National Advisory Committee
On Rural Health and Human Services

Affordable Care Act Plans and Premiums in Rural America
Policy Brief July 2014

Editorial Note: *During its Spring 2014 Committee Meeting in Omaha, Nebraska, the National Advisory Committee on Rural Health and Human Services discussed the pricing of insurance plans and premiums for rural populations on the 2014 Health Insurance Marketplace. The Committee met with available rural health research experts, health care providers, and insurance representatives, an held stakeholder meetings at two Critical Access Hospitals—Nemaha County Hospital, in Auburn, NE, and Myrtue Medical Center, in Harlan, IA—to gain perspective from the field. This policy brief continues the Committee's analysis of the Affordable Care Act implementation in rural communities and submits recommendations on the topic of insurance premium pricing to the Secretary of the U. S. Department of Health and Human Services.*

RECOMMENDATIONS

1. *The Committee recommends that the Secretary continue to educate states on the premium pricing implications of using small rating area designs in areas of low population density (see page 5).*

2. *The Committee recommends that the Secretary use the authority in ACA Section 1311(c)(1)(C) to include Rural Health Clinics under the definition of Essential Community Providers to ensure that low-income rural consumers are able to identify and obtain health coverage under their insurance network (see page 6).*

3. *The Committee recommends that the Secretary evaluate all 2014 Marketplace data, including premium pricing, enrollment, and network adequacy by rurality, to assist in future Marketplace planning and understand its impact on rural area consumer market place offerings (see page 7).*

4. *The Committee recommends that the Secretary provide hospitals maximum opportunity to conduct outreach and enrollment without limitations on the circumstances in which they can inform their patients about health coverage opportunities (see page 8).*

INTRODUCTION

With the close of the initial enrollment period of the Affordable Care Act (ACA), the Committee believes it is important to examine new issues related to insurance coverage expansion.[1] The main concerns include network adequacy and access to health care plans for rural residents, including prices of health insurance premiums. Because different plan options are available in different areas (specifically, more options in urban areas compared to rural), average pricing comparisons can be skewed by the ratio of higher-cost plans to lower-cost plans. One tentative area of concern is the combination of limited

[1] Affordable Care Act refers collectively to the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

insurance plans with the "cherry picking" of rating areas by insurers, a combination that preliminary findings show may drive up costs in areas with low population densities. These issues will continue to be important in the coming open enrollment periods in terms of ensuring that the ACA coverage expansion achieves its potential for rural communities. Rural residents have historically faced barriers to accessing both providers and private health insurance options.[2] Prior to the ACA, nearly one in five uninsured Americans lived in a rural area.[3] The Health Insurance Marketplace (Marketplace) could offer rural residents greater access to quality, affordable coverage than has generally been available on the individual market.

As the Department of Health and Human Services (HHS) evaluates lessons learned from the initial enrollment period, the next few months are an important period to assess ways to enhance the Marketplace for rural Americans. The Committee recognizes that there may be notable change in the composition of plans and pricing each subsequent year as insurers gain more experience in serving the rural market. Media coverage over the past year has focused on two rural aspects of the 2014 Marketplace plans, which are also called Qualified Health Plans (QHPs): premium pricing and affordability, and provider network adequacy. This policy brief presents preliminary research findings from the Rural Policy Research Institute (RUPRI) on the rural health coverage in the 2014 Marketplace and elaborates on the Committee's investigations into premium prices in rural Nebraska and Iowa, including conversations with national experts and local stakeholders. It also offers recommendations to ensure that as many rural Americans as possible can gain affordable and accessible health coverage.

BACKGROUND

At the April 2014 Committee meeting, RUPRI presented their findings from a study of rural Marketplace premium pricing. RUPRI emphasized that, when comparing health insurance plans on the Marketplaces by geographic area, it is important to consider the following factors:

- The rating area design (state-level decision)
- The "metal level" of plans
- The effect of age, family status, and tobacco use on actuarial value
- The cost of living in a rating area

It should be noted that there may be other factors—such as local variation in cost due to the health care delivery system or other health patterns—that could also influence premium pricing. However, focusing on these four main characteristics offers a convenient way to begin comparisons of premiums across geographic areas.

