National Advisory Committee
On Rural Health and Human Services

Rural Implications of the Affordable Care Act Outreach, Education, and Enrollment
Policy Brief January 2014

Editorial Note: *During its September 2013 meeting in Bozeman, Montana, the National Advisory Committee on Rural Health and Human Services discussed the challenges and opportunities presented by outreach, education, and enrollment in the new Health Insurance Marketplaces for rural and frontier populations. The Committee met with a range of rural health care providers and insurance representatives and also held stakeholder meetings at Community Health Partners, a Community Health Center in Livingston, MT, and Wheatland Memorial Healthcare, a Critical Access Hospital, in Harlowton, MT, to gain perspective from the field. This policy brief continues the Committee's analysis of the Affordable Care Act implementation by providing background on the unique position of the rural uninsured and offering recommendations to the Secretary based on the conclusions of the Committee.*

RECOMMENDATIONS

- *The Committee recommends that the Secretary evaluate the geographic efforts of year one enrollment and use that information to drive subsequent outreach, education, and enrollment efforts (see page 6).*
- *The Committee recommends that the Secretary work with the Internal Revenue Service to finalize the Community Health Needs Assessment Community Benefit reporting rules and promote the use of outreach, education, and enrollment as a way for non-profit hospitals to meet their Community Benefit requirement (see page 8).*
- *The Committee recommends that the Secretary direct the Centers for Medicare and Medicaid Services Advisory Panel on Outreach and Education to consider the unique needs of rural communities in the future (see page 8).*
- *The Committee recommends that the Secretary continue to work with rural human service providers such as Community Action Agencies to engage their client base in outreach, education, and enrollment (see page 9).*

INTRODUCTION

New health insurance options[1] available through the Affordable Care Act (ACA) represent an important opportunity to provide coverage to the 41.3 million[2] uninsured Americans, more than

[1] In this brief, new Affordable Care Act coverage options refer specifically to insurance under Medicaid expansion and the Marketplaces.
[2] This number is the estimate of American citizens or legal residents under the age of 65 (and thus eligible for health insurance on the Marketplace or through Medicaid).

7.8 million of whom live in rural areas.[3,4] The National Advisory Committee on Rural Health and Human Services (the Committee) believes that the U.S. Department of Health and Human Services (HHS) needs to do more to ensure rural Americans are able to take full advantage of the ACA's insurance expansion.

Educating people about the Health Insurance Marketplaces will continue to require substantial coordinated outreach efforts from federal and community stakeholders. The Committee is concerned, however, that there is a tendency to focus outreach efforts on areas with a higher population density where more people can be reached. The Committee's concerns about implementing the Affordable Care Act in rural areas hinges primarily on the need for more information, promotion, and technical assistance to enable these populations to effectively: 1) consider purchasing health insurance in the Marketplace; and 2) select a plan and enroll for coverage either online, with a paper application, by phone, or in person with an assister. The Committee sees the need to increase HHS efforts around outreach, education, and enrollment (OE&E) in rural areas not only for the remainder of this open enrollment period, but in each of the upcoming enrollment periods.

BACKGROUND

1. The Rural Uninsured

Both the need for and potential benefits of the ACA's coverage expansion are particularly notable in rural areas where the population is disproportionately older, chronically ill, lower-income, and uninsured compared to people living in urban areas.[5] Historically, rural residents are not only more likely to be uninsured (18 percent of non-metro residents are uninsured compared to 15 percent metro-residents[6]), but also suffer longer spells of uninsurance. Additionally, as population density and proximity to an urban area decrease, the uninsurance rate increases.[7,8] Alternatively stated, the more highly rural and isolated a person is, the less likely he or she is to be insured. This presents an obstacle for OE&E efforts because more rural non-elderly uninsured individuals are spread over a larger geographic area. The challenge for HHS is to ensure that rural individuals eligible for health insurance and financial assistance are made aware of their options and how to obtain coverage.

