Swatches

Connecting Rural Iowa

August 2012

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Iowa Rural Health Association
optimal health for all Iowans

President's Message

by Tori Squires, IRHA President

Regardless of your views on the Affordable Care Act or the Supreme Court's ruling in June on the constitutionality of the law, it is clear that fundamental changes in health care continue to occur and we all must be informed and prepared to adapt to these changes. The IRHA Board strives to track opportunities and challenges in this changing environment and provide members with information and educational sessions relevant to health care delivery in rural Iowa. This issue of the IRHA newsletter focuses on several aspects of this changing health care environment including a summary of the Supreme Court's decision on the Affordable Care Act and information on the state's health insurance Co-Op (Consumer Operated and Oriented Plan) funded through the ACA.

Additional updates on issues impacting rural Iowa will be provided on September 20 during our annual conference in Johnston, which we are co-sponsoring with the Iowa Association of Rural Health Clinics. With the theme of "Moving Rural Health Forward," presentations will be provided by Jay Angoff, Acting Regional Administrator, Region VII of the U.S. Department of Health and Human Services; Keith Mueller, University of Iowa Department of Health Management and Policy and RUPRI Center for Rural Health Policy Analysis director; and Russ Currier, DVM, Iowa State Public Health (ret.). Promising practices from local Iowa communities will also be shared. We hope to see you all there! For more conference information, visit the Educational Events page of the IRHA website at *www.iaruralhealth.org*.

Taking the Mission to the Quad Cities: The Iowa Mission of

Thank you for your

Thank you for your IRHA Membership!

Benefits of being an IRHA member:

1. Health advocacy with a rural perspective

2. Access to resources through the IRHA and NRHA websites and email distribution lists

3. Networking opportunities with professionals from diverse disciplines

4. Input opportunities for State and Federal Policy issues

5. Discounted rates for Annual Conference

6. Opportunities for leadership development

New IRHA Member Benefit!

IRHA is excited to announce a new benefit for our members - an Online Career Center.

IRHA members looking to fill open positions are now able to post employment

Mercy

As parents, each day brings challenges to balance the needs of themselves and their children and their financial resources. When it comes to oral health care, sometimes difficult decisions must be made. Many people face barriers to receiving adequate oral health care. Perhaps dental insurance is not offered by an employer or, even if there is insurance, the deductibles and out-of-pocket co-pays are out of reach financially. In today's economy, making decisions about oral health care is even more challenging. Parents will often forgo their own oral health to make sure their children receive at least a minimum amount of care.

Unfortunately, neglecting one's oral health care can lead to significant medical issues. Research shows linkages between poor oral health and heart and lung disease, diabetes, stroke, and pre-term low birth weight. Both children and adults can experience difficulty eating, speaking, and may have diminished self esteem.

The Iowa Mission of Mercy was created in 2008 to treat adults and children who face challenges in obtaining dental care. The Iowa Mission of Mercy is not intended to create a dental home for patients but, rather, to address immediate, acute needs and to connect those who have limited or no access to local oral health providers. Patients will receive treatment for their most urgent dental needs the day they come for treatment. Dental health professionals will perform dental exams, remove teeth, provide fillings, cleanings and replacement of one or more teeth with "flippers." Patients are also educated on the proper care of their teeth. Since the first Iowa MOM, over 5,600 patients have received over $3.5 million in free dental care.

The Iowa MOM is an event of epic proportions requiring well over 1,200 volunteers, including dentists, dental hygienists, dental assistants, as well as other volunteers, to serve the 1,300+ patients that will be seen during the two-day event. A field dental clinic with 100 dental chairs, sterilization, X-ray, laboratory, and triage areas are set up, maintained, and torn down after the event. Free day care is provided for children while their parents and/or family members receive care. Twenty-four hour security is required for patients, many of whom begin waiting in line the day before the clinic opens and spend the night outside the venue. Patient escorts assist in navigating patients through the various triage and treatment areas once the clinic opens. Volunteers and patients require food and beverages during the event, which begins at 6:00 in the morning and often ends after 8:00 in the evening. The Mission of Mercy is truly a multi-faceted community event! Volunteers and community support are vital aspects to the success of the Iowa Mission.

