National Rural Health Day

*Celebrating the **Power of Rural!***

ACA and You

National Organization of **State Offices of Rural Health**

National Rural Health Day

Celebrating the Power of Rural!

Speaking now:

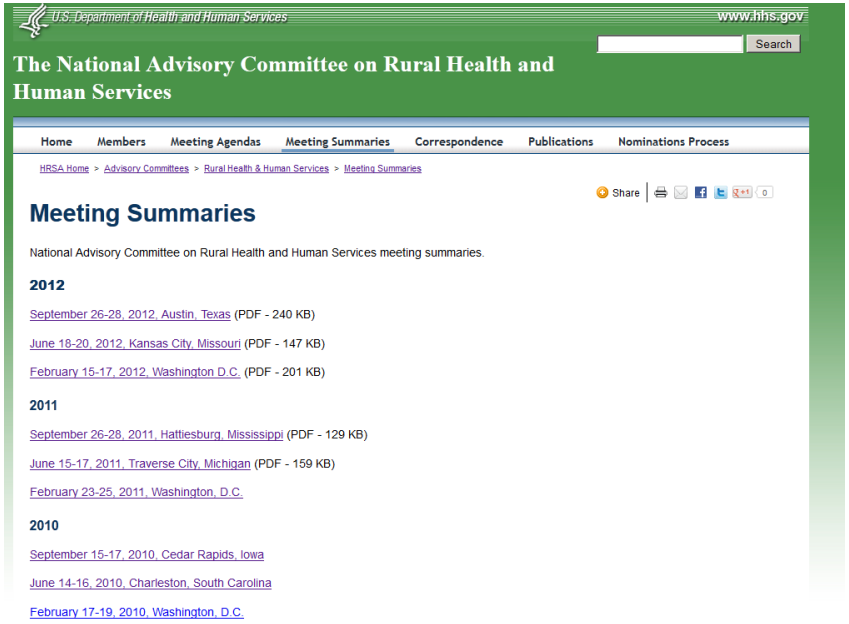
Dr. Mary Wakefield Ph.D. RN, *HRSA Administrator*, HRSA

National Organization of
State Offices of Rural Health

NOSORH

Where to Find More Information

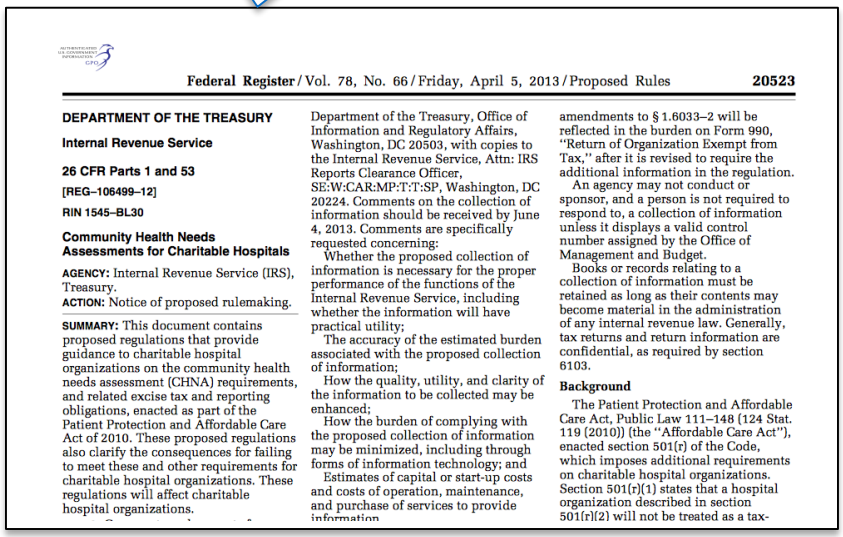
www.hrsa.gov/advisorycommittees/rural



Rural Hospitals: Key Partners

- Not-for-Profit Hospitals can consider doing Outreach and Enrollment to meet their Community Benefit requirements
- Getting patients into coverage can help improve population health
- Also helps improve the hospital's financial viability
- **Collaborative Opportunity?**

" … 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) …"



Federal Register / Vol. 78, No. 66 / Friday, April 5, 2013 / Proposed Rules 20523

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Parts 1 and 53

[REG–106499–12]

RIN 1545–BL30

Community Health Needs Assessments for Charitable Hospitals

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of proposed rulemaking.

SUMMARY: This document contains proposed regulations that provide guidance to charitable hospital organizations on the community health needs assessment (CHNA) requirements, and related excise tax and reporting obligations, enacted as part of the Patient Protection and Affordable Care Act of 2010. These proposed regulations also clarify the consequences for failing to meet these and other requirements for charitable hospital organizations. These regulations will affect charitable hospital organizations.

Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies to the Internal Revenue Service, Attn: IRS Reports Clearance Officer, SE:W:CAR:MP:T:T:SP, Washington, DC 20224. Comments on the collection of information should be received by June 4, 2013. Comments are specifically requested concerning:

Whether the proposed collection of information is necessary for the proper performance of the functions of the Internal Revenue Service, including whether the information will have practical utility;

The accuracy of the estimated burden associated with the proposed collection of information;

How the quality, utility, and clarity of the information to be collected may be enhanced;

How the burden of complying with the proposed collection of information may be minimized, including through forms of information technology; and

Estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information

amendments to § 1.6033–2 will be reflected in the burden on Form 990, "Return of Organization Exempt from Tax," after it is revised to require the additional information in the regulation.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number assigned by the Office of Management and Budget.

Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

Background

The Patient Protection and Affordable Care Act, Public Law 111–148 (124 Stat. 119 (2010)) (the "Affordable Care Act"), enacted section 501(r) of the Code, which imposes additional requirements on charitable hospital organizations. Section 501(r)(1) states that a hospital organization described in section 501(r)(2) will not be treated as a tax-

http://www.gpo.gov/fdsys/pkg/FR-2013-04-05/pdf/2013-07959.pdf

Getting the Word Out: ORHP Contacts (Craig Caplan) ccaplan@hrsa.gov (Helen Newton) hnewton@hrsa.gov

Medicaid and the Federally Facilitated Marketplace: Opportunities and Challenges in Rural America

Mark Holmes and George Pink

National Rural Health Day

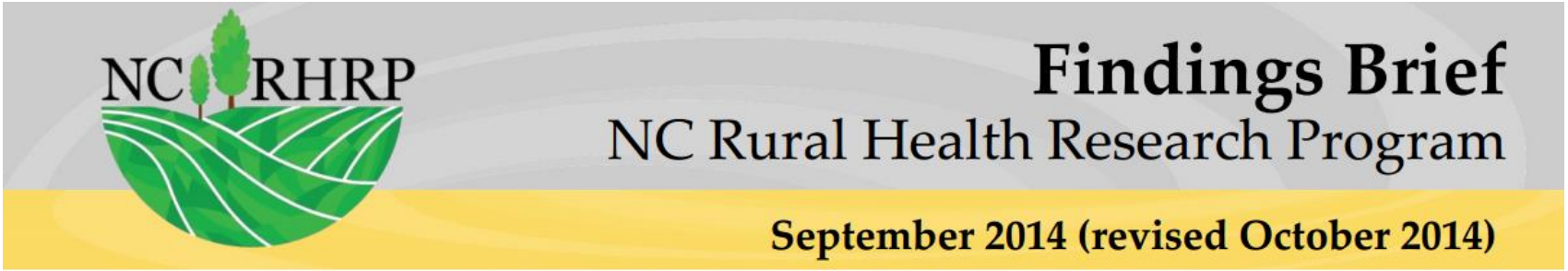
November 20, 2014

This work is partially funded by federal Office of Rural Health Policy, Award #U1GRH07633

Agenda

- Geographic Variation in Plan Uptake in the Federally Facilitated Marketplace
- How does Medicaid Expansion Affect Insurance Coverage of Rural Populations?

Did rural areas have similar enrollment in the "Health Insurance Marketplace" as urban areas?



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NC Rural Health Research Program

Concern about enrollment in the health insurance marketplace

- Rural policymakers, researchers, and advocates were concerned that enrollment in the health insurance marketplace would be lower than in urban areas
  - "Density of eligibles" – finding 100 eligibles more difficult in rural areas than in urban areas?
  - Institutional availability – providers, insurance brokers, community organizers
  - Potential benefit = tighter community ties?
  - E.g. National Advisory Committee, RUPRI
  - Do the data bear this out?