Rating Area Design

Rating area design is a key factor in understanding how geography and population density affect pricing. Rating areas are geographic areas within a state where health insurance plans must charge the same premium to consumers. Each state is required to establish one rating area across the entire state, create geographic rating areas equal to the number of Metropolitan Statistical Areas in the state plus one (MSAs +1), or do a combination methodology. Rating areas could be made of noncontiguous regions, but states must construct rating areas based on one of the following:

- counties

[2] Holmes, M. and Ricketts T. C. (2003). Rural-Urban Differences in the Rates of Health Insurance Coverage. North Carolina Rural Health Research and Policy Analysis Center. University of North Carolina at Chapel Hill.
[3] The Uninsured in Rural America. (April 2003). Factsheet. Kaiser Commission on Medicaid and the Uninsured.

- three-digit ZIP codes
- MSAs and non-MSAs
- a combination methodology

With HHS approval, states could create a greater number of rating areas if they felt the divisions were actuarially justified. If a state chose not to establish rating areas, the HHS default is to set one rating area for each MSA within the state and one rating area comprising all non-MSAs in the state (MSAs +1).[4] As a result of these state decisions, there is considerable variability (see Table 1) in rating area design from one state to the next: six states chose to make the entire state a rating areas, three states chose individual counties as rating areas, and seven states chose the default "MSAs+1" option. Most states decided on a combination methodology—either groups of counties (30 states) or groups of three-digit ZIP codes (4 states). Five states asked for HHS approval to create more rating areas than the MSAs+1 limit, including 3 of the states that made each county a rating area.[5]

Table 1: State Rating Area Decisions
Actively Established at the State Level

One Statewide Rating Area	Region within a State: Groups of Counties	Region within a State: Groups of 3-Digit ZIP Codes	Each County Its Own Rating Area	(ACA Default) MSAs + 1
DE HI NH NJ RI VT	AZ AK CA CO* GA IL IN IA KS KY LA ME MD MI MN MS MO* MT NV NY NC OH OR PA SD TN UT WA WV WI	AK ID MA NE	CT* FL* SC*	AL NM ND OK TX VA WY

RUPRI: State decisions on rating area design
* These states were permitted to use more rating areas than the statutory limit.

"Metal Levels" and Plan Availability

To accurately compare premiums by geographic areas, RUPRI researchers looked at the four metal levels (bronze, silver, gold, and platinum, as well as catastrophic plans available to young adults under 30) offered by the Marketplace. Insurance companies are not required to offer all levels of coverage across all rating areas. On average, 37.3 plans were available in urban counties compared to an average 25.7 plans in rural counties. In rural areas in particular, platinum plans were less likely to be offered. Specifically, 6.4 percent of the plans available in urban areas were platinum compared to 4.2 percent of the plans in rural areas. [6] In this context, a comparison of simple averages would be biased: because platinum plans have higher premiums, average premiums in urban areas would tend to be higher. Therefore, an accurate comparison of premiums across geographic areas must adjust for differences in plan availability. [7]

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[4] 78 FR 13405.
[5] Barker, A., McBride, T. D., Kemper, L. M., and Mueller, K. (May 2014). A Guide to Understanding the Variation in Premiums in Rural Health Insurance Marketplaces. RUPRI Rural Policy Brief 5, 1-5.
[6] Barker et al. (May 2014). "Premiums in Rural Health Insurance Marketplaces."
[7] *Ibid.*

Age, Family Status, Tobacco Use

In its presentation to the Committee, RUPRI noted that premium prices are affected by age, family size, and tobacco use within a rating area. By age, the maximum variation is restricted to a ratio of 3:1. This ratio could impact rural areas differently than urban areas, because rural residents tend to be older and, therefore, have higher risk based on morbidity. Similarly, premiums can differ significantly by family type. In addition, tobacco users may pay up to 50 percent more than nonusers.[8]