Encouraging volunteerism at your organization or in your community at the Mission of Mercy builds strong teamwork skills, a sense of giving back to the community and, most importantly, the great sense of satisfaction in helping people who are in need.

employment opportunities to the IRHA website at no cost. Also, IRHA members looking for positions are able to post their qualifications and type of employment they are seeking at no cost.

This service is also available to non-IRHA members for a nominal fee.

To take advantage of this new member benefit, visit www.iaruralhealth.org and click the "Career Center" link on the main menu.

The Iowa Mission of Mercy is being held this year in the Quad Cities area. Iowa MOM will be held Friday and Saturday, October 5 and 6, 2012, at the River Center in downtown Davenport. For more information about the Iowa Mission of Mercy or to volunteer, please visit our website at *www.iowamom.org*.

Health Insurance CO-OP Brings New Competition to Iowa and Nebraska

By now, we're all pretty familiar with the Affordable Care Act and key changes that will impact nearly every American. The individual mandate has received the most buzz, particularly with the challenge of constitutionality that went all the way to the Supreme Court. In late June, the Court upheld nearly all aspects of the ACA, including the mandate. Barring other challenges to the law, the mandate-and with it the way people will shop for insurance-will change beginning January 1, 2014.

A little-known feature of the ACA is the establishment of state-based CO-OPs, defined as consumer operated and oriented plans. Through mid-July, 17 non-profit organizations have been approved for low-interest federal loans to establish CO-OP health insurance plans that will begin member outreach and enrollment activities in late 2013. The federal loans provide start-up and solvency capital-funding that would be difficult to obtain through traditional private or venture capital mechanisms. This approach is similar to previous efforts to fund rural electricity, broadband access and other critical issues.

In Iowa and Nebraska, CoOportunity Health SM is the name of the new

In Iowa and Nebraska, CoOportunity Health SM is the name of the new CO-OP that will offer health insurance plans across the two states. The organization was among the first seven CO-OPs to be approved, receiving $112.6 million in federal loans. Start-up operations began in March led by three founding directors: David Lyons, Chief Executive Officer (former Iowa Insurance Commissioner); Cliff Gold, Chief Operating Officer (former Blue Cross Blue Shield executive); and Stephen Ringlee, Chief Financial Officer (venture capital and start-up executive).

How is a CO-OP different?
CoOportunity Health, like the other approved CO-OPs, is different than commercial health insurance carriers in fundamental ways:

- CO-OPs are member owned and member governed
- CO-OPs recognized by the IRS as a new category of non-profit 501(c)(29) organizations
- All profits earned must be used to pay back government loans, reinvested in member benefits, or returned to members
- HHS and CMS provide federal oversight of approved CO-OPs
- CO-OPs must participate in either the state or federal Affordable Insurance Exchanges beginning January 1, 2014
- CO-OPs were formed to provide affordable coverage options for individuals and small groups, including the uninsured.

Market Opportunity
CoOportunity Health will compete with established commercial carriers in two states that are highly concentrated-meaning that one or two insurers have a dominant share of the market. Few options are available in Iowa and Nebraska, particularly in the individual market where the highest rate of uninsured exists. In addition, the number of small businesses offering insurance has been decreasing, adding to the uninsured numbers. With no competition, there is little market pressure to innovate or keep costs down.

"The CO-OP health insurance model introduces a new playing field in Iowa and Nebraska. In fact, the idea probably has the best chance of working here in the heartland, where our economic livelihood is highly dependent on the healthy viability of small businesses, agriculture and rural business ventures," says David Lyons, CoOportunity Health CEO.

