

ACHI is a nonpartisan, independent, health policy center that serves as a catalyst for improving the health of Arkansans.

Patient Protection and Affordable Care Act: Benefits for Arkansas's Rural Communities

March 2011

Arkansas is largely a rural state, with about 40% of people living in rural areas compared to 21% nationally. Rural areas throughout the United States and in Arkansas face a number of challenges when it comes to health care. For example, studies show that many more people in rural areas than urban areas are either uninsured or covered through a public source of health care, such as Medicaid or Medicare. Also, rural residents usually are employed by smaller businesses than urban residents, and these businesses not only tend to pay lower wages but also are less likely to provide health insurance coverage.ⁱ Finally, rural Americans—on average—have a higher percentage of chronic conditions, such as diabetes, high blood pressure and heart disease.ⁱⁱ

This Issue Brief examines how new health-care reform laws help to address these and other health-care related issues in Arkansas's rural communities. The Brief discusses five important aspects of these recently passed laws that may significantly improve health care for Arkansans in these communities:

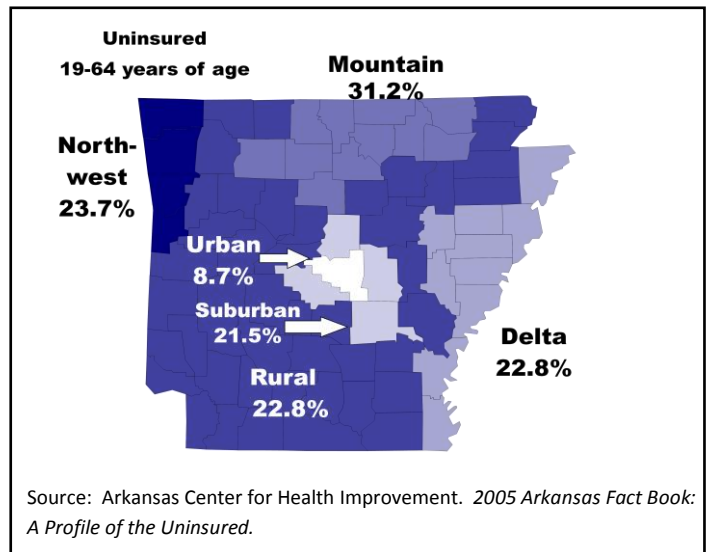
- Offering Medicaid to Arkansas's Poorest Adults
- Boosting the Number of Primary-Care Providers
- Expanding the National Health Service Corps
- Accelerating Broadband Access and Telemedicine
- Creating an Arkansas-Based Health Insurance Exchange

OFFERING MEDICAID TO ARKANSAS'S POOREST ADULTS

In Arkansas's rural communities, like communities throughout the U.S., a large number of residents have lower income levels than urban residents. In rural Arkansas the average income for an individual is \$34,788, whereas in an urban area it is \$41,265. In great part because of these income issues, rural Arkansans are much less likely to have insurance coverage than those living in urban areas. Thirty-nine percent of Arkansans living in rural areas are Medicaid recipients, compared to 25% of Arkansans living in urban areas.

Beginning in 2014, under the new health-care law, Medicaid will be expanded in Arkansas to cover families that earn 133% of the Federal Poverty Level; that is, about \$14,000 for an individual and about \$29,000 for a family of four. Estimates suggest that in 2014 about 251,000 Arkansans—many of whom will live in rural areas—will become newly eligible for Medicaid.

From 2014-2016, newly-eligible Medicaid enrollees will be 100% paid for through federal funding. After 2016, the federal funding gradually decreases to 90% federal funding and 10% funding by Arkansas in 2020 and the following years.

