National Advisory Committee
On Rural Health and Human Services

Rural Policy Implications for Health Insurance Exchanges

White Paper March 2011

Editorial Note: *In 2012, the National Advisory Committee on Rural Health and Human Services will focus on the rural implications of key provisions from the Patient Protection and Affordable Care Act through a series of white papers with policy recommendations that will be sent to the Secretary of the U.S. Department of Health and Human Services.*

INTRODUCTION

One of the key foundations for improving insurance coverage in the Patient Protection and Affordable Care Act (ACA) rests on the creation and functionality of Health Insurance Exchanges (HIEs) as outlined in Sections 1301-1304 and 1311-1313 of the legislation. This will be particularly true for rural residents given the traditional challenges they have faced in the individual and small business market. If implemented effectively, exchanges have the potential to make premiums affordable, increase the bargaining power of the many individual and small group purchasers in rural, increase access to services, and decrease the growing number of uninsured rural residents. The Committee recognizes that many legal and regulatory issues have not yet been addressed; however, these recommendations are intended to highlight policy issues of concern, as well as policy choices it believes would protect and benefit rural America.

Recommendations

1. The Committee recommends that the Secretary use the maximum regulatory authority available to encourage early participation in the planning and establishment process.
2. The Committee recommends that States be encouraged and incented to adopt successful models emerging from this process that have demonstrated the ability to provide enrollees with varied choices, while maintaining an easily navigable marketplace.
3. The Committee recommends that the regulations account for differences in broadband access, especially in the individual market.
4. The Committee recommends that the Secretary adopt standards with respect to provider networks that require insurers to enroll Critical Access Hospitals and other key rural health safety net providers within a reasonable distance of the individuals they insure such as Sole Community Hospitals, Medicare Dependent Hospitals, Rural Health Clinics and Federally Qualified Health Centers.
5. The Committee recommends that current Medicare payment levels serve as a floor for payments by non-public insurers who are required under the ACA to contract with essential community providers but not if those providers do not accept the plan's "generally applicable payment rates."

DISCUSSION & RECOMMENDATIONS

The Committee is aware that one State has announced that it does not intend to apply for Federal funding designated for development of exchanges. The committee believes that States that choose to delay participation in this process may ultimately lose any ability to garner Federal development funds, and in doing so, may deny their citizens and providers the valuable benefits of health care reform until a federally operated exchange can be put in place. Delays could also blunt incentives health insurers may have to develop certifiable "qualified health plans" suitable for sale through exchanges. Therefore, the Committee recommends that the Secretary use the

maximum regulatory authority available to encourage early participation in the planning and establishment process.

Rural citizens have traditionally had less access both to health care providers and private insurance coverage. One out of eight rural nonadjacent residents is underinsured (12%), compared with 10% of rural adjacent and 6% of urban residents.[1] This is largely due to the fact that rural residents are less likely to work for an employer that offers health insurance than urban residents. In rural, not adjacent areas, 64% of working adults are offered coverage through their employer compared to 71% in urban areas.[2] Many of these rural employers are unable to offer insurance because they are primarily small employers who have less purchasing power and increased risk of adverse selection. Based on these challenges inherent in creating viable insurance markets in rural areas, it is the opinion of the Committee that only through broad geographic coverage areas that include rural and urban markets, can one reasonably expect to increase coverage in rural America. To the extent possible, the Committee believes that rural interests are best served by exchanges if the exchanges are state wide or multistate to ensure an adequate number of insured, minimizing rural/urban premium cost differences and the potential for adverse selection.

Rural and small businesses have historically had a scarcity of adequate insurance choices. The complexity of the existing insurance market will be compounded within the exchanges by the need to take into account eligibility for Medicaid, CHIP, and various premium subsidies. This level of complexity strongly suggests that enhanced coverage will depend upon the ability of individuals and small employers to enroll in an efficient, simplified, and transparent process. The best practical solution to these needs lies in State's choices to establish exchanges with a broad range of functions that can meet all of these needs. Funding has been provided to a number of states to develop innovative and efficient exchange models. The Committee recommends that States be encouraged and incented to adopt successful models emerging from this process that have demonstrated the ability to provide enrollees with varied choices, while maintaining an easily navigable marketplace. Additionally, current and future efficiencies would be optimized by continuity among the exchanges from state to state. Both rural and urban participants and insurers should benefit as a result.