Measuring “uptake”

$$\text{Uptake} = 100 * \frac{\text{Numerator (number choosing a plan)}}{\text{Denominator (number eligible)}}$$

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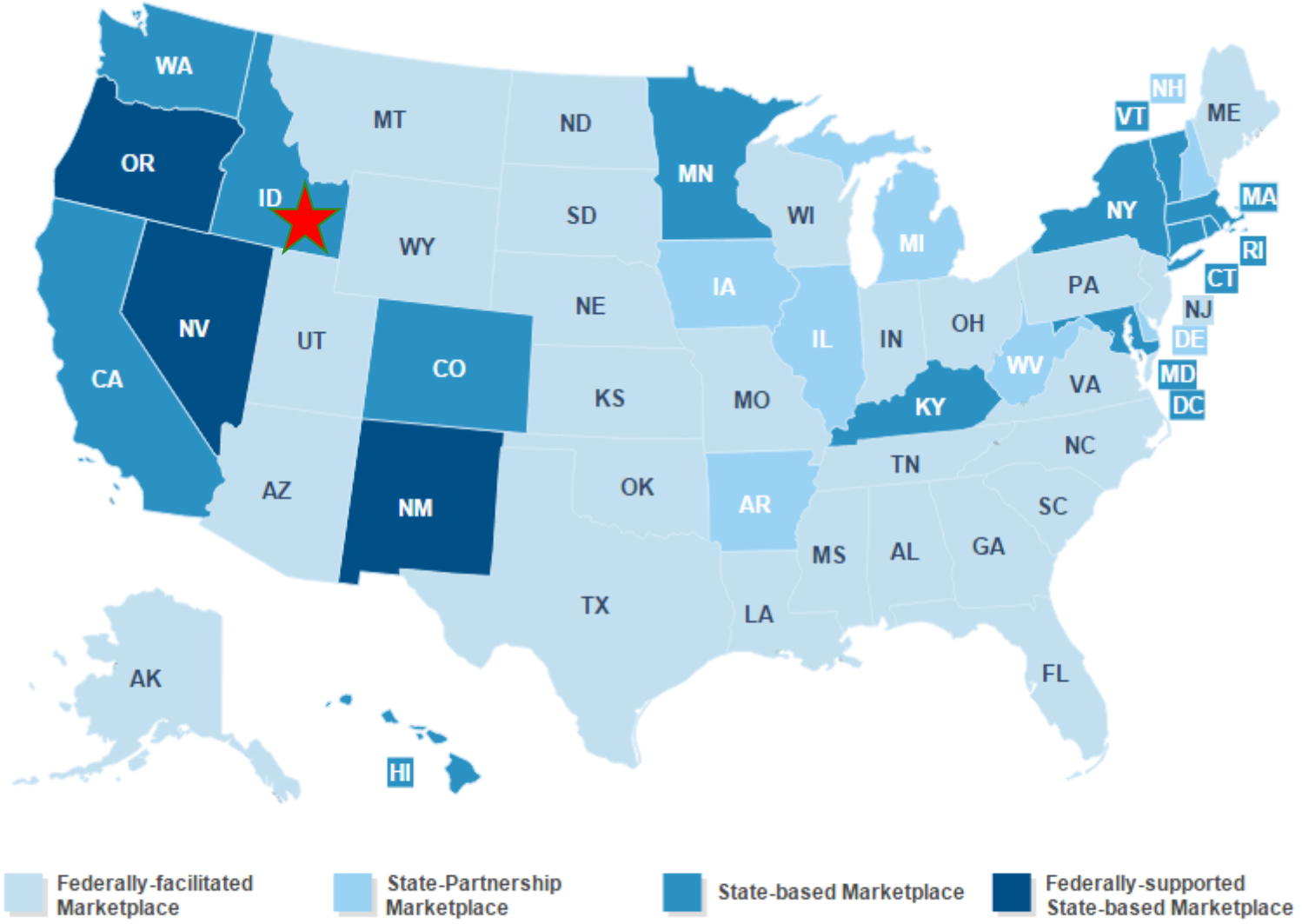
Uptake in the Federally Facilitated Marketplace

- NUMERATOR ("uptake")
  - In September, ASPE released ZIP-level counts of *plan selection* (n.b. not *enrollment*) in the FFM.
  - ASPE does not know who "paid", only who "picked a plan"
  - Suppressed ZIPs with small numbers
- DENOMINATOR ("eligible")
  - No good data
  - Using various data sources, we estimated the number eligible so we could compare the number of "plan selectors" to the number of "eligibles" to see if there was systematic variation

Most states deferred to a federal marketplace



State Health Insurance Marketplace Types, 2015

“Heat Map”

- ZIP-level estimates will be especially “noisy”, so we developed a “heat map” that looks at takeup rates in the “area”
- Hot = high takeup, cool = low takeup
- Next slide

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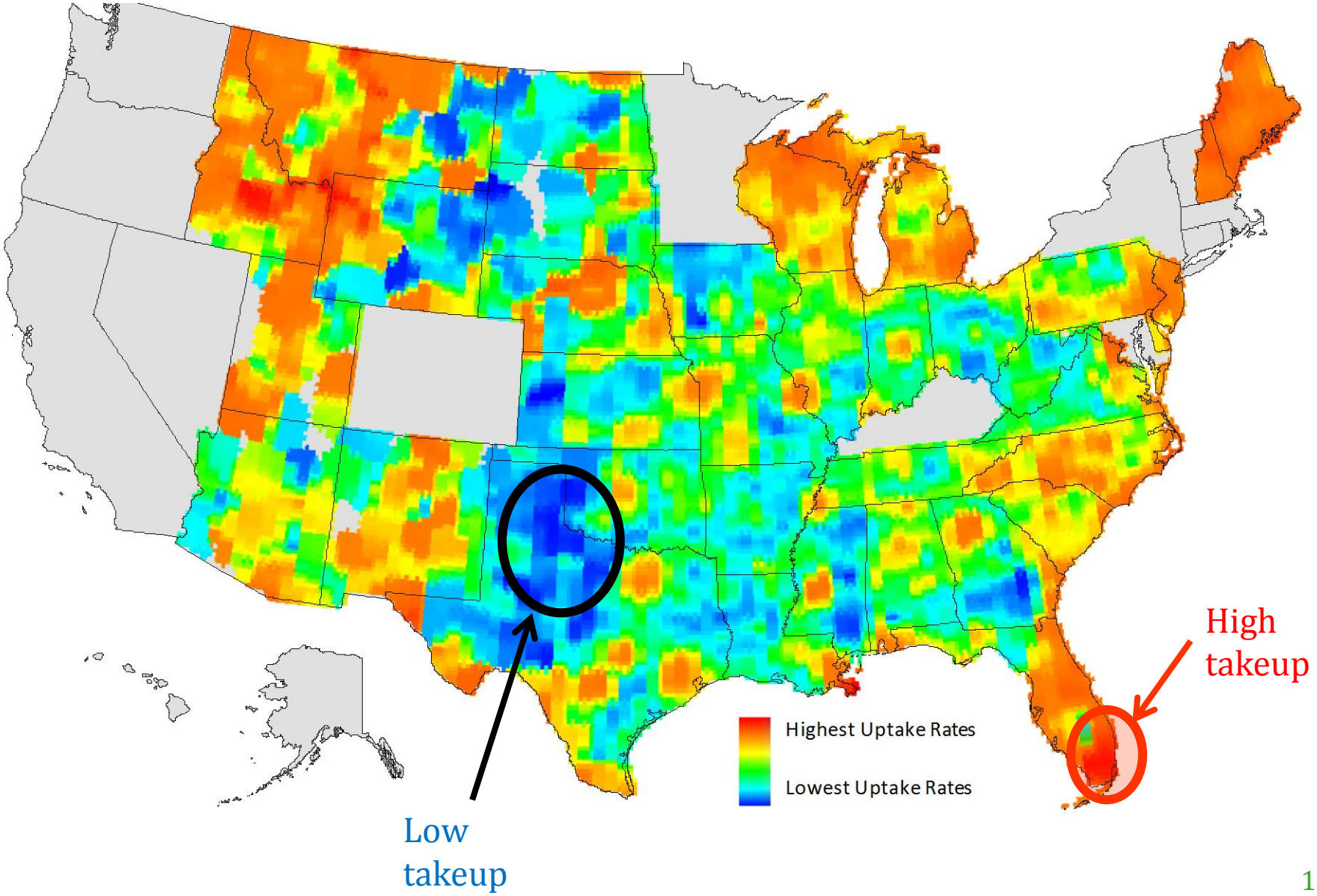
Highest Uptake Rates
Lowest Uptake Rates
High takeup
Low takeup

Aside: RUCAs

- Many ways to measure “rural”
- Here we use ZIP-based Rural-Urban Commuting Areas (RUCAs) (ORHP / ERS / WWAMI: http://depts.washington.edu/uwruca/)
  - Urban
  - Large Rural
  - Small Rural
  - Isolated