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[3] Skopec, L. and Gee, E. Fifty-Six Percent of the Uninsured Could Pay $100 or Less per Month for Coverage in 2014. *ASPE Issue Brief.* U.S. Department of Health and Human Services. 16 September 2013. Retrieved from http://aspe.hhs.gov/health/reports/2013/Uninsured/ib_uninsured.cfm.

[4] The Affordable Care Act – What it Means for Rural America. U.S. Department of Health and Human Services. September 2013. Retrieved from http://www.hhs.gov/healthcare/facts/factsheets/2013/09/rural09202013.html.

[5] Jones C. A., Parker T. S., Ahearn M., Mishra A. K., and Variyam J. N. Health Status and Health Care Access of Farm and Rural Populations. Economic Research Service. U. S. Department of Agriculture. Economic Information Bulletin No. 57. August 2009.

[6] National Advisory Committee Presentation: The Eligible Uninsured in Non-Metropolitan Areas. Office of the Assistant Secretary for Planning and Evaluation. U. S. Department of Health and Human Services. 4 September 2013.

[7] Holmes, M. and Ricketts T. C. 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. 2003.

[8] Lenardson J. D., Ziller E. C., Coburn A. F., and Anderson N. J. Profile of Rural Health Insurance Coverage: A Chartbook. Maine Rural Health Research Center. University of Southern Maine. June 2009.

The current barriers facing rural residents seeking insurance are well-known. At present, people living in rural communities may have more difficulty gaining affordable coverage, because they are farmers, seasonal workers, self-employed, or employed in a business that does not offer health insurance. This lack of employer-provided coverage can leave residents vulnerable to financial instability. On average, rural families pay nearly forty percent of their health care costs out of pocket.[9] Moreover, an estimated one in five farmers has outstanding medical debt.[10] Individuals living in rural areas may also have more limited provider networks to choose from, in part because rural health care providers suffer from more fragile financial margins than their urban counterparts.[11] In this context, the ACA's coverage expansion has the potential to significantly strengthen the health care infrastructure in rural areas for both patients and providers, as long as rural Americans are aware of their new coverage options.

In the current as well as future Marketplace enrollment periods, outreach and education are critical to fully realizing the ACA's benefits and implementation. As a result of state decisions on Marketplace[12] implementation and Medicaid expansion, consumer assistance efforts could be more difficult in particularly rural areas. The Committee is concerned that a significant portion of the rural uninsured may not be reached by the ACA OE&E efforts.

2. State Decisions on Health Insurance Marketplaces

The financial and administrative limitations on OE&E efforts in the 34 states that defaulted to a Federally-Facilitated Marketplace (FFM) or decided to run a State-Partnership Marketplace (SPM) impede OE&E.[13] Under the law, the federal resources available to State-Based Marketplaces[14] (SBM) differ significantly from that of the SPMs and FFMs.[15] Whereas states running a SBM may use establishment grants[16] for funding their own consumer assistance programs, states in which the federal government is running the consumer assistance function of the marketplace cannot use this funding stream.[17] Some reports estimate SBMs having almost four times more consumer assistance funding available to them than in Federally-facilitated

[9] Ziller E.C., Coburn A. F., and Yousefian A. E. Out-of-Pocket Health Spending and the Rural Uninsured. *Health Affairs* Vol . 25, No. 6: 1688-1699. 2006.

[10] 2007 Health Insurance Survey of Farm and Ranch Operators. *The Access Project* Issue Brief No. 1: 1-8. September 2007.

[11] The National Advisory Committee on Rural Health and Human Services. Policy Brief: Implications of Proposed Changes to Rural Hospital Payment Designations. December 2012.

[12] There are three main types of Marketplaces: a State-Based marketplace, in which the state assumes primary responsibility, a Federally-Facilitated Marketplace, operated by the Department of Health and Human Services, or the State-Partnership Marketplace, a hybrid of the two in which states decide how they share responsibility with the federal government.

[13] State Decisions for Creating Health Insurance Marketplaces. The Henry J. Kaiser Foundation. 28 May 2013.

[14] Two states, Utah and New Mexico, are running a State-Based Small Business Health Options Program (SHOP) Marketplace and a Federally-Facilitated Individual Marketplace.