"Cooperatives have been around for decades and are known as trusted resources that achieve scale and affordability for their members. Entities like credit unions, agricultural commodities, and rural electricity and water are successful examples in Iowa and Nebraksa. Why not apply that same successful model of member-owned and member-managed to health insurance? "

CoOportunity Health will offer a portfolio of PPO health plans for individuals and small businesses (under 100) with designs that provide unique upfront benefits that make it easy for members to access care and actively participate in practicing good health. These plans will be available through the Affordable Insurance Exchange-a new way of shopping for

through the Affordable Insurance Exchange-a new way of shopping for insurance particularly for individuals that qualify for subsidies beginning in 2014.

CoOportunity Health will also be offering enrollment directly through its website and through relationships with select brokers, agents, and affinity partners in Iowa and Nebraska. The company also plans to offer benefit solutions for large employers, either fully-insured or self-funded options.

What's Next for CoOportunity Health?
Currently, the company is in the process of applying for licensure in the state of Iowa and hopes to have this completed by the end of the summer. It will then work to obtain licensure in the state of Nebraska by year end.

In May, the company opened its headquarters in Des Moines, and began filling key staff positions in the areas of provider network administration, legal and regulatory affairs, product development, channel and sales management, market outreach, and financial management. Additional functions will be added as the company works to prepare for marketplace introduction in late 2013.

If you have questions or would like to schedule a representative of the company to speak to your organization, please contact:
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2012 Joint Fall Meeting - September 20

Plans are underway for the 2012 Iowa Rural Health Association (IRHA) and Iowa Association of Rural Health Clinics (IARHC) Joint Fall Meeting, which will be held in Johnston on September 20. We are excited to present this cooperative event between our two organizations, which will build on our individual efforts and reach a larger audience.

The theme for the event is "Moving Rural Health Forward." A number of local and national experts will be presenting during the morning sessions, including: Jay Angoff, Acting Regional Administrator, Region VII of the U.S. Department of Health and Human Services; Keith Mueller, University of Iowa Department of Health Management and Policy and RUPRI Center for Rural Health Policy Analysis director; and Russ Currier, DVM, Iowa State Public Health (ret.). Through Humanities Iowa, a special "rural" touch will be a presentation of Iowa artist Grant Wood, by Tom Milligan.

The afternoon will offer attendees a choice of two tracks. In Track 1, Janet Lytton will be presenting a Billing and Coding workshop for Rural Health Clinics. Track 2 will feature four presentations sharing promising practices

Clinics. Track 2 will feature four presentations sharing promising practices. These presentations include: The Direct Care Workforce Initiative, Iowa Physician Orders for Scope of Treatment (IPOST) Becomes Law, FIND - Fulfilling Iowa's Need for Dentists: A Rural Iowa Dental Health Initiative, and Development of an Evidence-Based Rural Physician Recruitment Plan.

The day will also allow plenty of time for networking with colleagues from across the state, catching up with old friends and making new connections.

A complete meeting brochure and registration form is available on the Educational Events page of the IRHA website - *www.iaruralhealth.org*

The Supreme Court of the United States Has Ruled: What is Next?

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On June 28, 2012 the Supreme Court of the United States (SCOTUS) issued its decision in *National Federation of Independent Business et al. v. Sebelius, Secretary of Health and Human Services, et al.* Now comes the aftermath, which is the still rocky road of implementing the Patient Protection and Affordable Care Act of 2010 (ACA). The SCOTUS decision upheld the requirement that individuals provide proof of health insurance through tax system, ruling it to be an appropriate use of the power Congress to "lay and collect Taxes" (Article I of the Constitution). The SCOTUS ruling on the question of Congress' power to require that state Medicaid programs change to include all persons with incomes up to 133% (plus a 5% offset, for an effective 138%) of federal poverty was a bit more complicated. Congress has the power to set specific conditions for accepting the federal match to fund Medicaid, but it cannot use the leverage of denying the match for the existing program as the penalty for not changing the program to eliminate categorical eligibility and change income eligibility to be 133% of the federal poverty guideline, determined solely on the basis of modified adjusted gross income. The SCOTUS ruled that states not choosing to expand their Medicaid programs cannot be penalized for that decision. The decision, while somewhat complicated, was very specific in its reach, saying that the "constitutional violation is fully remedied" with the ruling that the Secretary cannot withdraw current Medicaid funds; and that "The other provisions of the Affordable Care Act are not affected."