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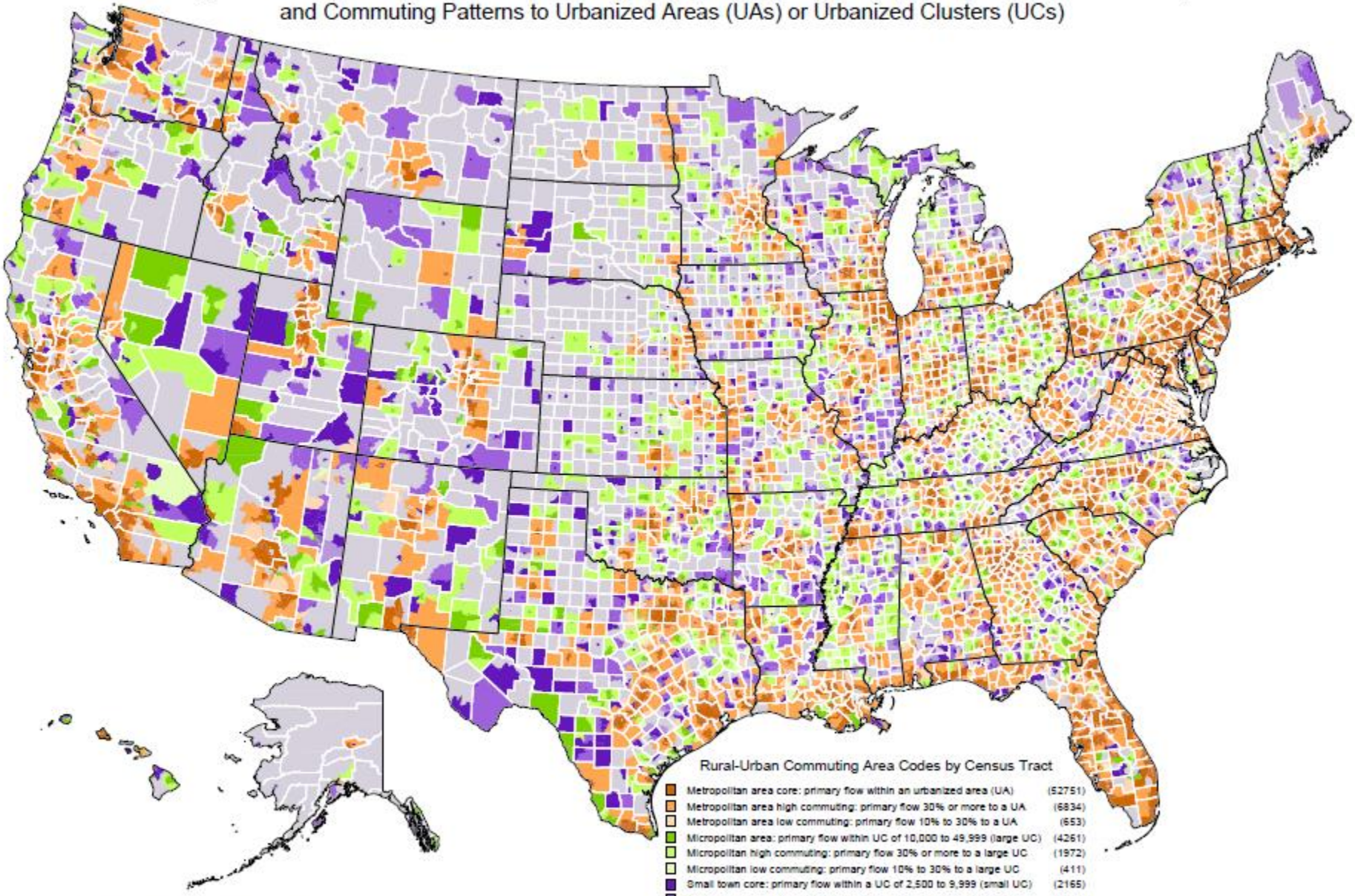
2010 Rural-Urban Commuting Area Codes by Census Tract

Designations using Core Based Statistical Area (CBSA) status (Metropolitan, Micropolitan, or Small Town)
and Commuting Patterns to Urbanized Areas (UAs) or Urbanized Clusters (UCs)



Sources: Census Tract Boundaries - U.S. Census Bureau, 2010.
RUCA Designations - U.S. Department of Agriculture, Economic Research Service, 2013.

Prepared by the North Carolina Rural Health Research and Policy Analysis Center,
Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

How did takeup in rural areas compare?

Table 1: Uptake Rates by Rural Urban Commuting Area

RUCA Type	% eligibles selecting a plan	% total non-elderly population selecting a plan
Urban	23.2%	3.7%
Large Rural	15.3%	2.5%
Small Rural	15.8%	2.8%
Isolated	23.1%	4.0%
Total	**22.4%**	**3.6%**

Comparing *Urban* to *Large Rural* and *Small Rural*, *Urban* had much higher takeup rates. Although *Isolated* rates were similar, there are considerable data limitations among these ZIPs.

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Best practices?

- NCRHRP investigators (led by Pam Silberman) conducted case studies in “high enrollment” rural areas to identify best practices.
- Frantically wrapping these up and hope to disseminate the by end of the month.
- Preliminary findings on next slide; may change in final version as we finalize the analysis
- (Also of interest: UMN’s “Successful Health Insurance Outreach, Education, and Enrollment Strategies for Rural Hospitals” rhrc.umn.edu)

Seven lessons (preliminary)

1. Coalitions at multiple levels key to reaching diverse populations
2. Paid media is great, but don't forget low/no cost (e.g. earned media, brochures)
3. Outreach begins with *in*-reach
4. Involve other community agencies
5. Word of mouth is highly trusted
6. Go to the target population
7. Use brokers

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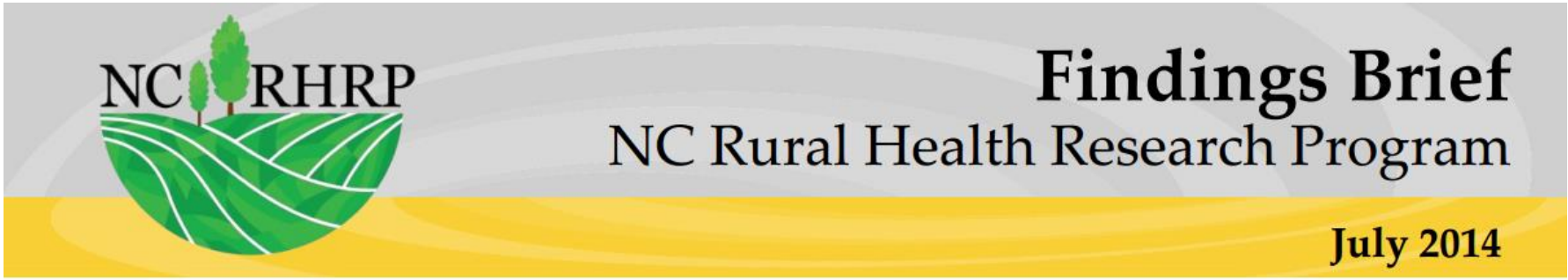
Medicaid


NC RHRP
Findings Brief
NC Rural Health Research Program
July 2014
How Does Medicaid Expansion Affect Insurance Coverage of Rural Populations?
Kristie Thompson, MA; Brystana Kaufman; Mark Holmes, PhD

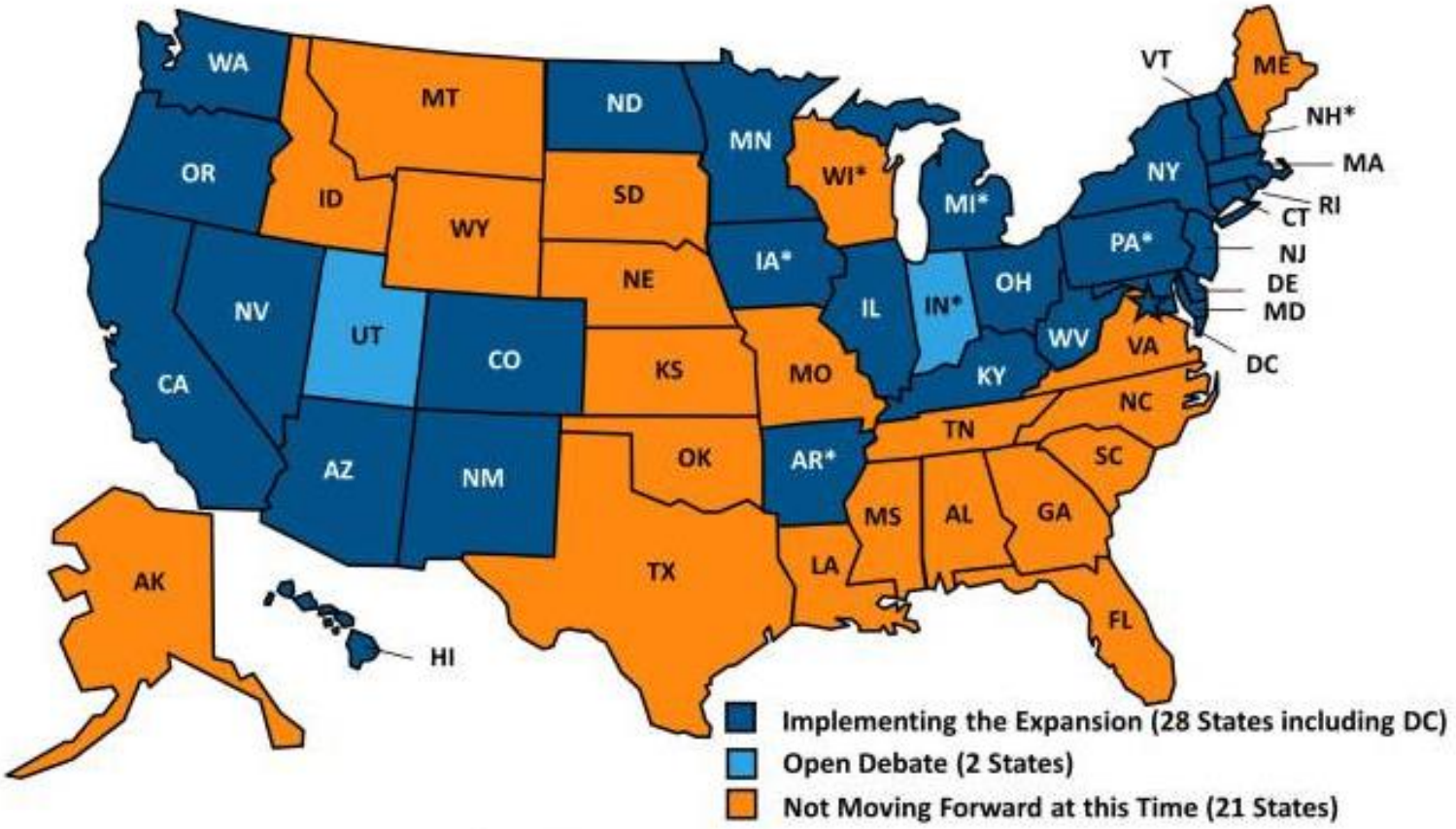
Medicaid

- June 28, 2012 SCOTUS ruled that States had power to decide whether to expand Medicaid
- Largely unanticipated decision that was a major (negative) development for the central design of the Affordable Care Act
- How has this affected rural areas?