[15] 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).

[16] Establishment grants are awards made by the federal government to ensure states have the necessary resources to build and further develop their marketplace.

[17] Exchange Establishment Cooperative Agreement Funding FAQs. Centers for Medicare and Medicaid Services. 29 June 2012.

states.[18] In total, $3.1 billion in funding has been granted to the 16 SBMs and the District of Columbia for exchange planning and establishment compared to the $340 million in planning and implementation given to FFM and SPM states.[19] The Committee understands that the disparity in available outreach resources is driven by a combination of State decisions on Marketplace administration and statutory limitations on OE&E for the FFMs. Still, the challenge remains as to how best identify alternative resources and strategies to reach rural residents in those states.

HHS is operating the Marketplaces in states that account for two-thirds of the uninsured population.[20] In these states the needs of rural Americans are particularly great. These states are responsible for a greater proportion of the eligible[21] non-metro population than the eligible metropolitan population (nearly 80 percent of the non-metro eligible population versus 60 percent of the eligible non-metro population).[22] Additionally, more than four out of every five uninsured non-metro individuals live in a state that has an FFM or SPM.[23] Overall, HHS is responsible for states that will have fewer dollars per resident to promote consumer assistance on the Marketplace.

3. Federal Funding for Marketplace Consumer Assistance

To begin to address these differences in consumer assistance funding, HHS has made commitments such as the $67 million in Navigator grants awarded to entities working in the 36 states with Federally-Facilitated and State Partnership Marketplaces, in addition to, the $150 million in Health Center Outreach and Enrollment Assistance Awards to health centers across the nation.[24] With respect to rural Americans, HHS has also made $1.3 million in supplemental awards to 52 rural health organizations. These grantees, which focus on increasing access to and coordination of care in rural communities, will undertake additional activities to educate rural residents about coverage options and help them through the enrollment process.[25] Through the U.S. Department of Agriculture (USDA), $1.25 million in funding was also granted to set up a network of Cooperative Extension Service educators in 12 Federally-facilitated states to help the uninsured and underinsured make educated decisions about enrolling in the Marketplace.[26] Furthermore, all Navigators are required to complete training to work effectively with

[18] Helping Hands: A Look at State Consumer Assistance Programs under the Affordable Care Act. The Henry J. Kaiser Family Foundation. September 2013.
[19] Dash, S., Monahan, C., & Lucia, K. Implementing the Affordable Care Act: State Decisions about Health Insurance Exchange Establishment. The Center on Health Insurance Reforms. Georgetown University. April 2013.
[20] Goodell, S. Health Policy Brief: Navigators and Assisters. *Health Affairs.* Note HHS operated Marketplaces refers to Federally-Facilitated and State-Partnership Marketplaces. 31 October 2013.
[21] Eligible refers to individuals eligible for coverage between the ages of 18 and 64.
[22] National Advisory Committee Presentation: The Eligible Uninsured in Non-Metropolitan Areas. Office of the Assistant Secretary for Planning and Evaluation.
[23] *Ibid.*
[24] Navigator Grant Recipients. Centers for Medicare and Medicaid. 18 October 2013; New Resources Available to Help Consumers Navigate the Health Insurance Marketplace. U.S. Department of Health and Human Services. 15 August 2013; Health Centers to Help Uninsured Americans Gain Affordable Health Coverage. U.S. Department of Health and Human Services. 10 July 2013.
[25] Rural Areas Gain Assistance for Enrollment in Health Insurance Marketplaces. U.S. Department of Health and Human Services. 20 September 2013.
[26] *Ibid.*

"vulnerable, rural, and underserved populations".[27] While these efforts to support OE&E work in states in which HHS is fully or partially operating the Marketplace make important strides, they may not be enough to meet the needs of the eligible uninsured population.