Cost of Living

The fourth factor considered by RUPRI to contribute to geographic differences in premium pricing is variation in regional cost of living. For example, a consumer shopping on the 2014 Marketplace would find the average lowest cost silver plans to be $188 in Waterloo, IA, while in Newark, NJ, the comparable lowest silver plan premium price is $241. This comparison would suggest that urban areas such as Newark, NJ, have higher premium pricing. However, after RUPRI adjusted for cost-of living, the premium prices were actually higher in Waterloo, IA: $191 in adjusted dollars versus $185 in Newark. [9] In rural areas, it may be cheaper to purchase housing, but other, more expensive cost-of-living items such as transportation and groceries, coupled with lower incomes, make it more difficult to afford premiums. Therefore, premium pricing may appear higher in urban areas, but, after cost-of-living is factored in, rural areas may have higher premiums.

RURAL PREMIUM COMPARISON: PRELIMINARY FINDINGS

Rurality

To more accurately reflect the geographic variation in premium prices, RUPRI adjusted for the cost of living, rating area design, and actuarial level. Most state rating areas cover more than one county and often cover a mix of rural and urban counties, which makes a comparison of rural/urban rating areas difficult. To overcome this difficulty, RUPRI used population density as a proxy for rurality. Preliminary findings suggested that states with a small total population, but with a high percentage of their population living in rural areas, tended to have higher premiums than other states (an average of $265 compared to $243 for the "least rural states"). Higher premiums were also associated with rating areas which had smaller populations, greater land areas, health provider shortages, or were situated in the Midwest. Average monthly premium prices decreased in rating areas as population density increased, falling about $1.22 for each increase in population density of 100 people per square mile. Overall, the findings suggested that areas with many characteristics of rurality, such as a small population, large area, or low population density, tended to have some of the higher premium prices.

Community Dialogues in Auburn, Nebraska, and Harlan, Iowa

At the two Committee site visits, panelists discussed the need for more education around plan selection and the ongoing challenges for affordable coverage. Some consumers were misinformed by the premiums quoted on the website because they did not realize they were the average premiums and did not pursue coverage based on the prices. One panelist summed up the relationship between premium pricing and plans by saying "coverage is a pocketbook issue." The Navigator said that in addition to premiums, high deductibles and cost-sharing were also discouraging some consumers. Consumers between 100 percent and 250 percent FPL may find more affordable plans because they are eligible for subsidized cost-sharing on silver plans.

[8] Public Health Service Act Section 2701(a)(1).

[9] Barker et al. (May 2014). "Premiums in Rural Health Insurance Marketplaces."

Rating Areas

RUPRI also suggested that premiums seem to be impacted by rating area design. In low-density rating areas (with fewer than 100 people per square mile), the MSAs+1 design was linked to lower-than-average premiums on both the Federally-Facilitated Marketplaces (FFMs) and the State-Based Marketplaces (SBMs). Their results also indicate that in states such as South Carolina and Florida, where rating areas were individual counties, premiums were higher. Smaller rating areas and the resulting lack of competition could be linked to higher insurance rates.[10]

These preliminary findings offer us a valuable snapshot of the 2014 premiums in rural areas. However, the 2014 data could differ significantly from data from the 2015 Marketplace and in subsequent years, as insurers gain experience on this market and have more demographic data available to them.