Medicaid is more important for rural areas

- Higher proportion of rural (non-elderly) are uninsured
  - E.g. Univ. Southern Maine “Health Insurance Profile Indicates Need to Expand Coverage in Rural Areas”
- Rural populations are generally more likely to be covered by Medicaid than urban populations
  - Lower income
  - Lower rate of employer-based coverage
- Have the state-based decisions led to changes in rural-urban disparities in coverage?
- Method: Use Urban Institute state-level uninsured estimates, interpolate down to county level (Buettgens et al)

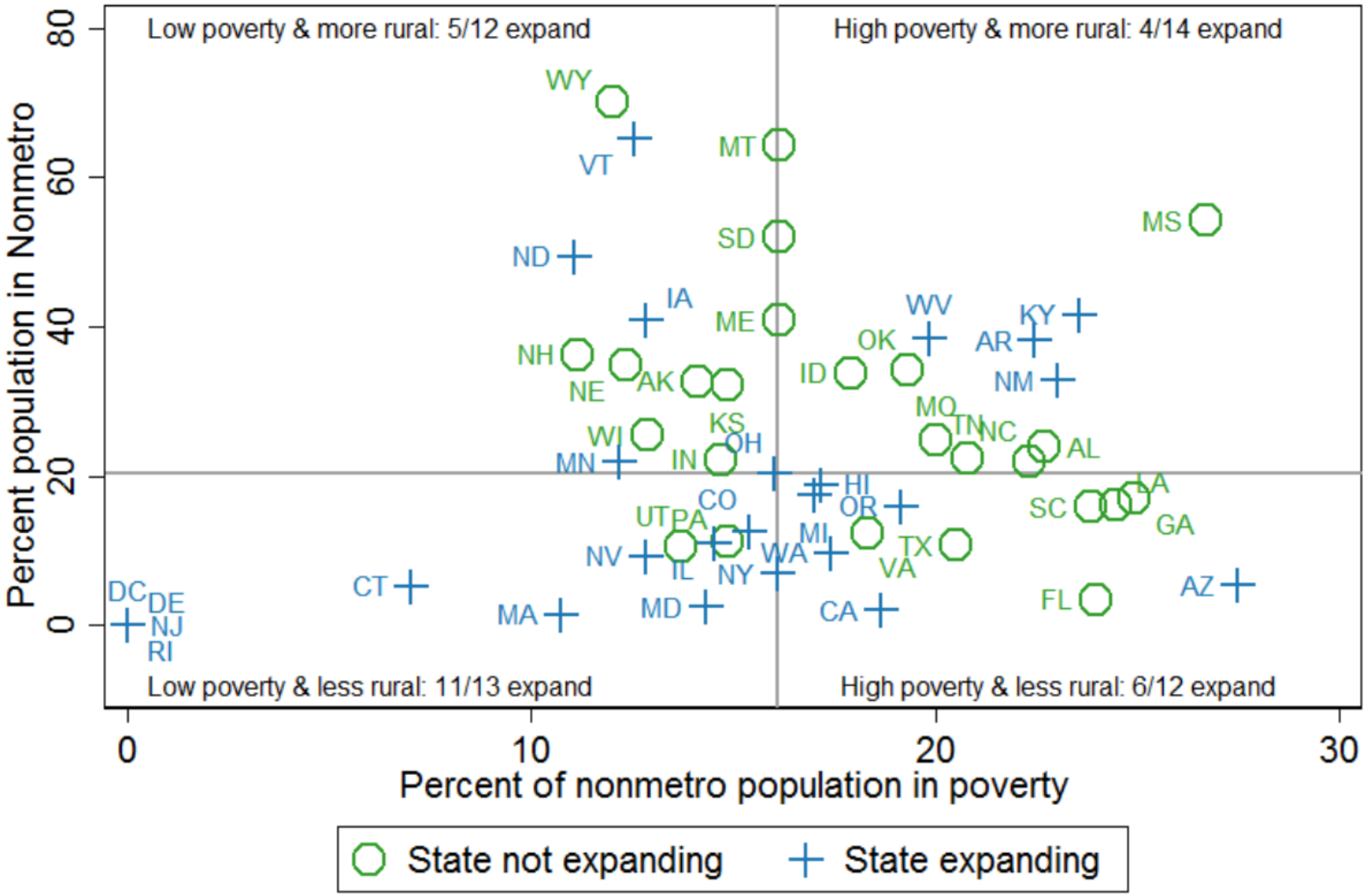
Current Status of State Medicaid Expansion Decisions



NOTES: Data are as of August 28, 2014. *AR, IA, MI, and PA have approved Section 1115 waivers for Medicaid expansion. In PA, coverage will begin in January 2015. NH is implementing the Medicaid expansion, but the state plans to seek a waiver at a later date. IN has a pending waiver to implement the Medicaid expansion. WI amended its Medicaid state plan and existing Section 1115 waiver to cover adults up to 100% FPL in Medicaid, but did not adopt the expansion.

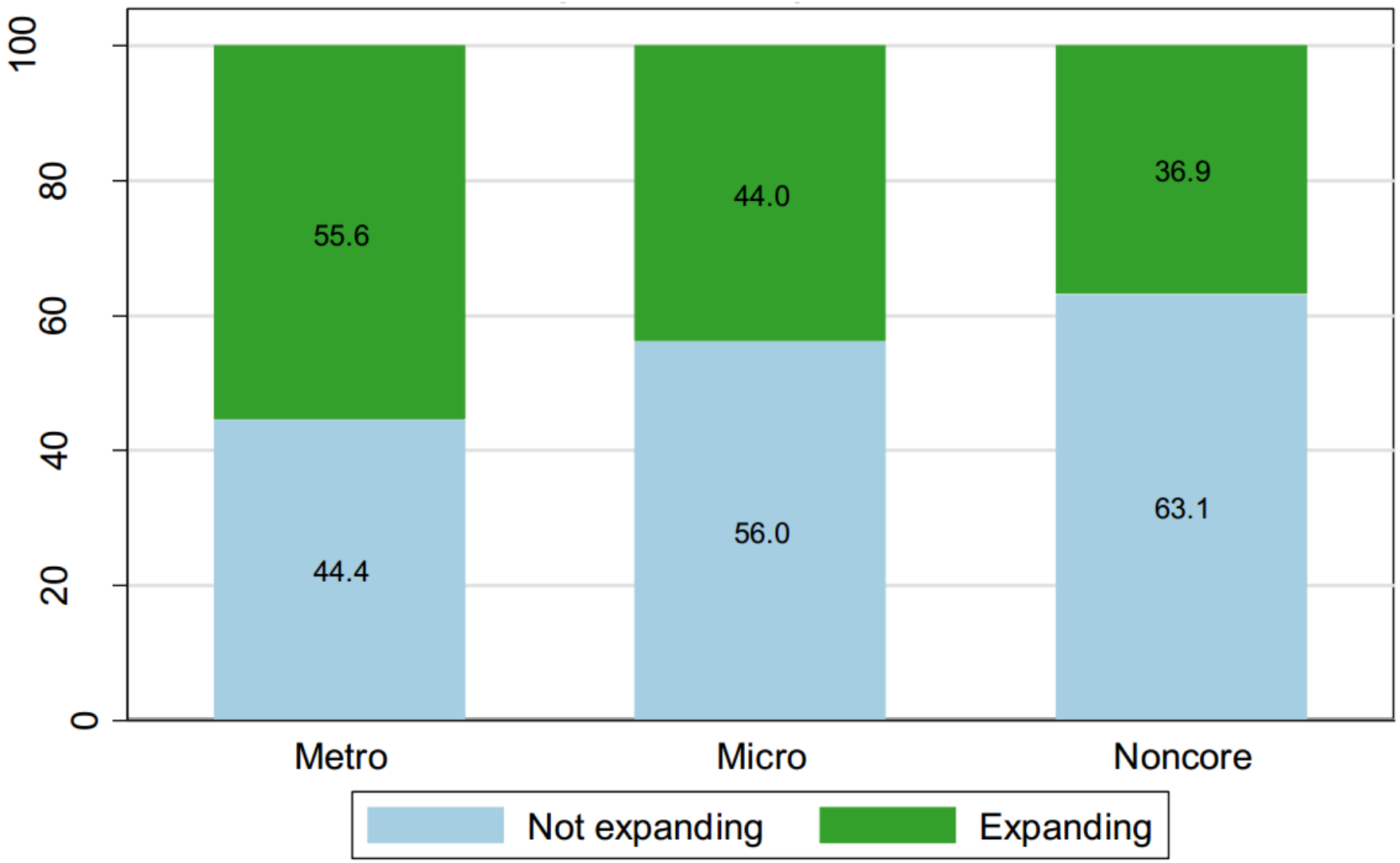
SOURCES: Current status for each state is based on data from the Centers for Medicare and Medicaid Services, available here, and KCMU analysis of current state activity on Medicaid expansion.

Figure 1: Rural, Poor States Are the Least Likely to Expand Medicaid



Note: DE, DC, NJ, and RI have no nonmetro population; poverty rate displayed as 0.
Grey lines denote medians.

Figure 2: Medicaid Expansion and Percent of Population in Rural Areas



A majority of residents of metropolitan counties live in a state expanding Medicaid; but only a minority of rural residents live in an expanding state.

