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Health Panel

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Highlights of Rural Perspective/Commentary Regarding Proposed Options to Provide Affordable Coverage to All Americans

The RUPRI Health Panel offers the following comments on the Senate Finance Committee document for the purpose of discussion on rural implications of proposed policy options. Panel comments parallel the sections of the Senate Finance Committee document excerpted from a longer Panel document (available at www.rupri.org/healthpanel).

Section I: Insurance Market Reform

- 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.
- 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.
- 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.
- 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 policy to strengthen evidence-based expectations of effects on affordability of coverage in rural areas.

Section II: Making Coverage Affordable

- 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 service area is an important rural consideration and requires assessment to be sure there is not an adverse affect on affordability.
- 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.

Section III: Public Health Insurance Option

- The answers to critical rural questions about private plans will determine whether there is a need for a public plan option:
    - Will rural areas be included within the service area of at least one private plan?
    - Will private plans marketed in rural areas contract with local primary care providers?
    - Will private plans remain active in rural areas, or will there be market turnover that threatens access to affordable plans?
    - 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:
    - 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).
    - Consider a payment system that differentially pays providers a sliding bonus based on societal needs for geographic provider distribution and specialty availability.
    - 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.
- 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.
- 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.
- 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.

Section IV: Role of the Public Program

- 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 will likely have a slightly greater impact in rural areas.
- Including EPSDT benefits is important to rural given the importance of CHIP in covering rural children.
- 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.
- 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 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.

Section VI: Prevention and Wellness

- 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

- Require that surveys include sufficient sample to allow for rural disparities to be examined.