In establishing these exchange market places it will be crucial for the participation of rural persons that the market places are not solely accessible via internet portals. Research has shown that the digital divide between urban and rural is due in part to the high cost of providing services across the more widely dispersed rural population which serves as a barrier to the development of infrastructure in rural areas. As a result, rural areas lag behind in the infrastructure required for optimal Internet use (such as broadband or other high-speed service), and rural residents have lower reported use of the Internet than urban residents.[3] The Committee recommends that the regulations account for differences in broadband access, especially in the individual market. There is a need for physical outreach, enrollment strategies, as well as materials that will provide those without internet access with the same easily navigable and transparent comparisons of plans that will be available through the internet portals.

There are a number of cultural characteristics in rural communities that may also become barriers to achieving widespread participation in exchanges if they are not addressed. First, the Committee is acutely aware many rural citizens (as well as urban citizens) may not have access to credit cards

[1] E. Ziller & A. Coburn, *The Rural Underinsured: Fact Sheet*. Maine Rural Health Research Center Muskie School of Public Service, University of Southern Maine.
[2] Id.
[3] Wang JY, Bennett K, Probst J. *Subdividing the Digital Divide: Differences in Internet Access and Use among Rural Residents with Medical Limitations.* J Med Internet Res 2011;13(1):e25.

or checking accounts, the currently common methods for making payment. These citizens will be closed out of the insurance market unless standards for exchanges include acceptance of a wide range of payment methods, to include cash and money orders. Second, significant language and literacy barriers will need to be overcome by culturally competent exchanges and culturally competent navigators in order to aid enrollees in making appropriate coverage decisions. While the Committee is aware that the legislation requires navigators to "provide information in a manner that is culturally and linguistically appropriate to the needs of the population begin served by the exchange," we recommend that regulations relating to the establishment of exchanges include these requirements as mandatory and elaborate on what "culturally and linguistically appropriate" information will include, if the law permits.

In addition to full-service exchanges, the Committee anticipates there will be a strong need for a corps of skilled navigators to assist people in contacting the exchange, making the necessary choices, and securing coverage. Public employees, including school personnel and public health officials could prove helpful to citizens in navigating the system. It is the Committee's view that if a State establishes an exchange with broad responsibilities, a share of the costs associated with certifying Medicaid and CHIP eligibility could be included in the State's Medicaid administrative costs, even after Federal support for the exchanges is discontinued.

The Secretary's authority to establish essential health benefits for insurance plans should be used to assure not only an appropriate list of services but also ensure that plans are required to meet certain standards with regard to the distance or travel time required to reach services. Under current law, the distance between Medicare Critical Access Hospitals is the *de facto* standard of accessibility. The Committee recommends that the Secretary adopt standards with respect to provider networks that require insurers to enroll Critical Access Hospitals and other key rural health safety net providers within a reasonable distance of the individuals they insure such as Sole Community Hospitals, Medicare Dependent Hospitals, Rural Health Clinics and Federally Qualified Health Centers. Without such a requirement, it is likely that some plans may establish minimal networks, limiting access to appropriate and timely care.

Finally, the Committee is concerned that the disparities between the economic strength of many rural providers and the insurance plans working to establish networks in their areas may lead to situations in which they are forced to provide services at a loss or face exclusion from the network. To ensure the continued viability of rural providers, the Committee recommends that current Medicare payment levels serve as a floor for payments by non-public insurers who are required under the ACA to contract with essential community providers but not if those providers do not accept the plan's "generally applicable payment rates."

CONCLUSION

The potential for the creation of exchanges to drastically increase coverage in rural America is great. However, without taking into consideration the inherent challenges in rural insurance markets, cultural and broadband barriers, network adequacy and the potential for rural carve outs in drawing geographic rating areas, rural populations may be essentially barred from participation. The Committee hopes these issues will be addressed in drafting the regulations surrounding the establishment of exchanges so that rural America will be able to take advantage of this new fair, competitive, transparent, and more affordable insurance market.