Let's compare rural-urban uninsured rates under 4 scenarios

1. Percent of non-elderly who are uninsured if ACA were not implemented
2. Percent of non-elderly who are uninsured with ACA implemented, but without Medicaid expansion in any state
3. Percent of the non-elderly who are uninsured with our current situation [ACA and partial Medicaid expansion (25 states plus DC expand)]
4. Percent of the non-elderly who are uninsured with ACA and complete Medicaid expansion

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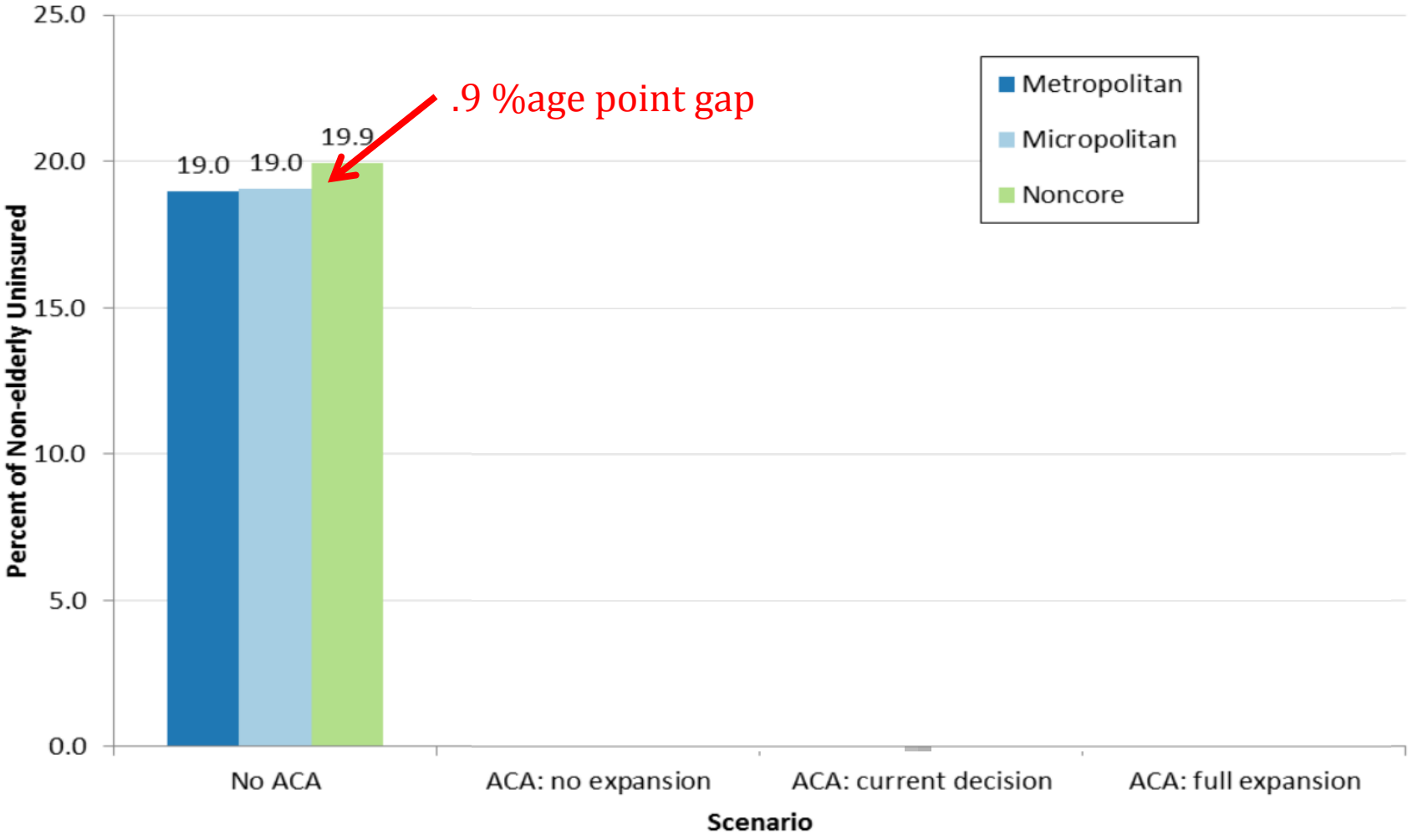
Figure 3: Estimated Percent of Non-elderly Uninsured by Rurality and Medicaid Expansion Status by Scenario



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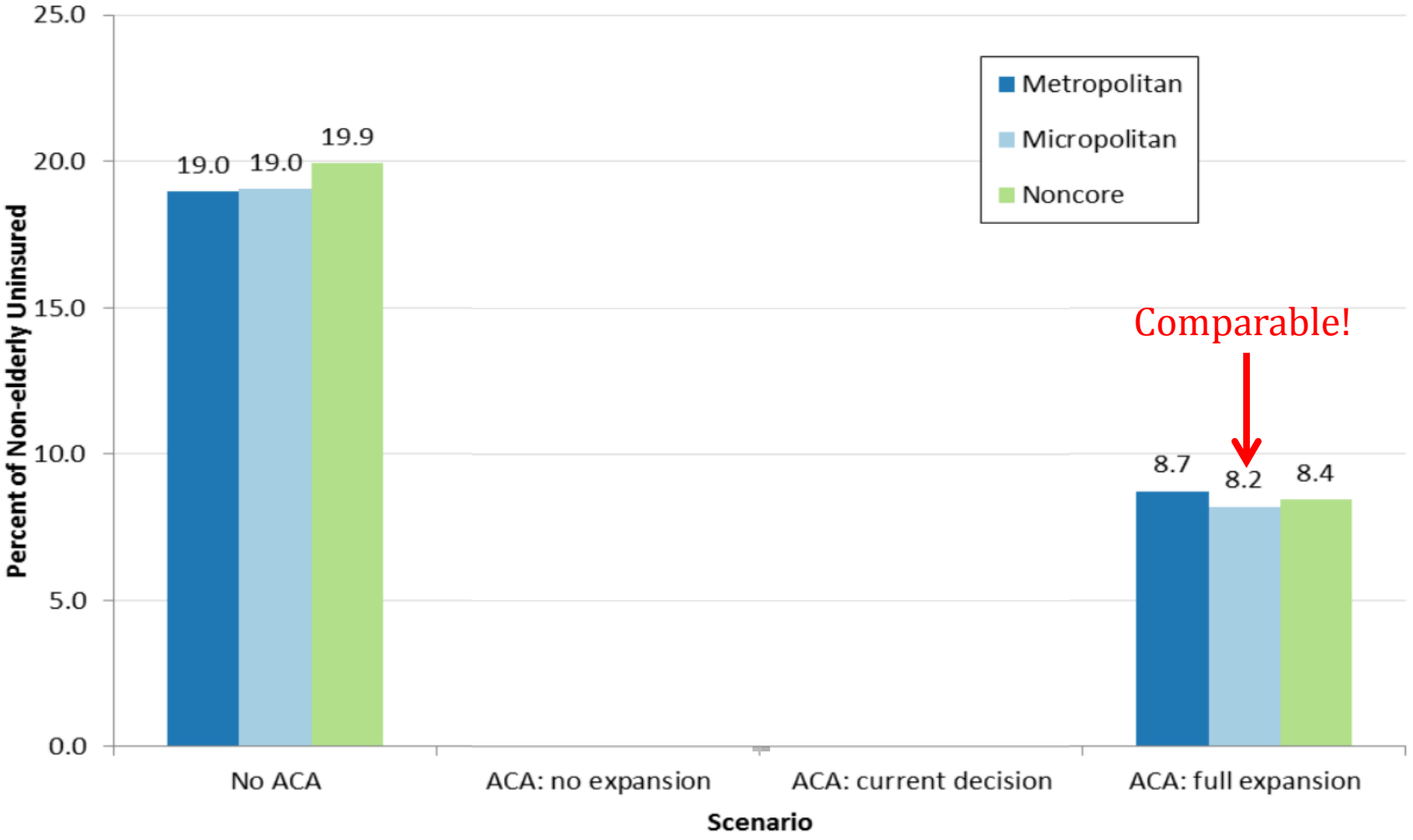

