

THE AFFORDABLE CARE ACT AND RURAL NEBRASKA

Jon Bailey

Director, Research and Analysis Program

Center for Rural Affairs



CENTER *for*
RURAL AFFAIRS
Lyons, NE 68038 Population 963

HEALTH CARE REFORM LAW

- Actually two bills passed by Congress
- “Patient Protection and Affordable Care Act” – Public Law 111-148, signed by President Obama on March 23, 2010
- “Health Care and Education Reconciliation Act of 2010” – Public Law 111-152, signed by President Obama on March 30, 2010



CENTER *for*
RURAL AFFAIRS
Lyons, NE 68038 Population 963

ACA Timeline

Tax year 2010

- Medicare part D donut hole begins to close—\$250 rebates in 2010, coinsurance rates reduced from 100% to 25% by 2020
- Small business tax credits for tax years 2010-2013
- Loss ratio minimums for health insurance companies—85% for large group market plans, 80% for individual and small group markets (the amount of premiums that must go to medical claims); consumer rebates if minimums not met
- Establish a process for reviewing increases in health plan premiums and require plans to justify increases
- Require states to report on trends in premium increases and recommend whether plans should be excluded from the Exchange

ACA Timeline

June 2010

- Temporary high-risk pools (until 2014) to provide health coverage to individuals with pre-existing conditions
- Temporary reinsurance program for early retirees

ACA Timeline

September 2010 and later

- State option to expand Medicaid to childless adults up to 133% of the federal poverty level
- Require dependent coverage option for children through age 26 for all individual and group policies
- Prohibit individual and group health plans from placing lifetime limits on dollar value of coverage
- Prohibit insurers from rescinding coverage except in cases of fraud
- Prohibit pre-existing condition exclusions for children
- Eliminate co-payments and deductibles for preventive care under new private plans
- Require qualified health plans to provide at a minimum coverage without cost-sharing for certain preventive services
- Impose a tax of 10% on the amount paid for indoor tanning services

ACA Timeline

2011

- Phase-in lower Medicare Advantage payment rates
- Eliminate cost-sharing for preventive services for Medicare and Medicaid recipients
- Establish CLASS, a voluntary program for purchasing community living assistance and supports
- Establish the National Prevention, Health Promotion and Public Health Council to develop a national strategy to improve the nation's health
- Increased funding for community health centers
- Award five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations
- Provide grants for up to five years to small employers that establish wellness programs
- Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item

ACA Timeline

2012

- Begin quality-based payments under Medicare

2013

- Increase Medicare tax on earnings over \$200,000 for individuals and \$250,000 for married couples filing jointly, and impose a 3.8% tax on unearned income for high-income taxpayers
- Elimination of employer Medicare Part D retiree prescription drug subsidy
- Begin Medicare bundled payment pilot program
- Create the Consumer Operated and Oriented Plan (CO-OP) program, for non-profit, member-run health insurers in all states
- Impose an excise tax of 2.3% on the sale of any taxable medical device

ACA Timeline

2014

- Begin state-based Health Insurance Exchanges
- Exchange premium and cost-sharing credits for individuals and families with incomes up to 400% of poverty level
- Expand Medicaid to individuals and families with incomes up to 133% of poverty level
- Individual mandate to have health insurance begins; penalties begin (phased in from \$95 in 2014 to 2.5% of taxable income in 2016)
- Employer mandate to provide health insurance to employees begins (for employers with 50+ employees); penalties begin
- Require guarantee issue and renewability and allow rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5 to 1 ratio) in the individual and the small group market and the Exchanges
- Create an essential health benefits package that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the current law HSA limits (\$5,950/individual and \$11,900/family in 2010), and is not more extensive than the typical employer plan
- Medicare payment Advisory Board begins—submit recommendations for Medicare payment reductions if spending exceeds determined thresholds

2014 and Beyond

- Individuals and small businesses will purchase insurance through Health Insurance Exchanges
- Special small business Exchange (SHOP)
- Individual Mandate
- Hoped that Exchanges will be state run
- Option for regional and multi-state Exchanges
- If a state doesn't set up an Exchange, federal government will
- Anticipated will be online marketplace
- Many questions and administrative action to come