DISCUSSION AND RECOMMENDATIONS

The Construction and Review of Rating Areas

In addition to the finding presented by RUPRI, the Committee also heard from rural health stakeholders representing the University of Nebraska Medical Center, HHS, the Washington University in St. Louis Institute for Public Health, CoOpportunity Health, and BlueCross and BlueShield of Nebraska. Based on the RUPRI findings and this expert testimony, the Committee is concerned that rating area designs in areas of low population density could be too small to adequately spread risk within the insurance pool and, therefore, create higher premiums than would otherwise exist in greater populations with a larger risk pool. The Committee believes that in order to prevent unintentionally higher prices in these smaller, lower-population density areas, it is important that states, particularly those with larger rural populations, continue to examine how their rating area design decisions affect rural areas. The MSA+1 default rating areas associated with lower premium pricing in areas with low-density population could be a better approach to serving small rural communities. **The Committee recommends** that the Secretary educate states on the implications of using small rating area designs on premium pricing for low population density areas. The Committee also encourages the Secretary to look into other alternative approaches to making premiums more affordable for rural communities, as cost of living and other rural variables such as smoking could have a significant impact on rural Marketplace plans and consumer purchases.

Additionally, while geographic rating areas must be used uniformly by insurers as part of their rate-setting, service areas do not have to cover entire rating areas.[11] At site visits during the April Committee Meeting, some rural health experts expressed concern that, because insurers

Essential Community Providers

Essential Community Providers (ECPs), by definition, serve predominately low-income, medically-underserved individuals and qualify to participate in the 340B prescription drug discount program under the Public Health Service Act. Only nonprofit and public health care organizations that have certain federal designations or receive funding from specific federal programs are eligible 340B organizations (see Table 2). There are six categories of ECP provider types, designated by HHS: 1) hospitals 2) federally-qualified health centers 3) family planning providers, 4) Ryan White clinics, 5) Indian Health providers, and 6) other ECP providers. The last category, "Other ECP Providers" was constructed as a catch all category for other 340B entities, but excludes non-340B entities such as independent Rural Health Clinics.

[10] Gosselin, P. (8 October 2013). Exchange Competition Cuts Health Insurance Costs. Bloomberg Government.
[11] 78 FR 13405.

are able to choose their service areas, they may "cherry-pick" parts of the geographic rating areas with lower cost. This could lead to reduced competition, consumer access issues, and higher premiums in areas with low-population density. During the April 2014 meeting, RUPRI indicated that it was too early to determine whether insurers' service areas matched their rating areas, particularly in rural areas. The Committee believes that it is essential that HHS continue to monitor these issues in the coming years to understand how rural areas are impacted.

Network Adequacy and Essential Community Providers – Need for Rural Health Clinics

Over the past few months, considerable attention has been given to the question of QHP network adequacy and the use of limited provider networks to maintain lower pricing. Though narrow network plans existed before the ACA, HIMs narrower provider networks correlate with lower premiums, signaling a consumer tradeoff between provider network size and plan pricing.

Among the requirements to ensure that these narrow networks offer sufficient provider choice, the ACA requires all QHPs to include "essential community providers (ECPs), where available, that serve low-income and underserved populations."[12] The final regulation defines ECPs as providers that meet the criteria for providers under Section 340B of the Public Health Service Act. It also clarifies that provider networks must have a "sufficient number and geographic distribution of essential community providers, where available to ensure reasonable and timely access to a broad range of such providers … in the QHP service area, in accordance with the Exchanges' network adequacy standards."[13]

In essence, the ACA rules tend to serve as a floor, with the option for states to apply more stringent standards, such as requiring plans to offer a contract with any willing ECP. The ACA minimum requirements do not include standards for minimum geographic distances or travel times for access to providers.[14] Some states. such as Washington and Colorado, have set up more flexible standards of "reasonable criteria established by the carrier" and "any reasonable requirement," respectively. In contrast, Nevada requires silver plans serving rural counties to have provider networks with primary care physicians no more than 60 miles or one hour away, and specialists who are no more than 90 miles or 1.5 hours away.[15] These safeguards related to provider choice are particularly important to rural Americans who more often deal with provider shortages and longer travel times to health care facilities.