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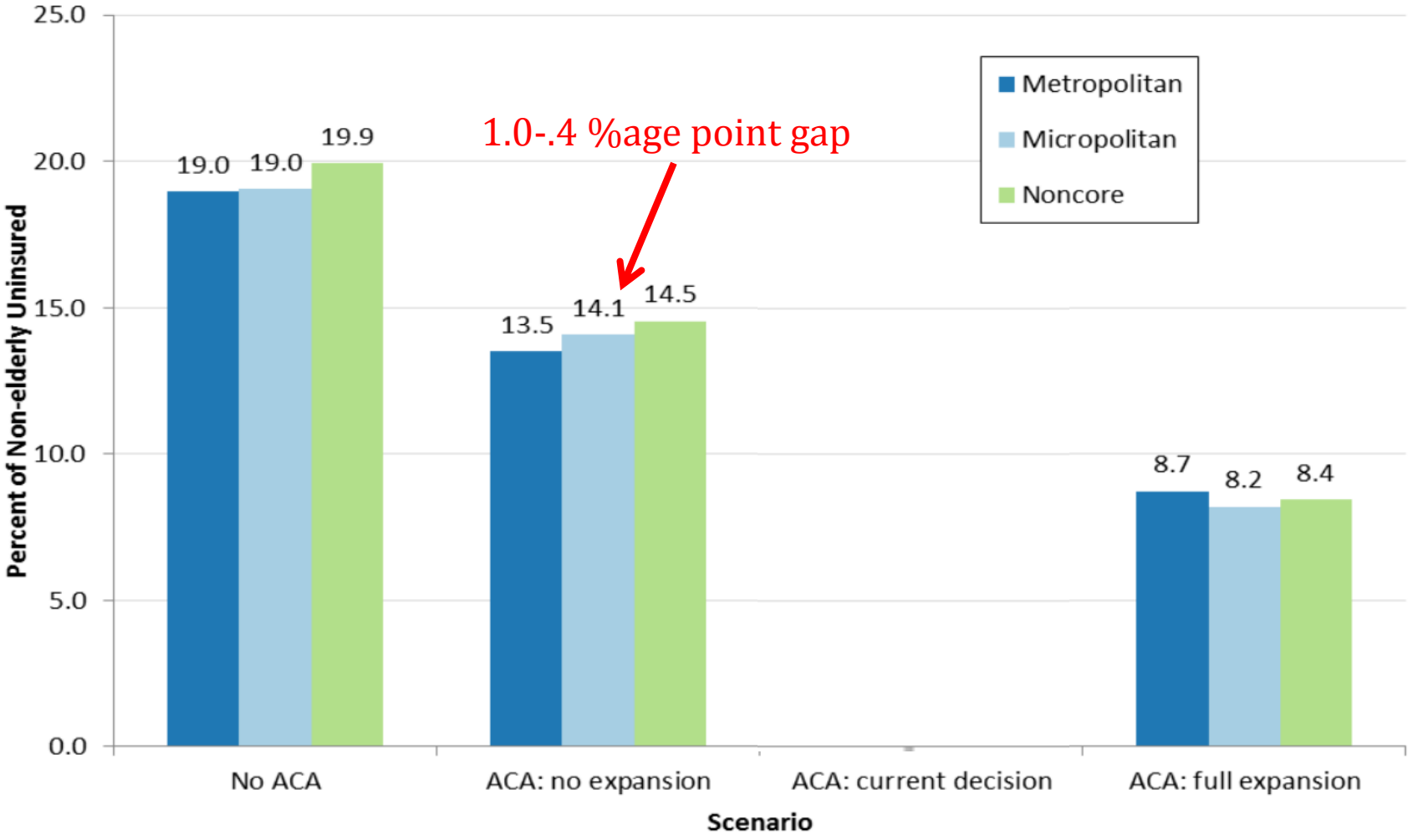

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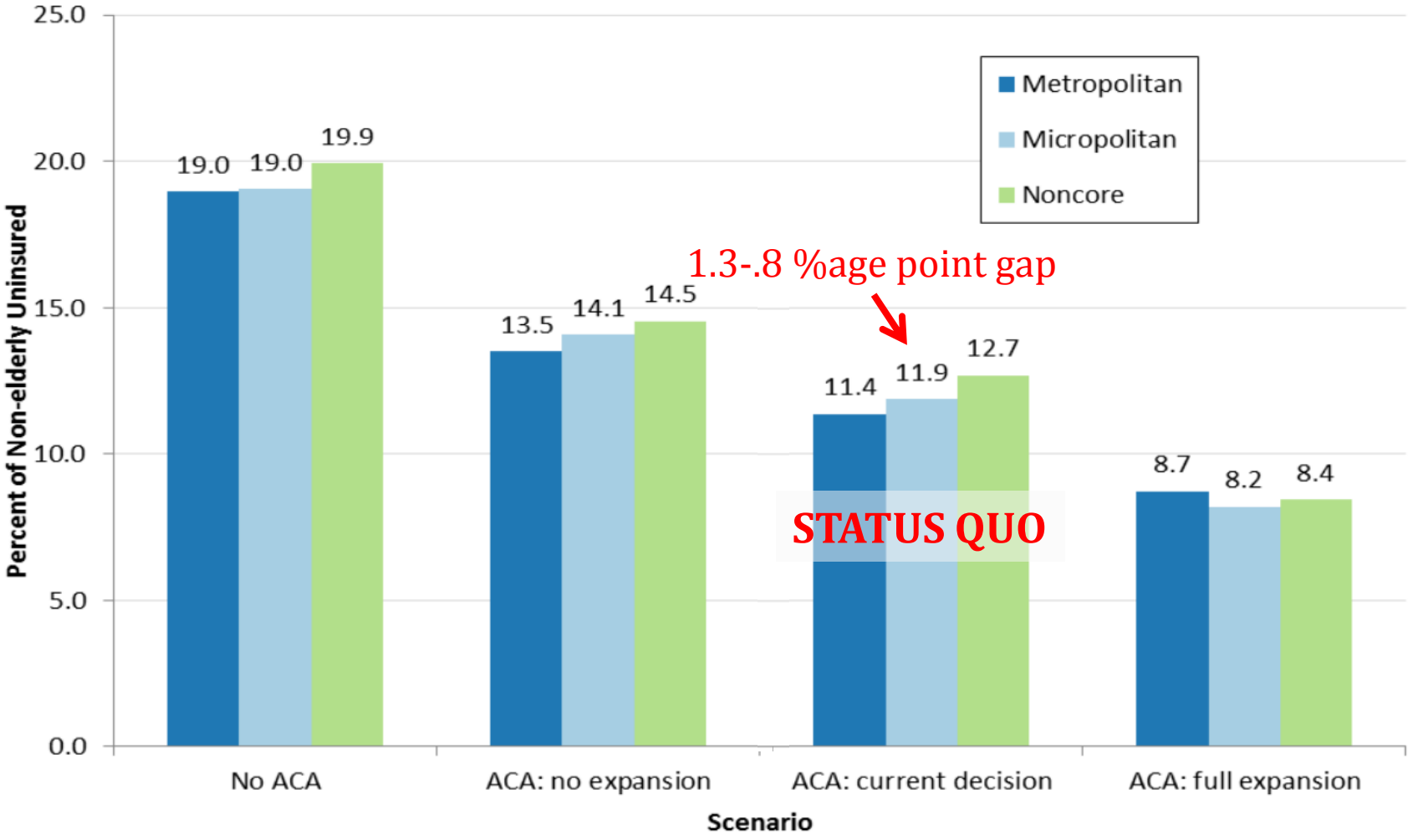
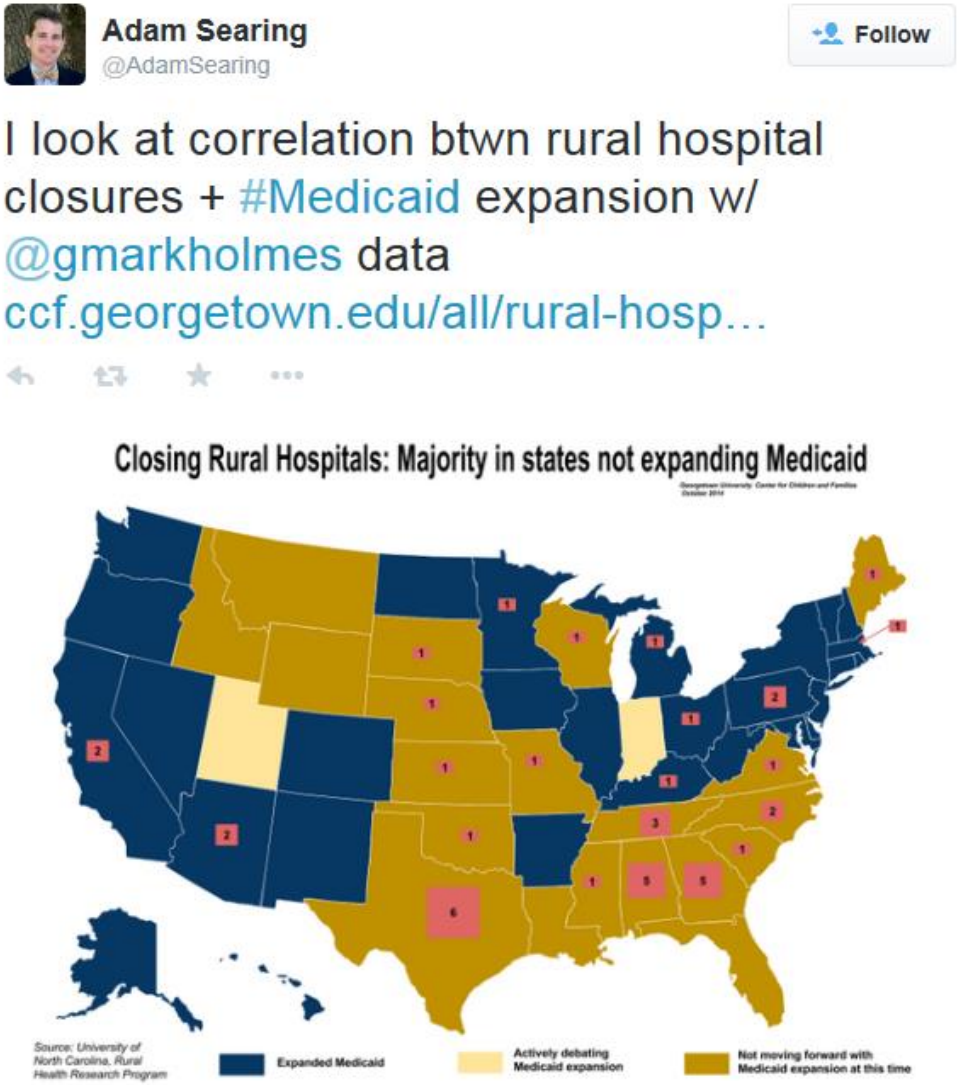


The "health insurance marketplace" appears to benefit the metro/micro areas more than rural; **the incomplete expansion of Medicaid has exacerbated existing rural-urban gaps in insurance coverage**.

Other effects for Medicaid expansion decisions?