So, what does this mean in rural Iowa? The first part of the ruling means that, unless a new congress were to overturn the ACA shortly before scheduled full implementation, a process will need to be in place by January 2014 to facilitate entry of otherwise uninsured individuals and small groups into the insurance market. Iowans should have access to competing health plans through a health benefits exchange, and those households with incomes less than 400% and more than 100% of federal

households with incomes less than 400% and more than 100% of federal poverty guidelines will get some assistance in paying the insurance premiums. Iowa state government has completed some of the early planning steps for a state-run exchange; the choice now is to continue with that effort and establish the exchange, or have the federal government take on that function. There are also some intermediate actions whereby the state and federal government can each assume some of the functions of exchanges.

The second part of the ruling creates potential for the number of newly insured persons in rural America to differ dramatically from forecasts based on the assumption of full implementation of Medicaid expansion in 2014. Some states will not choose to participate, either by delaying their decision to a year after 2014, or not adopting the new eligibility determinations at all. The Congressional Budget Office estimates that in 2022 Medicaid (and the Children's Health Insurance Program) will cover approximately 6 million fewer people than previous estimates. Those 6 million, according to CBO estimates, would divide about evenly between persons who would obtain insurance through exchanges, and those who would be uninsured.[1] With the implementation occurring in 2014, and the US Department of Health and Human Services saying it will consider state plan amendments to participate as late as shortly before implementation, only estimates are possible now. In Iowa, the Urban Institute has estimated that 106,000 residents would be newly eligible, and that 80,000 of them would have incomes below 100% of the federal poverty guideline (not currently eligible based categories of eligibility).[2] As enacted the ACA provides 100% federal support for the newly eligible Medicaid recipients for the first three years, then phases to a 90% federal match. Officials in some states, and their national associations, have raised doubt about the federal commitment, given pressures to reduce the federal deficit and a proposal during debt reduction discussions to blend the 90% rate with the base rate in each state. However, at the present time there are no changes to the ACA provisions under consideration (except, of course, the House Republican proposal to repeal the entire statute).

In addition to the direct impact of Medicaid expansion on persons without health insurance, it would also affect health care providers, especially hospitals. The ACA includes a reduction in disproportionate share payments to hospitals, which are designed to compensate for lack of payment from the uninsured. The provision was agreed to by hospital trade associations under the assumption that approximately 30 million uninsured Americans would be covered by the combination of Medicaid expansion and subsidized private insurance. In states not participating in Medicaid expansion, a higher number of persons would remain uninsured, leaving hospitals with unpaid bills and reduced disproportionate share payments. Given the slightly greater rural impact of the Medicaid program,[3] this loss could be of special concern to rural hospitals.

Time will tell the full impact of implementing the ACA now that the SCOTUS has acted. Rural residents and providers in Iowa and elsewhere have a special interest in the outcome of further state and federal actions

during implementation.

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[1] Congressional Budget Office (2012) Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision. July. Available from http://cbo.gov/publication/43472
[2] Genevieve M. Kenny, Lisa Dubay, Stephen Zuckerman, and Michael Huntress (2012) Making the Medicaid Expansion an ACA Option: How Many Uninsured Adults Would not Be Eligible for Medicaid? July 29. Downloaded July 30, 2012 from http://www.urban.org/UploadedPDF/412607-Opting-Out-of-the-Medicaid-Expansion-Under-the-ACA.pdf
[3] Timothy McBride (2009) Impact of the Patient Protection and Affordable Care Act on Covered Persons. December 9. RUPRI Health Panel. Downloaded August 1, 2012: http://www.rupri.org/Forms/McBride_Insurance_Dec09.pdf