4. State Decisions on Medicaid Expansion

The challenges to accessing new health coverage options under the ACA are further complicated by the fact that states in which a FFM is operating have also decided against or have not yet decided on Medicaid expansion. Originally, the ACA established a national minimum Medicaid eligibility of up to 133 percent of the Federal Poverty Line (FPL).[28] Because the law assumed that uninsured individuals up to 133 percent of FPL would be eligible for Medicaid, it prevented U.S. citizens under 100 percent of the FPL from receiving premium tax credits on the Health Insurance Marketplace.[29] However, the 2012 Supreme Court ruling on the ACA made Medicaid expansion optional for states, resulting in a health coverage gap; in the states that have declined Medicaid expansion or have yet to decide to expand, individuals below 100 percent of the FPL will find themselves with few options for affordable coverage.[30] To date, 25 states and the District of Columbia (26 total) are moving forward with Medicaid expansion. 25 states have decided against or have not yet decided to expand Medicaid.[31] For all states, OE&E efforts will play an important role in helping people understand the health insurance plans they could be eligible for.

5. ACA Outreach and Enrollment for Rural America

The Committee recognizes many examples of efforts to educate rural Americans about the new ACA health coverage options, but there is still much to be done. The Committee is concerned that these efforts will not be enough to address and meet the unique needs of the rural uninsured. The Congressional Budget Office estimates that the ACA will reduce the number of people without health insurance by 11 million in 2014 and by 24 million by the end of 2023.[32] It is important to note that these OE&E efforts are ongoing and critical not only in this current period but also for the success of future enrollment windows. Adapting OE&E to reflect the needs of individuals who live in rural communities is critical to the successful ACA implementation in rural America and more generally the success of the rural health care system. This policy brief offers recommendations to address the rural needs for more information and technical assistance to enable the population to 1) make informed decisions about purchasing health insurance and 2) enroll in the Marketplace in the present and coming years.

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[27] Patient Protection and Affordable Care Act; Exchange Functions; Standards for Navigators and Non-Navigator Assistance Personnel. 78 Federal Register 42823. Pp. 42860. 17 July 2013.

[28] The ACA set the Medicaid eligibility at a Modified Adjusted Gross Income (MAGI)-level of 133 percent FPL but with the ACA's additional five percentage point income disregard Medicaid eligibility effectively includes up to 138 percent FPL.

[29] Legally residing non-citizens who recently arrived in the country are eligible for premium tax credits if their income does not exceed 400 percent FPL.

[30] National Federation of Independent Businesses v. Sebelius, 567 U.S. ___ 2012.

[31] Status of State Action on the Medicaid Expansion Decision. The Henry J. Kaiser Family Foundation. 22 November 2013.

[32] Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision. Congressional Budget Office. May 2013.

RECOMMENDATIONS

1. Target Subsequent OE&E Efforts to Build on Rural Lessons Learned and Baseline Data from Initial Enrollment Period

The Committee recognizes that there are ongoing efforts to collect and disseminate successful OE&E methods among consumer assisters and community leaders. The Committee is concerned, however, that outreach efforts may be designed more for areas with high population density, where more people can be reached. As HHS continues its marketing campaigns for the Marketplace and as these campaigns occur in subsequent enrollment periods, the Committee believes that the campaign should have a defined rural component that utilizes best practices for reaching rural communities.

Throughout the Committee meeting, rural stakeholders emphasized the importance of trust and personal relationships in conducting OE&E in rural America. One speaker, who worked on enrolling people from Libby, MT in health insurance after the asbestos contamination from vermiculite mines, emphasized the value in maintaining a physical presence in the community and having one-on-one conversations about health coverage. She found that mass campaigns through direct mail, phone calls, and state-wide media blasts to be ineffective at reaching the target population. The Speaker noted that these campaigns were less successful because individuals wanted to receive information from neighbors and people they trusted and found talking on the phone with a stranger about personal issues such as health coverage disagreeable. Another stakeholder highlighted that these large-scale efforts can also have difficulty reaching mine workers who may not have a permanent mailing address.