Conclusion

- ACA, with a fully expanded Medicaid, would eliminate rural-urban disparities in insurance coverage
- The state-based decisions have tended to *exacerbate* the gap

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North Carolina Rural Health Research Program

Location:

Cecil G. Sheps Center for Health Services Research
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Variation in Premiums for Private Plans in Health Insurance Marketplaces under the Affordable Care Act

November 2014

rupri

Timothy D. McBride, Abigail Barker, Leah Kemper, Keith Mueller
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Outline

- Background:
  - Affordable Care Act (ACA) and "Marketplaces"
  - What is the issue? Why is variation important?
  - How do we think through this?
- Findings
  - 2014 and early, preliminary 2015 findings
- Implications

Work funded by grant provided by U.S. Department of Health and Human Services, Health Resources and Services Administration, Federal Office of Rural Health Policy (ORHP)

Marketplaces: Key Questions

- Is there variation in premiums, premiums systematically higher in rural areas?
- If there is variation, what explains it?
- Changes from 2014 to 2015?

Marketplaces and Variation

- Marketplace "Variation": What is the Issue and Why Important?
  - Prior to passage of ACA, a great deal of variation in premiums
    - Across individuals and families
      - Why? Main reason: insured more likely to be sick? Small risk pools?
      - Implication for some: insurance not affordable
    - Across geographic regions (states, substates, groups, employers)
      - Why? Variation in costs, adverse selection, risk pool size, regulations
      - Implication again: in some places insurance not affordable
  - Question: has ACA fixed/removed this variation in premiums, especially in rural areas?
    - Explicit goal of ACA to eliminate variation due to adverse selection based on health
    - Was other variation removed?

Comparing Apples to Oranges

- Early anecdotal reports: Open enrollment period 2014
  - *"Evidence is emerging that one of the program's loftiest goals — to encourage competition among insurers in an effort to keep costs low — is falling short for many rural Americans…. While competition is intense in many populous regions, rural areas and small towns have far fewer carriers …of the roughly 2,500 counties served by the federal exchanges, more than half, or 58 percent, have plans offered by just one or two insurance carriers…two might not be enough to create competition that would help lower prices."* [New York Times, 10/24/13]

  - *"'The way the pricing came in under the Affordable Care Act … was anything but affordable in Summit and Eagle counties," Rep. Jared Polis says. 'Upwards of $500 to $600 a month, minimum. Whereas in other parts of my district — like Fort Collins and the Boulder area — the pricing is really good. You [can] get a very strong, good insurance program for $300 to $350 a month.' People in the mountain communities are upset because insurance rates across the county line are dramatically lower. They want to be added into a so-called rating area with the regions paying lower rates." [National Public Radio, 12/12/13]*

- The problem here: comparing apples to oranges?

Proper methods: Compare Apples to Apples

- So how do we compare apples to apples?
  - Need to recognize that plans vary:
    - "Metal level" of plan
    - "Actuarial value" of premiums and other costs of plans
    - Rating area plan is offered in (n=501 rating areas across U.S.)
    - Cost of living by rating area to control for price differences
  - After adjusting for all this, does premium variation disappear? Or:
    - Differences remain across plan organizations
      - (especially because of plan design?)
    - Reflect uncontrolled for geographic variation?
      - (perhaps reflecting role of geography, rurality, sociodemographics, economics), or
    - Random noise?
  - Also: what does 2015 look like, compared to 2014?

More on Adjustment Factors

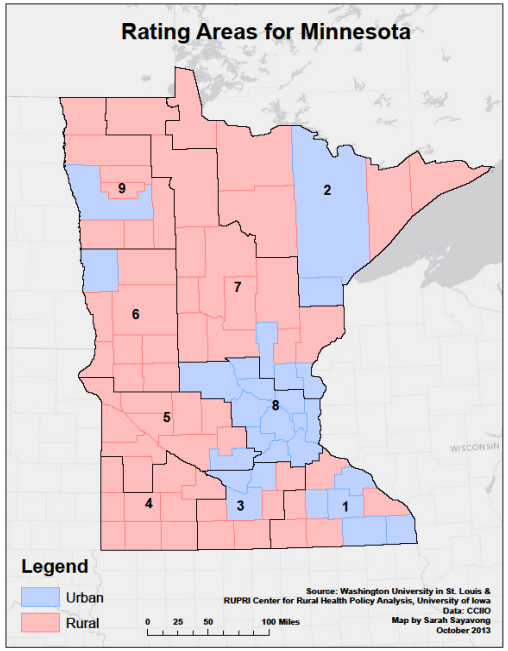
- Rating Areas (RAs) are the relevant geography for comparing premiums
  - LAW requires state: number of rating areas NOT TO EXCEED the number of MSAs in the state plus one
    - Seven states chose default option
    - Important points:
      - Rating Areas are determined at state level, subject to states' motivations
      - Does setting of these choices affect premiums, competition, choice?

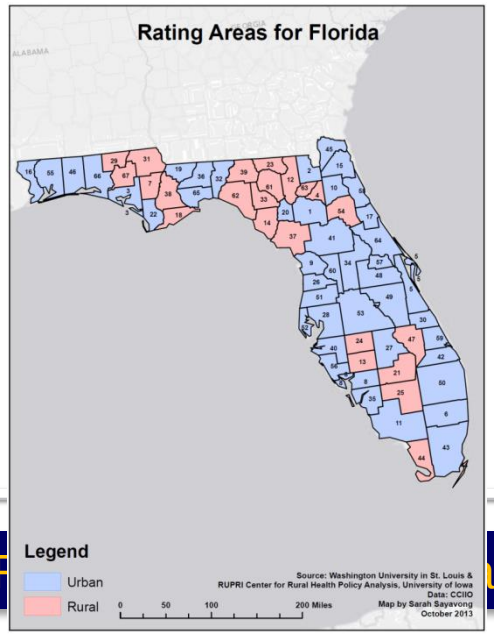
- Metal Levels and Actuarial Value (AV): the expected percentage of costs that will be covered by the plan for the *average* consumer
  - **Bronze** (60% AV); **Silver** (70% AV); **Gold** (80% AV); **Platinum** (90% AV)
  - Firms submit bids with costs that vary around these levels by 4 percentage points (+/- 2%)
    - Source: www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/av-calculator-final.xlsm
  - Comparable,underlying "sample" population used regardless of location
    - 2010 claims data provide utilization and cost estimates based upon the parameters of the plan.
  - Key point: if we know metal level, and we know premium, we roughly know expected AV and expected OOP costs and Loss Ratio

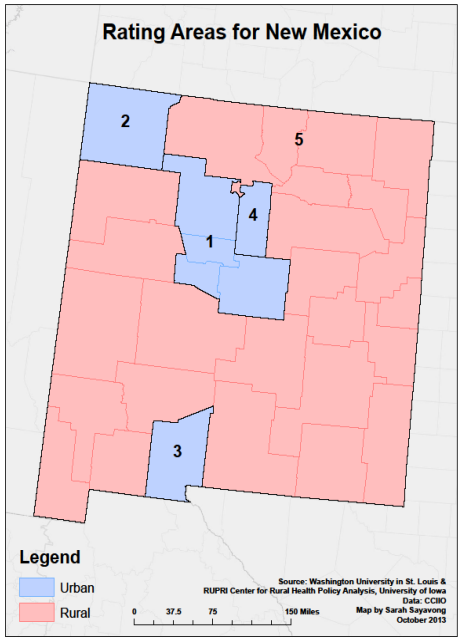
Rating Area Decisions

State Rating Area Decisions

Actively Established at the State Level				ACA Default
One Statewide Rating Area	Regions within State: Groups of Counties	Regions within State: Groups of 3-Digit ZIP Codes	Each County Its Own Rating Area	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







More on Adjustment Factors

- Cost of living across rating areas
  - Premiums may simply reflect overall price differences
    - For example: $200/mo. premium in Waterloo, IA is more expensive than $200/month in Newark, NJ, after adjusting for cost of living
      - Why? $200 could buy more other goods in Waterloo than in Newark.
  - How do we adjust for cost of living?
    - Purchased county-level COLA index
    - Models prices based on various factors and can successfully predict 78% of geographic variation. We adjust premiums with this index.

Other Geographic Effects?

- Even after controlling for all these other factors, what about:
  - Plans setting "Narrow Networks"
    - Evidence there are "narrow" networks in plans offered in the Marketplaces
    - From anecdotal and other evidence that plan organizations have adjusted or varied the "networks" of their plans
    - An effort to control costs?
      - Example: In St. Louis, two plan organizations and one offers the BJC network (Coventry), and the other does not (Anthem)
    - Is there a rural/urban differential here? Unclear
  - Other characteristics of rating area/region
    - For example, health status, economic factors
    - This should not be a factor given how AV was computed.