2014 and Beyond

- Purchasers through the Exchange will receive premium assistance subsidies
- Those up to 400% of federal poverty level eligible for subsidies (approximately \$88,000 for family of 4 in 2010 guidelines)
- Subsidy is a percentage of individual/family modified adjusted gross income

2014 and Beyond

Choice of plans in Exchange

- Platinum—90% cost of care coverage
- Gold—80% cost of care coverage
- Silver—70% cost of care coverage
- Bronze—60% cost of care coverage
- Catastrophic—limited to those under 30, exempt from individual mandate due to affordability

2014 and Beyond

Premium tax credit subsidy amounts are linked to the second lowest cost of a “Silver Plan” in the area. The subsidy amounts are set on a sliding scale such that the family premium contribution for a Silver Plan does not exceed the following percentage of income for the specified poverty levels in 2014:

- Below 133 percent of poverty: 2.0 percent of income
- 133 up to 150 percent of poverty: 3.0-4.0 percent of income
- 150 up to 200 percent of poverty: 4.0-6.3 percent of income
- 200 up to 250 percent of poverty: 6.3-8.05 percent of income
- 250 up to 300 percent of poverty: 8.05-9.5 percent of income
- 300 up to 400 percent of poverty: 9.5 percent of income

2014 and Beyond

Example of how the Exchange may work

The Johnsons, a family of four (two adults, two children under age 18), annual income of \$33,075 (150 percent of poverty):

If the annual premium for the Silver plan for family coverage in the Exchange in the Johnson's zip code is \$4,500, the most the Johnson family would have to spend out of their own pockets on annual premiums to cover their family would be about \$1,323 (or about \$110 a month). The remainder of their premium for the silver reference plan would be covered in the form of a tax credit for \$3,177 (or that amount could be credited toward the premiums for a more or less expensive plan of their choice).

Expanding the Rural Health Care Workforce

Provision	Funding
Rural Physician Training Grants—Grants to medical schools to develop programs to recruit students most likely to practice in underserved rural areas	\$4M/yr (2010-2013)
Rural Graduate Medical Education—1) grants/contracts to train medical residents in community-based settings such as Rural Health Clinics and FQHCs; 2) Grant/contract program to train primary care residents in community-based settings; preference to programs in underserved communities	\$125M through 2014

Expanding the Rural Health Care Workforce

Provision	Funding
Redistribution of Residency Slots—Redistribute unused slots to primary care positions; preference to states with low physician numbers and large population in health profession shortage areas	
National Health Service Corps—Increased funding	Additional \$290M (2011) to \$310M (2015)
Health Care Workforce Loan Program—Loans of \$35,000/yr. up to 3 years for pediatric, medical or surgical specialists or child behavioral specialists in underserved/ health professional shortage areas	\$150M/yr (2010-2014)

Expanding the Rural Health Care Workforce

Provision	Funding
U.S. Public Health Sciences Track—Selected sites for team-based service in public health and emergency preparedness; will graduate a specific number of physicians, dentists, RNs, public and behavioral health professionals, PAs, nurse practitioners. Priority to students from rural/underserved areas	As needed
Increased Primary Care Teaching Capacity—Grants to support new primary care residency programs; priority to those with affiliation with AHECs	\$25M (2010) \$50M (2011) \$50M (2012)

Expanding the Rural Health Care Workforce

Provision	Funding
Nurse Managed Health Clinics—grants for clinics providing primary or wellness care to underserved or vulnerable populations	\$50M/yr (2010-2014)
Nursing student loan program—increases the loan amounts for nursing student	
Training for mid-career public health and allied health professionals—grants for state and local programs for scholarships for those working in public health programs at all levels	\$60M for 2010 and sums as necessary for 2011-2015

Expanding the Rural Health Care Workforce

Provision	Funding
Training opportunities for direct care workers— grants to institutions of higher education for tuition assistance for those who wish to work in geriatrics, disability services, long-terms services or chronic care management	\$10M (2010-2013)
Training in general, pediatric and public health dentistry— grants to schools of dentistry, hospitals or nonprofit entities for financial assistance to students; priority to entities with a record of training students for rural populations or with a relationship with health clinics	\$30M for 2010 and sums as necessary for 2011-2015

