o Will there be a minimum number of plans (using local providers) available in rural areas to assure benefits of competition among plans? • Critical issues related to the interaction of choice among plan options (including a public plan option) and access to medical services in rural areas: o Consider implementing payment policies and incentives to attract and retain health care professionals in rural areas (e.g., bonus payments, loan repayment policies, guaranteed minimum salaries). o Consider a payment system that differentially pays providers a sliding bonus based on societal needs for geographic provider distribution and specialty availability. o Reimbursement for alternative delivery modalities such as telemedicine. • Continue special payment policies as a requirement for all plans to assure access to essential services, including cost-based reimbursement for Critical Access Hospitals, payment policies for Sole Community Hospitals and Rural Referral Centers, bonus payments for physicians, and cost-based reimbursement for rural health clinics.

Section III: Public Health Insurance Option

Proposed Option A – *Approach 1: Medicare-Like Plan*

Proposed Option	Rural Commentary
• Administered by new agency within DHHS • Eligibility rules, markets and income-related tax credits mirror those for all other plans • Medicare providers required to participate and be paid Medicare rates plus 1-10% • Rating rules apply to public option same way they apply to all plans in the non-group and small group markets • Risk adjustment apply in same way that it applies to plans offered through HIE in non-group and small group markets • Public option incorporate any medical delivery system reforms adopted from the overall reform effort • Would not have solvency requirements	• Payment using Medicare rates has to very clearly include all current special payment categories, including bonuses, in Medicare payment policy. • Basing new payments on current Medicare methodology reinforces current Medicare inequities. • Public plan solvency guaranteed by the government potentially increases taxpayer burden or threatens provider payment. • Research is needed to determine minimum payment requirements of providers such that payments include a reasonable margin for all providers; without this evidence there is a risk that a dominant public plan option could threaten access to services because providers cannot meet their costs. • Not clear if providers will not accept Medicare if they have to accept the public plan; if payment only marginally higher than Medicare may risk having places where providers accept neither. • The public plan would be operating under different circumstance from private plans, which may require legislative consideration regarding where and under what circumstances to make the public plan available. Those considerations could include places where a very limited number of private plans (e.g., 0 – 3) offer options using local providers, places where there is a history of very limited or no access to affordable health plans using local providers, and places where particular populations have difficulty accessing affordable coverage.

Section III: Public Health Insurance Option

Proposed Option A – *Approach 2: Third Party Administrator*

Proposed Option	Rural Commentary
• Similar to proposal 1 with differences as follows: • Administered through multiple regional third-party administrators (TPAs) required to report to the Secretary • Separate from agency overseeing completion among other private plans • TPA required to establish networks of participating medical providers • Payments for participating providers negotiated by TPAs • Public option required to have reserve funds the plan, not the TPA, would maintain this reserve)	• Given use of provider networks, should include access standards, based on historical patterns of utilization by community residents (standard applied to MA plans). • Given a public option, negotiated payment should not be less than providers now receive from Medicare, protecting special payment categories. • If this option is designed to create a competing public plan in markets where there are a limited number of private plans, the following elements of plans would need to be comparable across public and private options (assured by legislative requirements applying to *both* types of plans): o Payment to providers o Requirements to form provider networks o Standards for access to essential services o Reserve requirements o Rating used to determine premiums o Expectations for marketing o Support, or lack thereof, for innovation in the plans such as new methods for managing chronic illness

Proposed Option A – *Approach 3: State Run Public Option*

Proposed Option	Rural Commentary
• Either mandatory or optional for States with details of administration left to the States • An option for States might be to allow individuals to purchase coverage through the State-employee plans	• Would need to enforce federal access standards in each state. • Purchase through state-employee plans requires assurance that those plans contract with local providers throughout the state (current contracts could be concentrated in areas of the state with critical mass of employees) and that plans truly are accessible across the state, and are actuarially equivalent.

Proposed Option B *(No Public Health Insurance Option)*

Proposed Option	Rural Commentary
• No public option and rely on private options in a reformed and well regulated private market	• Access standards would be critical, especially for primary care, public health services, and emergency services. • Could severely restrict access to competing plans in remote rural areas.

Section IV: Role of Public Program

Medicaid Coverage

Since Medicaid represents a higher percentage of coverage in rural than in urban areas and is one reason for a smaller difference in uninsurance rates as of 2008, any provisions expanding Medicaid coverage are expected to have a slightly higher impact in rural areas.

Children's Health Insurance Program (CHIP)

Proposed Option	Rural Commentary
• No federal changes to structure of CHIP prior to end of current reauthorization period (September 30, 20134) or to when HIE fully operation, whichever is later • After that point CHIP income eligibility increased to 275% of FPL and CHIP programs not able to use low income disregards and income based on MAGI • CHIP coverage would include Medicaid EPSDT benefit • When HIE full operation, CHIP enrollees obtain primary coverage through the HIE with CHIP as secondary payer • HIE plans would have to contract with state to provide services to CHIP beneficiaries • *Variations*: allow states to create or act as an HIE plan, allow Medicaid-only plans to participate in HIE, limit premium reimbursement of services covered by Medicaid that are not in HIE plan	• Including EPSDT benefits important to rural given the importance of CHIP in covering rural children.