Findings

rupri

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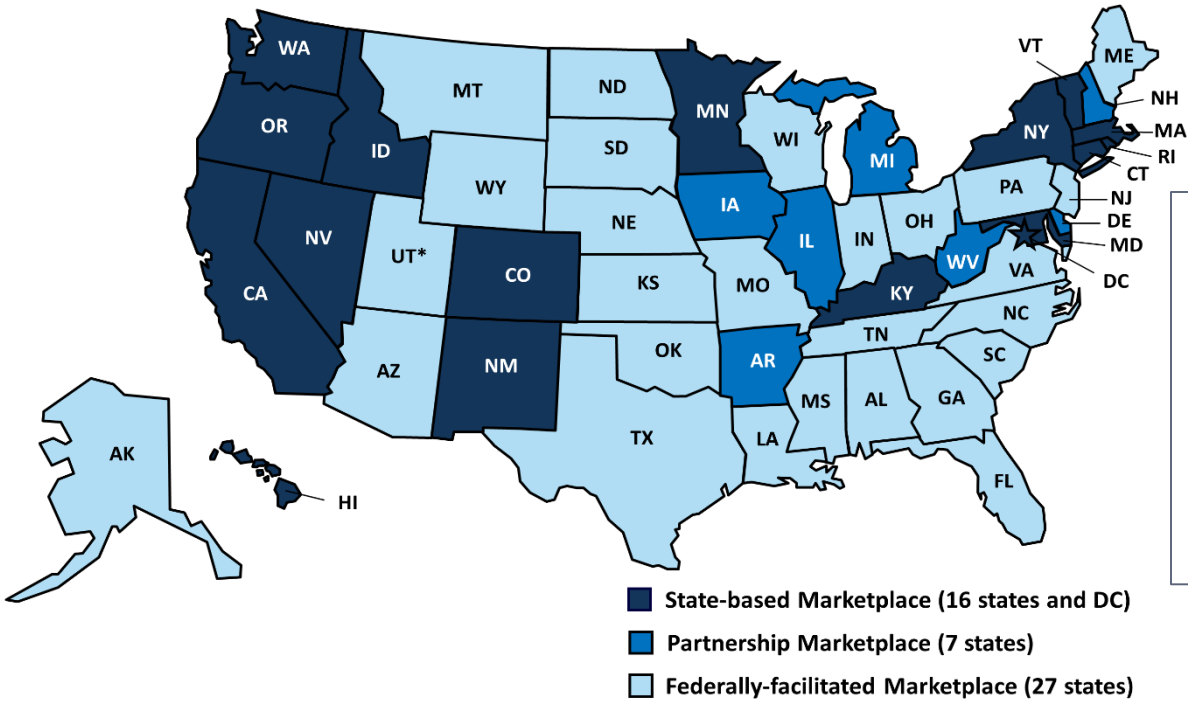
Establishment of State Health Exchanges, 2014

State Health Insurance Marketplace Decisions, 2014



* In Utah, the federal government will run the marketplace for individuals while the state will run the small business, or SHOP, marketplace.
SOURCE: State Decisions For Creating Health Insurance Marketplaces, 2014, KFF State Health Facts: http://kff.org/health-reform/state-indicator/health-insurance-exchanges/.

State activity on Health Insurance Exchanges:

17 State-Based Exchange

7 Partnership Exchange

27 Federal Exchange

SOURCE: Kaiser Family Foundation, http://www.statehealthfacts.org/comparetable.jsp?ind=962&cat=17&sub=205&yr=1&typ=5

Enrollment in Affordable Care Act Marketplaces and Medicaid

(Marketplaces: October 2013-end of April 2014
Medicaid: September 2013 to September 2014)

By Type of Marketplace (Federal or State) And Medicaid decision

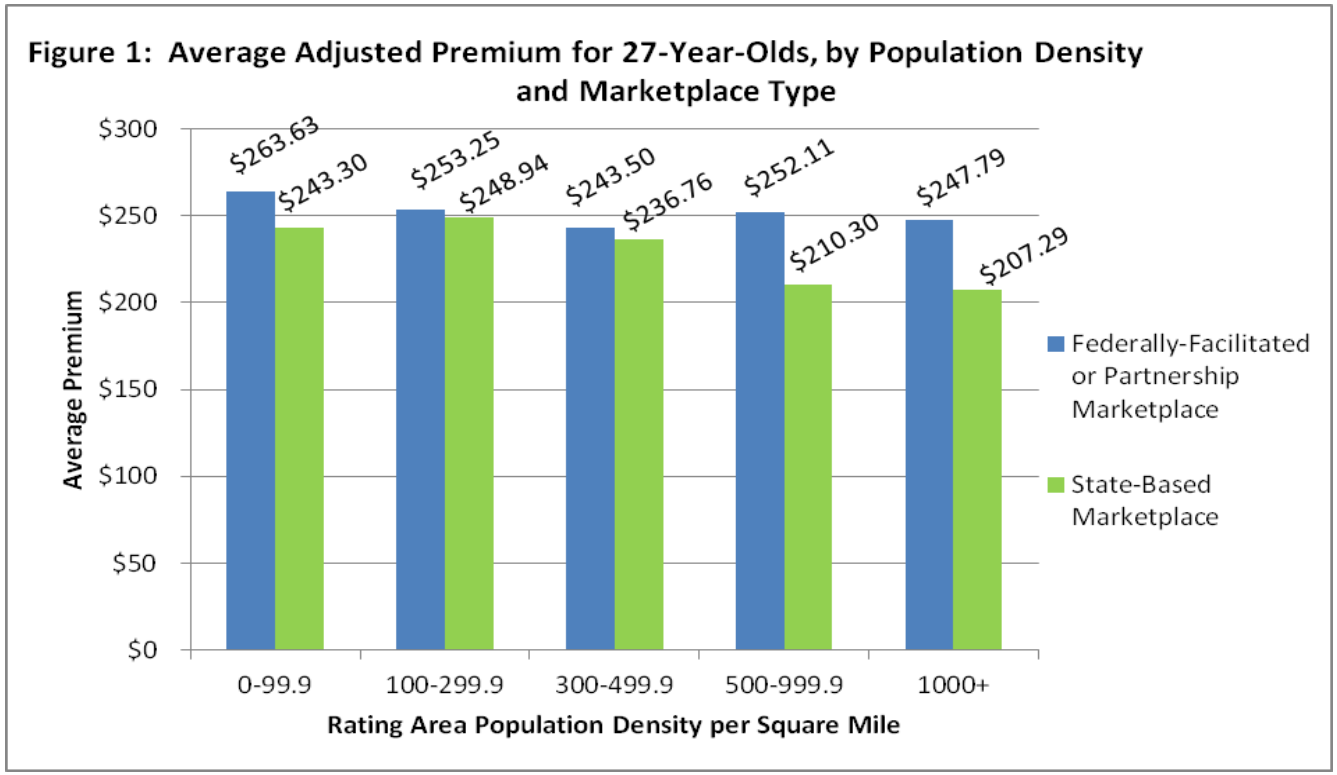
Type of Marketplace	TOTAL	Marketplace Plans (millions)	Medicaid (millions)	Average population density
State-based Marketplaces (Medicaid=Yes)	8.1	2.6	5.5	117
FFM/Medicaid-Yes	3.6	1.3	2.3	139
FFM/Medicaid-No	5.5	4.2	1.3	64
TOTAL	**17.1**	**8.0**	**9.1**	**90**

*Sources: RUPRI Center analysis of HHS/ASPE data, http://aspe.hhs.gov/ adjusted for recent enrollment by figures from ACA Signups data, http://acasignups.net/, retrieved, 4/26/14.

What about Premium variation?

- Analysis using large database on Marketplaces
  - All rating areas in the U.S. (n=500)
  - Sources:
    - Federal, state marketplaces, CCIIO, US Census, ERS
    - Unfortunately no enrollment data by firm/plan as of this point
- Methods:
  - Descriptive and Multivariate methods

Descriptive Findings



- Adjusted premiums in State-Based Marketplaces (SBMs) tend to be lower ($20 on average) than premiums in Federally-Facilitated and Partnership Marketplaces (FFM/PMs)
  - Average premiums drop slightly as population density increases, but declines more in SBM

Premium Analysis: Key Findings

- Average-adjusted Premiums lower:
  - In areas with higher population density
  - Where more firms offer coverage
  - In state-based marketplaces
  - Controlling for all other factors
  - Marginal effects (all for 27-year-old)
    - About $40/pmpm lower in area with higher population density area
      - Area with Population density=1600 compared to 370 (mean)
    - About $35 lower in state based marketplaces (compared to federal)
    - About $16 lower if there are two more firms (compared to average of 3.3)
- Work is preliminary, and findings cautious
  - Findings from first year of marketplaces
  - Anecdotes suggest firms based premium bids on little information
  - Little information so far on other characteristics of plans such as
    - Networks (broad or narrow), enrollment, payment policies
  - 2015 or 2016 data may provide much more sense of marketplace

Preliminary Findings: 2015

- These results are preliminary
  - (data only just released; based only on federal marketplaces)
- Some possible findings:
  - In 97% of rural counties (and 98% of urban), the same number of firms or more firms
    - Increase in number of firms in 59% of rural (and 78% of urban) counties
  - Average premium increase slightly higher in rural (5.0%) compared to urban (4.7%)
    - Premium increase lower in areas with 3 or more firms entering: rural (2.6%), urban (2.0%)
    - Second lowest silver plan: up 6.3% in rural and 5.0% in urban
  - In general, there appears to be some "compression" in premiums (regression to the mean?)
    - (that is, firms that offered low premiums in 2014 raised them more; firms that offered higher premiums in 2014 raised them less or cut premiums)
    - In some areas of the country, some possible concerns about rising premiums in rural areas
- Fits our findings from 2014:
  - Marketplace still evolving
  - As more firms enter, competition in marketplaces helpful to consumers

Conclusions, Policy Implications, Limitations, Future Work

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Implications

- To make careful comparisons of premiums across geographic areas, important to:
  - compare similar types of plans to each other (by metal level) and for people at the same age, understand the context of how rating areas were set, adjust for relevant factors
  - Understand that total costs consumers face are not just premiums, but AV is a good proxy
- Marketplaces should evolve over time
  - Need to wait until 2016 before all this gets settled out?
- Preliminary results suggest that high premiums may be an issue for some people
  - In states with Federally-Facilitated Marketplaces
  - In rating areas with lower population density
  - In areas with fewer firms competing
- Congress, federal and state policymakers need to be mindful of these issues as they monitor ACA implementation and assess the fairness and affordability of plans across the U.S.

Questions, Discussion?

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- Questions??