Expanding the Rural Health Care Workforce

Provision	Funding
Increased authorization for nursing workforce programs – increases authorizations for sections of the Public Health Services Act for advanced nursing education grants and nurse education, quality and retention grants	\$338M for 2010 and sums as necessary for 2011-2016
Mental and behavioral health education grants—grants to institutions of higher education for recruitment and education of students in social work, psychology and child mental health; priority to programs producing professionals serving high-need populations	\$35M (2011-2013)

Expanding the Rural Health Care Workforce

Provision	Funding
U.S. Public Health Sciences Track—Selected sites for team-based service in public health and emergency preparedness; will graduate a specific number of physicians, dentists, RNs, public and behavioral health professionals, PAs, nurse practitioners. Priority to students from rural and underserved areas	Funding transferred from the Public Health and Social Services Emergency Fund
Demonstration grants for family nurse practitioner training programs—funding for one additional year of training for careers as primary care providers in health clinics	Sums as necessary (2011-2014)

Recruiting for Health Care Careers and Health Care workforce Strategies

Provision	Funding
Continuing and Expanding Area Health Education Centers (AHECs)—local organizations providing health care workforce training programs to high school and younger students	\$125M/yr (2010-2014)
State Health Care Workforce Development Grants— Partnerships with states and National Health Care Workforce Commission to develop comprehensive workforce development strategies	\$8M (planning) \$150M (implementation)
Public health workforce recruitment and retention—loan program for public health students	\$195M/yr (2010-2015)

Rural Hospitals and Clinics

- Authorizes and appropriates \$9.5 billion to a new Community Health Centers Fund to expand the operational capacity of health centers and clinics across the nation (starting with \$1 billion in 2011, gradually increasing to \$3.6 billion in 2015). It is estimated this will allow community health centers to serve 20 million new patients.
- Authorizes and appropriates \$1.5 billion over five years to meet Community Health Centers meet new construction and expansion needs.
- Authorizes nearly \$34 billion in additional funding for FQHCs, starting with an additional \$3 billion in 2011, increasing to \$8.3 billion in 2015, with increases thereafter based on costs per patient served and the number of patients served.

Rural Hospitals and Clinics

- Several provisions that provide grants to medical schools, institutions of higher education, non-profits and community-based organizations for workforce expansion strategies, and nearly always require a linkage with a community health center, rural health clinic or FQHC.
- Allows rural hospital outpatient departments to participate in the 340B Prescription Drug Discount Program (Section 340B of the Public Health Service Act). This program allows prescription drugs to be sold at a discount in certain rural hospitals.
- Provisions regarding payment provisions for rural hospitals. Most try to better equalize rural hospitals and non-rural hospitals in Medicare and Medicaid reimbursements. Others assist rural hospitals in implementation of delivery system reforms in the law (items such as Value Based Purchasing and bundling). Three percent bonus payment for home health services in rural areas; that is extended through 2016.

ACA and Prevention and Public Health

- ACA seeks to fully implement the National Quality Strategy developed by the U.S. Department of Health and Human Services.
- National Quality Strategy has three primary aims:
 - Better care—improving the overall quality of health care and making health care more patient-centered
 - Healthy people and communities—improving the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health
 - Affordable care—reducing the cost of quality health care for individuals, families, employers and the government

ACA and Prevention and Public Health

- On June 16, 2011, the Obama administration released the National Prevention and Health Promotion Strategy, a plan that was called for in the ACA.
- This plan is viewed as a roadmap that will help public entities and the private sector to partner to build a system that focuses on wellness and prevention rather than sickness and disease.

ACA and Prevention and Public Health

- Four “strategic directions”:
 - Building healthy and safe community environments
 - Expanding quality preventive services in both clinical and community settings
 - Empowering people to make healthy choices
 - Eliminating health disparities

Prevention and Health Insurance Reforms

- Beginning in 2010, the Affordable Care Act requires new health plans (those plans joined after March 23, 2010) to cover recommended preventive services at no charge by exempting those benefits from deductibles, co-pays and other cost-sharing requirements. Include vaccinations, annual physicals, screenings for common conditions, and well-baby and well-child visits.
- In 2011 co-pays and other cost-sharing for preventive services are eliminated in Medicare. Section 4103 of the Affordable Care Act adds a covered annual wellness visit for Medicare beneficiaries with necessary advice and referrals
- Beginning in 2014 health insurance plans sold through the health insurance marketplaces, or Exchanges, must provide minimum essential benefits or coverage. General categories contained in the ACA include preventive and wellness services and chronic disease management.
- The Affordable Care Act encourages states to improve coverage and access to recommended preventive services and immunizations to Medicaid beneficiaries with bonus payments.