***Other Improvements to Medicaid** – Enrollment and Retention Simplification*

Proposed Option	Rural Commentary
• Eliminate state option to rely on face-to-face interviews to determine eligibility and ability to apply an assets test for eligibility for acute care services • States required to implement 12 month continuous eligibility, establish enrollment website, permit states to enroll and redetermine eligibility for all beneficiaries at DSH Hospitals, FQHCs and State DMVs, and extend administrative automatic renewal and Express Lane renewal to all Medicaid beneficiaries	• Eliminating the assets test could benefit rural residents owning farm/ranch properties that are not yielding current income above the eligibility threshold. • Many rural areas do not have the proposed enrollment sites (such as DSH hospitals and, in some states, FQHCs). Consider including other sites for enrollment and determining eligibility in rural areas, such as Rural Health Clinics and Critical Access Hospitals.

Section IV: Role of Public Program

Other Improvements to Medicaid – *Mandatory Coverage for Prescription Drugs*

Proposed Option	Rural Commentary
• Make prescription drugs a mandatory benefit for categorically and medically needy	• Should be combined with meaningful access standards for pharmacy services. The current Medicare Part D access standards should not be used as a model, as they do not apply to many rural areas.

Other Improvements to Medicaid – *Changes to Medicaid Payment for Prescription Drugs*

Proposed Option	Rural Commentary
• Increase the federal upper payment limits (FUPL) percentage from 250% to 300% of weighted average of the most recent average manufacturer price (AMP) for pharmaceutically and therapeutically equivalent multiple sources drugs available nationally through commercial pharmacies • Clarify what discounts and other price adjustments were included in the definition of AMP (no detail provided) • Change definition of multiple source drug from at least one other drug product to two or more drug products • New prior authorization requirement prevent more expensive drugs from being dispensed when generic equivalents are available absent medical necessity justifications	• Increasing the FUPL will help rural pharmacies struggling to maintain sufficient revenue from sales of prescription medication to remain in business by increasing their income from prescription medications, which for independent pharmacies that are the only retail service in their community typically represents over 80% of their income. • Include a request to GAO or MedPAC to study the effects of treating certain rural pharmacies as critical points of access to pharmacy services and thereby establishing a special payment classification for those pharmacies.

Other Improvements to Medicaid – *Changes to the FMAP Formula*

Proposed Option	Rural Commentary
• Incorporates state poverty level as well as state per capita income • Base on two year average rather than current three-year average • One third based on poverty rate and remove the squaring factor • Year-to-year FMAP fluctuations capped at +/- two percentage points	• May increase federal share in states with high poverty in rural areas and statewide.

Dual Eligibles – *Waiver Authority for Dual Eligible Demonstrations*

Proposed Option	Rural Commentary
• Congress would establish a new Medicaid demonstration authority of five years to explore alternative approaches to coordinating care for dual eligibles	• No less than 20% of the authorized demonstration sites should be rural.

Section VI: Prevention and Wellness

Options to Prevent Chronic Disease and Encourage Healthy Lifestyles

Proposed Option	Rural Commentary
• Annual capped grants to states for three or five years, or until options available through HIE, to provide access to evidence-based primary preventive services such as tobacco use screening, influenza immunization, counseling on daily aspirin use, hypertension screening, or obesity screening of uninsured adults and children • Competitive grant program to promote health and human service program integration, improve care coordination and access to preventive services and treatments, and better integrate delivery of health care services to improve health and wellness; and require DHHS to review and improve administration of its low income programs • States submit application to create locally integrated delivery systems including establishing multidisciplinary care teams • Community health teams required to provide: comprehensive care management and patient and family support in conjunction with primary care providers; care coordination and health promotion activities (includes behavioral services and nutritional counseling), coordination with local public health offices; social and economic support to facilitator patient and family assistance ith social support services (includes coordination with and referral to community based programs); comprehensive transitional care from inpatient to institutional care settings or care provided in community-settings • Allow states to implement service integration and delivery reform activities, including individualized plan • States allowed to submit proposal meeting goals and objectives of this grant • DHHS would study best practices to improve wellness outcomes for low-income families and issue best practices on how to establish well integrated model of care for health maintenance, reducing chronic disease, promoting patient care and facilitating coordination between health and human service systems • Within 2 years of DHHS disseminating best practices states required to submit plan to better integrate services for low-income families	• Integrated delivery systems should be encouraged to include local providers. • Grants should be available for establishing rural community and/or regional health teams, recognizing that not all services will be available locally.

Section VIII: Options to Address Health Disparities

Data Collection Methods

Proposed Option	Rural Commentary
• Require federally funded population surveys collect sufficient data on racial/ethnic subgroups to generate statistically reliable estimates in studies comparing health disparities populations • Ensure quality reporting requirements include proposals to collect data on patients by race, ethnicity, and primary language and extend MIPAA provisions regarding collection of health disparities data to the Medicaid and CHIP populations	• Require that surveys include sufficient sample to allow for rural disparities to be examined.

Language Access

Proposed Option	Rural Commentary
• Extend 75% matching rate for translation services to all Medicaid beneficiaries for whom English not primary language • Establish grants for outreach and enrollment efforts to fund, for example, multi-lingual help lines and for data collection efforts	• These provisions will be helpful in many rural areas experiencing increasing immigration of Hispanics. • Help lines would be a particularly important strategy for rural providers that might not have either the available workforce or a reasonable volume to support in-person translation services.