After hearing from this speaker and other Montana community leaders with past experience in health coverage enrollment, it became clearer that the OE&E efforts to reach urban residents may not fit the needs of rural areas. Access to broadband Internet in rural areas continues to be a concern, given the emphasis on health insurance enrollment through the web-based Marketplace portals. In 2011, the Department of Commerce reported that only 60 percent of households in rural America used broadband Internet service, compared to 70 percent in urban areas.[33] Additionally, cell phone access, which many now use as a primary communication source, is also not always available on a continuous basis in rural areas. Though there has been an uptick in smartphone users nationwide, there were still only 34 percent rural smartphone users compared to 50 percent urban smartphone users in 2012.[34] For individuals in rural areas that lack Internet access, there will be a greater need to engage other forms of media and in-person OE&E strategies to supplement web-based efforts.

Though the initial open enrollment period on the Marketplace ends on March 31, 2014, OE&E initiatives will be ongoing, with opportunities for improvement in subsequent years. The end of the first enrollment period provides an opportunity to assess current OE&E efforts and their efficacy in reaching rural communities. The Committee **recommends** that the Secretary

[33] Digital Nation: Expanding Internet Usage. U.S. Department of Commerce. February 2011.
[34] Zickuhr, K. and Smith, A. Digital Differences. Pew Research Center. 13 April 2012.

evaluate the geographic efforts of year one enrollment and use that baseline information to drive subsequent OE&E efforts.

To evaluate the progress made in enrolling the uninsured thus far, the Committee believes that it is critical to develop a strong baseline assessment of Marketplace enrollment in the first year and examine enrollment data and analysis by geographic location. This level of analysis will provide the appropriate information to examine how OE&E efforts are reaching rural America during the first year of the Marketplace. Further, tracking specific enrollment details could provide insight into consumer assistance trends and successful OE&E strategies. For instance, evaluating how many consumers enrolled in the Marketplace with the help of an in-person assister or at a Health Center could inform the emphasis of future OE&E activities. Understanding the usage of paper applications compared to online applications might improve targeted consumer assistance. Finally, any differences between FFMs, SPMs, and SBMs could highlight gaps in consumer assistance that need to be addressed.

2. Inform hospitals on the IRS Form 990 Community Benefit

Small rural hospitals tend to be a trusted resource in the community and hub of local health care. These hospitals could be key partners in addressing the concern for rural OE&E if they are made aware of the potential benefits of such efforts. Under section 501(c)(3) of the Internal Revenue Code, hospitals classified as tax-exempt charitable organizations are required to provide and report benefit to the community. The Internal Revenue Service (IRS) notice of proposed rulemaking on the Community Health Needs Assessment[35] for charitable hospitals implies that helping uninsured individuals and their families learn about and enroll in sources of insurance, including insurance plans on the Marketplaces, can be reported under the IRS Form 990 Community Benefit.[36] The proposed Community Health Needs Assessment rule states:

> For example, a hospital facility's Community Health Needs Assessment (CHNA) may identify as significant health needs financial or other barriers to care in the community, such as high rates of financial need or large numbers of uninsured individuals and families. Its implementation strategy could describe a program to decrease the impact of these barriers, such as by expanding its financial assistance program or helping uninsured individuals and families learn about and enroll in sources of insurance such as Medicare, Medicaid, Children's Health Insurance Program (CHIP), and the new Health Insurance Marketplaces (also known as the Exchanges).[37]

It could be easy for hospitals to overlook this opportunity within the regulation, where OE&E efforts are only briefly mentioned as an example of the community benefit requirement. This issue is important for all hospitals but particularly for rural areas. Preliminary analysis of the most recent cost report data from the Center for Medicare and Medicaid Services (CMS) indicates that approximately 87 percent of rural hospitals have non-profit status whereas

[35] The updated CHNA requirements under the ACA can be found at New Requirements for 501(c)(3) Hospitals Under the Affordable Care Act. Internal Revenue Service. 7 November 2013.
[36] 78 FR 20523. Community Health Needs Assessments for Charitable Hospitals.
[37] *Ibid.*

approximately 70 percent of urban hospitals report the same designation.[38] Speaking with rural hospital administrators in Montana, it was clear that they are ready and willing to participate in OE&E efforts, but need assurance that their efforts will be counted under the Community Benefit requirements. Clarifying that OE&E efforts qualify under the Form 990 Community Benefit would be a valuable incentive for hospitals to participate in OE&E efforts. The Committee **recommends** that the Secretary work with the IRS to finalize these rules and promote the use of OE&E as a way for hospitals to meet their Community-Benefit reporting.