Prevention and Public Health Fund

Title IV, Subtitle A of the Affordable Care Act creates the Prevention and Public Health Fund, a \$15 billion fund over 10 years to expand investment in prevention and public health programs. The goal of the Fund is to shift from treating diseases to preventing illness.

- July 2010 to June 2011—\$250 million from to support the training and development of primary care professionals, a major deficiency and critical need in rural areas.
- April 2011—\$250 million from the Fund for prevention and public health initiatives at the federal, state and local levels. Priority areas include:
 - Community and Clinical Prevention
 - Public Health Infrastructure
 - Public Health Training

H.R. 1217—Would repeal Prevention and Public Health Fund. Approved by House on April 13, 2011. Not been considered in the U.S. Senate and President Obama has indicated he would veto any legislation repealing the Fund.

Grants to Support and Promote Prevention and Public Health

- Section 4202 provides grants to states, tribes and local health departments to help operate programs for those ages 55 to 64 to evaluate chronic disease risk factors, conduct evidence-based public health interventions, and help at-risk individuals receive clinical treatment. Funding is authorized through 2014. Rural areas are specifically mentioned as grantees to be included.
- Section 4201 creates the Community Transformation Grant program. To entities at the state and local level for programs that promote individual and community health by reducing chronic disease rates, addressing health disparities, implementing smoking cessation initiatives and supporting physical activity projects. All projects must use evidence-based interventions. There is a 20 percent set aside in the program for projects in rural communities. On February 9, 2011, the U.S. Department of Health and Human Services announced that \$145 million would be available in the first round of grants through the Centers for Disease Control and Prevention.

Grants to Support and Promote Prevention and Public Health

- Section 4301 authorizes the Center for Disease Control and Prevention to provide grants to support research on community preventive interventions. There is no specific funding authorization for this provision.
- \$25 million (through 2013) for the Childhood Obesity Demonstration Project (established in the 2009 Children's Health Insurance Program Reauthorization Act) to award grants to develop a model for reducing childhood obesity.
- Section 10408 provides grants to small businesses (less than 100 employees) for workplace wellness programs. Such programs are to include health awareness initiatives, efforts to maximize employee participation, initiatives to change unhealthy behaviors and lifestyle choices and supportive efforts to encourage healthy living and lifestyles. Authorizes \$200 million over five years (through 2015) for this provision.

Grants to Support and Promote Prevention and Public Health

- Section 4102 establishes an oral healthcare prevention campaign. Grants will be made to community-based providers to demonstrate the effectiveness of research-based dental preventive activities. Grantees may also incorporate analysis of the dental delivery system and to enhance access to dental health services. Funds are authorized through 2014.

Enhancing Access to Community Preventative Services

- Section 4101 allows the Secretary of Health and Human Services to establish a grant program to operate school-based health centers. Preference is given to entities that serve a large population of children eligible for medical assistance. \$50 million is authorized each year through 2013.
- Section 3502 establishes a program to support primary care practices in several areas, including patient education and prevention services. Grants to establish Community Health Teams to support primary care practices within a hospital service area. Grants would go to states or tribes and would entities receiving grants would be required to submit a plan to ensure the teams are interdisciplinary and interprofessional teams of health care providers and incorporate prevention and patient education into their delivery of health services. Community Health Teams must also integrate their services with community-based prevention and treatment resources. No funding is authorized for this program.

Enhancing Access to Community Preventative Services

- Section 5313 seeks to provide greater access to preventive resources by creating Community Health Workers. As defined in this section, a “community health work” is an individual who promotes health or nutrition in the community. This section would provide grants to public or nonprofit entities to educate, guide and provide outreach to medically underserved communities regarding strategies to promote healthy behaviors and discourage risky health behaviors. Grant priority is given to areas that have high rates of uninsurance or underinsurance or high rates of residents with chronic diseases. No funding is authorized for this program.

Questions?

For More Information

Jon Bailey

Center for Rural Affairs

P.O. Box 138

Lyons, NE 68038

402-687-2100

jonb@cfra.org

<http://www.cfra.org/policy/health-care>