In response to concerns about network adequacy, HHS proposed in its 2015 Letter to Insurers that 2015 QHPs increase ECP participation to 30 percent from the 20 percent required in 2014 or, if insurers fall short, they must submit narrative justification that they are adequately meeting the needs of the medically underserved and low-income enrollees.[16] Having a reasonable number of ECPs in plan networks can be especially important for individuals in rural areas, in which ECPs are often a main provider. In rural areas, Rural Health Clinics play an important role in providing access to services and receive special Medicaid and Medicare reimbursement, but are not currently considered ECPs. **The Committee recommends** that the Secretary use the authority in Section 1311(c)(1)(C) of the ACA to include Rural Health Clinics under the definition of Essential Community Providers and ensure that low-income rural consumers are able to seek health coverage from these critical health care providers under their insurance network.

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[12] ACA Section 1311(c)(1)(C).
[13] 78 FR 13405.
[14] McCarty, S. and Farris, M. (August 2013). ACA Implications for State Network Adequacy Standards. State Health Reform Assistance Network: Charting the Road to Coverage. The Robert Wood Johnson Foundation.
[15] Network Adequacy Standards for Qualified Health Plans: Marketed in the Silver State Health Insurance Exchange. (April 2013). Nevada Exchange.
[16] 2015 Letter to Issuers in the Federally Facilitated Marketplaces. (14 March 2014). Centers for Medicare and Medicaid Services. U.S. Department of Health and Human Services.

Table 2: ECP Category	ECP Provider Types
Federally Qualified Health Center (FQHC)	FQHC and FQHC “Look-Alike” Clinics, Outpatient health programs/facilities operated by Indian tribes, tribal organizations, programs operated by Urban Indian Organizations
Ryan White Providers	Ryan White HIV/AIDS Providers
Family Planning Provider	Title X Family Planning Clinics and Title X “Look-Alike” Family Planning Clinics
Indian Health Providers	Indian Health Service facilities, Indian tribes, Tribal and Urban Indian Organization Providers
Hospitals	Disproportionate Share Hospital (DSH) and DSH-eligible Hospitals, Children’s Hospitals, Rural Referral Centers, Sole Community Hospitals, Free-standing Cancer Centers, Critical Access Hospitals
Other ECP Providers	STD Clinics, TB Clinics, Hemophilia Treatment Centers, Black Lung Clinics, and other entities that serve predominantly low-income, medically underserved individuals.

Analyzing the Marketplace – Data Collection and Rural/Urban Comparisons

As the Committee looks toward the 2015 enrollment period, using data to inform Marketplace progress will be critical to ACA implementation in rural communities. At the Committee’s site visits to Auburn, Nebraska, and Harlan, Iowa, they heard about rural challenges to outreach efforts and enrollment, including longer travel times and more limited resources for one-on-one consumer assistance. The Committee recommended in its January 2014 brief on outreach, education, and enrollment (OEE), that the Secretary evaluate the impact on rural areas in year one as a baseline to help inform future OEE efforts. To date, the periodic reporting on HIMs enrollment has not included any rural/urban analysis. As HHS continues to evaluate the data from the 2014 enrollment period, **the Committee recommends** that the Secretary evaluate all Marketplace data—including premium pricing, enrollment, and network adequacy—by rurality.

Using information that includes a rural versus urban comparison could be instrumental in formulating future ACA policies appropriate for rural populations. The Committee understands that HHS intends to use information gathered from the network adequacy review process to inform its future rulemaking on time and distance or other standards for QHP networks. There is some concern that insurers may choose not to cover certain portions of a rating area based on higher costs. It will also be important to pay attention to how insurers are constructing their service areas within the HHS-approved rating areas to allow equal opportunity for rural consumers.

Connecting Outreach and Enrollment to Premium Pricing and Rural Coverage

Examining the enrollment numbers by a rural/urban comparison could also provide some indication of plan affordability in rural areas. The Committee believes that continuing to enroll the rural uninsured will reduce rural providers’ amount of uncompensated care.