3. Leverage existing community infrastructure to reach rural communities

The CMS Advisory Panel on Outreach and Education[39] encourages consumer assistance to meet beneficiaries where they "work, pray, and play".[40] Given the expertise of the CMS Advisory Panel members, the Committee **recommends** that the Secretary direct the panel to also include rural considerations in the future. At present the Committee offers its own strategies for reaching rural America in line with the CMS Advisory Panel's approach:

- Radio
- Local newspaper
- Flyers through bill statements (e.g. cable, electricity bills) and bank deposit slips
- Leveraging family members and respected members of the community
- Town-hall meetings and community dinners
- State fairs
- Community health enrollment fairs
- School-based campaigns
- Working with Chambers of Commerce, Rotary Clubs, and other civic groups
- Training retirees as OE&E volunteers
- Working with USDA Cooperative Extension Service
- Working with the faith based communities

Using multiple channels to reach the rural uninsured ensures numerous access points to enrolling in health coverage. Considering "place-based" outreach is also an important key to successful OE&E activities. For example, libraries, schools, post offices, barbershops, churches, hospitals, clinics, and other frequently visited places could be hubs for educating the rural uninsured about the Marketplaces. In fact, small hospitals and medical providers have an economic incentive to promote enrollment in the Health Insurance Marketplace, because, expanding the population of insured Americans translates to a greater number of covered patients. This economic incentive is particularly true in rural communities where the patient population is disproportionately uninsured and rural hospitals and providers operate on more fragile financial margins than their urban counterparts.[41] The Health Resources and Services Administration has created a provider

[38] CMS Cost Report Analysis: Rural and Urban Hospitals. North Carolina Rural Health Research and Policy Analysis Center. University of North Carolina. Unpublished raw data. 2013.
[39] The CMS Advisory Panel on Outreach and Education advises the Secretary on opportunities to enhance the federal government's effectiveness implementing public insurance programs (e.g. Medicare, Medicaid, and CHIP).
[40] Advisory Panel on Outreach and Education. Centers for Medicare and Medicaid Services. 16 September 2013.
[41] The National Advisory Committee on Rural Health and Human Services. Policy Brief: Implications of Proposed Changes to Rural Hospital Payment Designations.

toolkit with resources and materials for health care administrators and practitioners to learn more about the Marketplace and to share with their communities.[42] The Committee encourages specifically targeting rural medical providers and staff to take part in OE&E and educate their uninsured patients about the new insurance options. Medical professionals rank as the public's most trusted sources of information on the ACA.[43] Rural health care providers should leverage this trust to aid OE&E efforts. In rural communities, disseminating information about affordable health coverage can be most effective when the full range of trusted sources is engaged in sharing information. As such, medical providers in rural America could initiate conversations with patients about whether they have insurance and if the patient is uninsured, offer to refer him or her to a consumer assister to learn more about the enrollment opportunities.

To increase the access points to the Marketplace for rural communities, rural human services agencies and organizations across the country should be fully engaged as another OE&E entrance point in rural areas. The Committee met with several Community Action Agencies (CAAs) representatives in Montana and heard that they are eager to help with OE&E but lack technical assistance on how to participate. These types of rural human services agencies and organizations work with many of the low-income rural populations that will be eligible for the Medicaid expansion and premium tax credits and reduced cost-sharing for health insurance coverage on the Marketplace. The Community Services Block Grant Network, of which the CAAs are part, reported that they served 3.2 million uninsured Americans in 2012 and made health care more accessible to over 593,000 low-income individuals.[44] The Committee **recommends** that the Secretary continue to work with rural human services providers such as Community Action Agencies to engage their client base in OE&E. Integrating these community stakeholders into OE&E is critical piece of meeting the rural uninsured where they are.