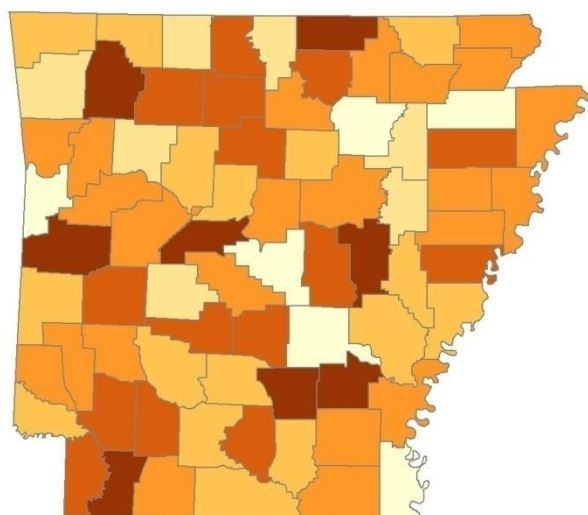


BOOSTING THE NUMBER OF PRIMARY-CARE PROVIDERS

It is often said that primary care is the “backbone” of rural health care.ⁱⁱⁱ Strengthening the availability of primary-care providers is a key goal of the new health-care law, and this could significantly benefit rural Arkansas, where primary-care providers are greatly needed but often absent.

In Arkansas there are far fewer primary-care physicians (based on the ratio of primary-care physicians to population) than in urban areas of Arkansas. An expansion of 38.5% would be required for residents in rural Arkansas to have the same access to primary-care doctors as residents of urban areas in Arkansas. Studies also have shown that states that have a higher per-capita ratio of primary-care physicians have lower mortality rates from a variety of illnesses.^{iv}

Providers per 1000 Population (2009): Primary Care Physician*



Providers: 0-.13 .14-.38 .39-.59 .60-.79 .80-.99 1.00-1.33

*Primary Care Physician = Family Practice/General Practice/Internal Medicine/Pediatrics/Obstetrics-Gynecology who reported direct patient care as their major professional activity

Source: Population: US Census Bureau. County population, population change and estimated components of population change: April 1, 2000 to July 1, 2009 (CO-EST2009-alldata). Available at: <http://www.census.gov/popest/counties/counties.html>. Accessed 10/29/2010. Primary Care Physician: American Medical Association Physician Masterfile, 2010

Starting in 2010, federal funds will be invested from the new health-care law to help boost primary-care providers, by helping Arkansas to:

- Create additional primary-care residency slots;
- Support physician assistant training in primary care;
- Increase the number of nurse practitioners who are trained;
- Establish nurse practitioner-led clinics; and
- Help states plan for health-care workforce needs.^v

The new health-care law creates important financial incentives for primary-care doctors. As Medicaid programs and providers prepare to cover more patients in 2014, primary-care doctors—including pediatricians—will be reimbursed no less than 100% of Medicare rates in 2013 and 2014.^{vi} This is a very significant change because currently Medicaid reimbursement rates are much less than Medicare

reimbursement rates. As a result, there is a chronic shortage of doctors accepting Medicaid patients. Also, for primary-care physicians who treat Medicare patients in areas where physicians are scarce, such as rural areas, they will receive a 10% payment bonus from 2011-2015.^{vii}

EXPANDING THE NATIONAL HEALTH SERVICE CORPS

The new law also helps to expand the National Health Service Corps. The National Health Service Corps offers primary medical, nursing, dental and mental health clinicians up to \$60,000 to repay student loans in exchange for 2 years of service in medically underserved areas. All Arkansas counties are designated at least partially a medically underserved area or a primary-care health professions shortage area.

Currently in Arkansas there are a total of 132 available National Health Service Corps positions, but only 38 are filled. The new health-care law invests \$1.5 billion over five years to expand the National Health Service Corps. On top of this, the American Recovery and Reinvestment Act invests \$300 million to expand the Corps.^{viii}

ACCELERATING BROADBAND ACCESS AND TELEMEDICINE

Because rural areas in Arkansas often lack an adequate number of health-care providers of all types, telemedicine holds considerable promise to help residents of these areas. This technology can be used to:

- Provide quicker and more convenient access to specialty care, like conferring with a specialist or having a radiologist read a scan from far away;
- Provide education for rural health-care providers whose patients may be many miles away from subspecialty experts;^{ix} and
- Create a more patient-centered approach to medicine, by saving patients time and transportation costs associated with traveling long distances for health care.

In August 2010 the University of Arkansas for the Medical Sciences received a \$102 million grant—from the Recovery Act Broadband Technology Opportunities Program—to upgrade and expand broadband networks at 474 health care and education sites throughout Arkansas.^x This grant is one of the largest that an Arkansas institution of learning has ever

received, and will be used to create new infrastructure, construct network connections throughout the state and provide telemedicine equipment for hospitals, clinics and home health sites.