Ensuring that individuals are able to obtain continual coverage and are able to access the health services they need will also benefit overall outcomes of population health. Take, for example, the coverage for federally recognized tribal populations under the Marketplace. For the first time, Native Americans will

be able to receive continuous health insurance coverage. The Committee hopes that promotion of this opportunity to the tribal population will increase during the upcoming enrollment because most of this population does not realize that they finally have freedom of choice and services.

During the Committee's site visit to Harlan, Iowa, a health insurance broker noted that many consumers were more concerned with the premium price than provider network. He shared an experience helping a consumer who wanted to enroll in a plan with a low premium price, but the network's nearest covered provider was over 50 miles away. Enrolling in a plan that has a network of providers within a reasonable distance from a consumer's location is an important consideration to having affordable health coverage. Though rural health experts indicate that it is too early to draw conclusions on network adequacy in rural areas from the 2014 data, the Committee believes that this issue is a critical topic to continue to evaluate as consumers seem to be more interested in cost rather than network locality making them vulnerable to poor health care access.

At the site visits in Auburn, Nebraska, and Harlan, Iowa, the Committee heard that more training and coordination between Navigators, Certified Application Counselors, and other consumer assisters would be a critical tool to leverage more limited OEE resources in rural communities. Community Action Agencies and other rural resources also could then be incorporated further into OEE as they serve many of the rural uninsured. During the discussion, it also became clear that independent insurance agents, who often have existing relationships in small communities, can play an important role working with patients, providers, and consumer assisters to enroll the rural uninsured. The Committee encourages HHS to utilize and engage these independent insurance agents in OEE efforts because of their role as a trusted source of information for rural consumers in making health care decisions.

During panel presentations, the Committee also heard that individuals living in rural areas were purchasing plans with lower premiums that featured high deductibles and co-pays that could ultimately make coverage unaffordable. As more of the rural uninsured enroll in coverage, they may require education on the basics of health insurance. Many of the newly insured may be receiving insurance for the first time and may not know the full range of services they can now receive. Educating patients about the basics of health insurance can also be a way for non-profit hospitals to meet their "Community Benefit" reporting requirement, creating a win-win situation. Consumer assisters and other rural stakeholders will be critical to educating consumers on insurance basics such as deductibles, cost-sharing, and co-pays, as well as helping them make the best decisions for their financial and health needs. For these reasons, the Committee commends HHS for launching its "From Coverage to Care" initiative to help people with new coverage understand their benefits and connect to the services that they need to live a healthy life.

With limited resources and few Navigators in rural areas, successful OEE requires engagement by all key stakeholders in small communities, including health providers. The proposed rule "Exchange and Insurance Market Standards for 2015 and Beyond" limited the enrollment efforts of health care providers to cases in which patients requested assistance.[17] The Committee is concerned that such limitation will prevent trusted health care providers from having important conversations with their patients about health coverage. **The Committee recommends** that the Secretary provide hospitals and other health care providers with maximum flexibility to conduct outreach and enrollment without limitations on when they can inform and educate their patients about health coverage opportunities.

[17] 79 FR 15807.

CONCLUSION

The Committee recognizes the potential that the Health Insurance Marketplace offers to increase affordable health coverage options for the rural uninsured. The Committee is concerned, however, that the current regulatory framework may allow for disproportionately higher premium prices and narrower network availability in rural areas compared to urban areas. Examining state decisions on rating area design and continuing to monitor network adequacy, premium pricing based on true cost and premiums, and enrollment success in rural areas could lead to approaches that support affordable and quality coverage options in low density rural populations. The Committee believes that improved cooperation with consumer outreach and education will result in improved enrollment in rural areas. This education can play a role in changing the insurance landscape and reducing the amount of rural providers' uncompensated care and, therefore, lower future premiums. With the initial enrollment period over, the next months are a critical time for HHS to evaluate how to improve the Marketplaces in 2015. The Committee offers these recommendations on ways to improve the Marketplaces for rural Americans in the hopes that they may improve access and quality to affordable health insurance.