Identifying the rural uninsured through other public programs could also expand the entrance points to affordable health coverage for people who may be eligible for public health insurance. The Express Lane Eligibility (ELE) provision gives states the option to streamline enrollment and renewal of children in Medicaid and Children's Health Insurance Program[45] (CHIP) by allowing states to use eligibility data from other public programs[46] to determine eligibility for Medicaid and/or CHIP enrollment and renewal process for low-income children and families.[47] There is considerable overlap between the population served by public health insurance programs and other public need based programs. For example, of the 35 million individuals projected to be enrolled in Supplemental Nutrition Assistance Program (SNAP) in 2014 and

[42] Affordable Care Act and HRSA Programs: Provider Marketplace Toolkit. Health Resources and Services Administration. n.d. Retrieved from http://www.hrsa.gov/affordablecareact/toolkit.html.
[43] Kaiser Health Tracking Poll. The Henry J. Kaiser Family Foundation. August 2013.
[44] Community Service Block Grant Annual Report. National Association for State Community Services Programs. 2013.
[45] CHIP is a state designed program that provides free and low-cost health coverage to U.S. children and eligible immigrants up to the age of 19.There are 38 states with a separate CHIP-funded program.
[46] For an overview of public program descriptions see Table 1: Federal Human Services Programs in the National Advisory Committee on Rural Health and Human Services. Policy Brief: The Intersection of Rural Poverty and Federal Human Services Programs. January 2014.
[47] Section 203. The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (P.L. 111-3).

2015, about 75 to 80 percent of SNAP households may have members eligible for Medicaid.[48] This ELE strategy could also be particularly useful for rural America where the participation rate in SNAP – the percentage of eligibles receiving benefits- was 85.6 percent compared to 72.9 percent in urban areas.[49,50] As of January 1, 2013, nine states offer Express Lane Eligibility (ELE) for Medicaid, six for CHIP, and seven support aligned Medicaid and CHIP.[51,52] Using ELE as a tool to facilitate the enrollment process could increase coverage stability for millions of Americans and reduce administrative backlog.

4. Enhance the ease of use and clarity of the Health Insurance Marketplace Website

The Committee understands that improvements to the Healthcare.gov website are ongoing, but it also recognizes a few key features that could be added to the online portal to particularly benefit rural America. For people living in rural areas where distance can prove an impediment to accessing care, it is especially critical that they have clear information about the hospitals and doctors included in insurance plan networks available on the Marketplace. For people considering purchasing plans, having a provider directory tool that gives geographic and plan-specific information could support more informed consumer decisions on different coverage options. The Committee encourages the Secretary to direct the development of additional website tools to ensure that consumers are not choosing plans that do not offer accessible health care providers based on the location of enrollees for year two of the open-enrollment period.

CONCLUSION

Rural uninsured populations could benefit considerably from the health insurance options available on the Marketplaces. However, the ACA's ability to significantly increase coverage in rural America is dependent upon effective consumer assistance. There is still time left in this initial enrollment period to make improvements and it is anticipated that participation in the Marketplace will only continue to grow in subsequent enrollment periods. It is critical to understand that OE&E work is ongoing and each upcoming enrollment period presents opportunities for further progress and development. At its September meeting, the Committee was concerned that OE&E efforts would not be enough to meet the needs of rural America. The Committee offers these recommendations to enhance the services and projects already initiated for rural ACA coverage expansion and improve the health of the underserved in rural America.

[48] Rosenbaum D., Gonzales S., and Trisi D. A Technical Assistance of SNAP and Medicaid Financial Eligibility Under the Affordable Care Act. Center on Budget and Policy Priorities. 6 June 2013.
[49] 27.1 percent of the rural uninsured participate in SNAP compared to 23.4 percent of the urban uninsured.
[50] Mills, G. Urban-Rural Trends in SNAP Participation. The Urban Institute. 7 January 2013.
[51] Aligned Medicaid and CHIP refers to states that have simplified the application, enrollment, or renewal procedure to better align children's Medicaid and the separate CHIP-funded program.
[52] State Has Express Lane Eligibility for Children in Medicaid and CHIP. The Henry J. Kaiser Family Foundation. January 2013.