Spending from the grant will include:

- \$28 million to construct fiber optic network routes to serve community colleges;
- \$24 million for connectivity lease charges for participating sites;
- \$23 million for network infrastructure;
- \$22 million for telemedicine equipment for hospitals, clinics and home health sites; and
- \$5 million for network equipment for community colleges.

CREATING AN ARKANSAS-BASED HEALTH INSURANCE EXCHANGE

Beginning in 2014, Arkansas will have a web-based health insurance exchange where individuals and small businesses may shop for health insurance. The exchange will allow people to compare the costs, benefits and other features of many different health insurance plans.

Likewise, the federal government will offer financial help to assist individual Arkansans and families between 133-400% of the Federal Poverty Level to pay for private insurance bought through the exchange, if they do not qualify for Medicaid or

cannot get health insurance from their job. The financial assistance may be available for individuals (up to about \$43,000) and families of four (up to about \$88,000) in two forms: (1) credits that will help pay for insurance premiums; and (2) direct payments that will help pay for out-of-pocket spending, such as deductibles and co-pays. Because a higher percentage of rural residents lack health insurance compared to their urban counterparts, the new Arkansas insurance exchange will provide a new way for rural Arkansans to access health-care insurance.

Under the new health reform laws, the majority of Arkansas businesses will not be required to offer health insurance to their employees. In 2014, the two-thirds of Arkansas businesses with less than 50 full-time employees will not be required to provide health insurance to employees, but those that do may receive tax incentives. Beginning in 2010, businesses with up to 25 employees and average wages of up to \$50,000 may receive tax credits to offset the cost of coverage, if they elect to provide health-insurance coverage to employees. Most businesses in rural areas are small businesses, often with less than 50 employees, and many could be helped by these new tax incentives.

For a more detailed discussion on the health insurance exchange and tax credits for small businesses, please refer to the following Arkansas Center for Health Improvement Issue Briefs: [The American Health Benefits Exchange in Arkansas](#) and [Implications for Arkansas Small Businesses](#).

CONCLUSION

Certain provisions of newly passed health-care reform laws offer the promise of significantly helping residents in rural Arkansas to gain health-insurance coverage and improved access to health-care providers. Whether rural residents and small businesses who otherwise lack health insurance take advantage of these new provisions will be key, however, to realizing the potential promise of the new laws.

Note: Information shared in this overview is based on the law as it is known at this time and is ACHI's best interpretation of the information. As the law continues to be written into rules, it will be further interpreted. Details may change during this process.

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13. U.S. Census Bureau, 2009 American Community Survey

Endnotes

ⁱ Profile of Rural Health Insurance Coverage: A Chartbook, Rural Health Research & Policy Center (June 2009). For other resources on how the new health-care law affects rural communities, see the following two sources from the RUPRI Center for Rural Health Policy Analysis: The Patient Protection and Affordable Care Act of 2010, Impacts on Rural People, Places, and Providers: First Look (Sept. 16, 2010) and The Patient Protection and Affordable Care Act: A Summary of Provisions Important to Rural Health Care Delivery (June 2010).

ⁱⁱ US Department of Health and Human Services, The Affordable Care Act (November 2010).

ⁱⁱⁱ See, for example, Rural Health News, A Family (Doctor) Affair (Summer 2001).

^{iv} Baicker and Chandra, Health Affairs, April 7, 2004.

^v See Creating Jobs and Increasing the Number of Primary Care Providers, http://www.healthcare.gov/news/factsheets/creating_jobs_and_increasing_primary_care_providers.html

^{vi} Summary of New Health Reform Law, p. 10, Kaiser Foundation (March 26, 2010).

^{vii} Summary of New Health Reform Law, p. 10, Kaiser Foundation (March 26, 2010).

^{viii} See Creating Jobs and Increasing the Number of Primary Care Providers, http://www.healthcare.gov/news/factsheets/creating_jobs_and_increasing_primary_care_providers.html

^{ix} For a discussion of the use of telemedicine in Arkansas, see Gonzalez-Espada, Hall-Barrow, Hall, Burke and Smith, Achieving Success Connecting Academic and Practicing Clinicians Through Telemedicine, Pediatrics (March 2009).

^x "UAMS Receives \$102 Million for Statewide Broadband to Benefit Health Care, Education", UAMS Press Release, August 18, 2010.