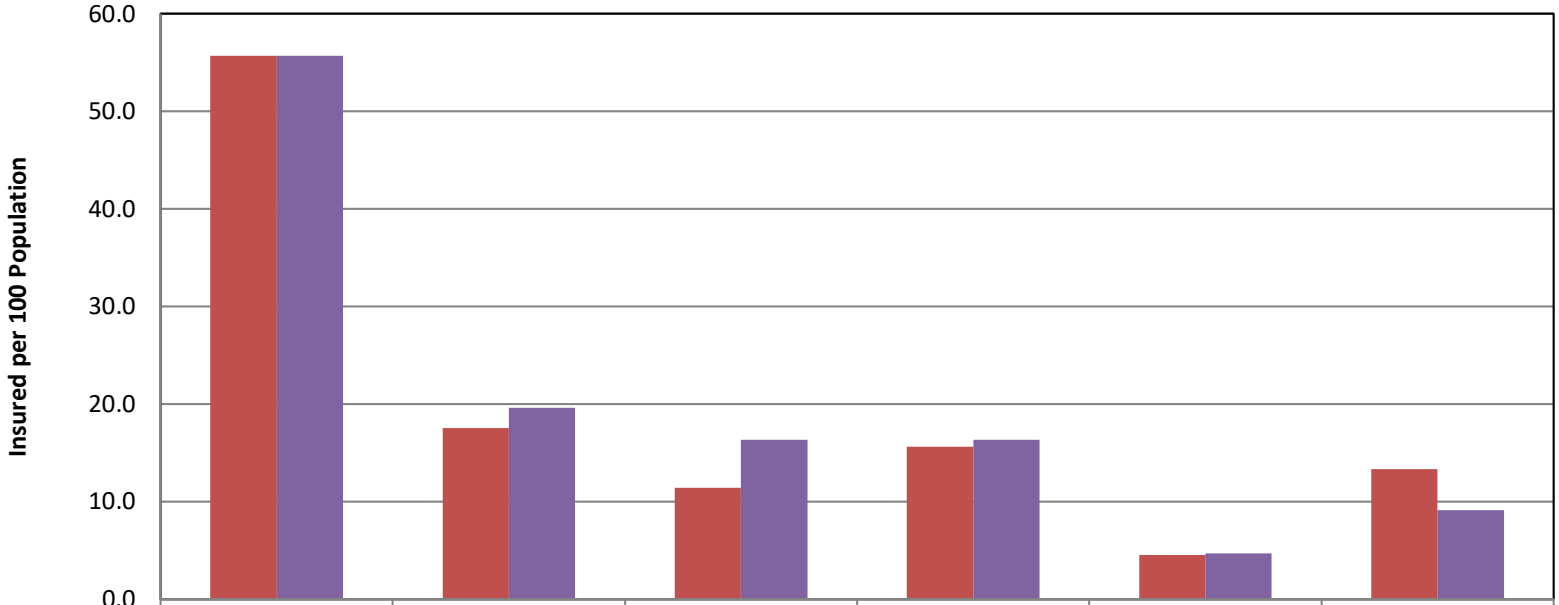
State Policy Approaches for Stabilizing Rural Health Insurance Markets

Harvey Licht
Varela Consulting Group
September 2017

State Decisions Which Can Impact Rural Health Systems

- State level decisions can have significant impact on the rural health system environment.
- This is particularly true given the current status of the Affordable Care Act (ACA). State decisions will likely be more important if there is any modification of the ACA.
- State level decisions have greatest impact in two parts of the market:
  - Direct purchase individual/family health plan market – both on and off exchange.
  - Medicaid markets – both managed care and fee-for-service.
- States have retained powers in these markets as well as potential additional flexibility under Medicaid waivers and ACA Section 1332 waivers.

Estimated US Health Insurance Coverage Rates 2013-2015



	Employment-Based	Medicaid	Direct-Purchase	Medicare	Military Health Care	Uninsured
2013 Rate	55.7	17.5	11.4	15.6	4.5	13.3
2015 Rate	55.7	19.6	16.3	16.3	4.7	9.1

These estimates show the Census-estimated changes in US health coverage over the first two years of ACA implementation. Note that State policy affects a relatively small portion of the overall market compared to Federal policy. Nevertheless, these impacts have a significant influence on rural health provider sustainability.

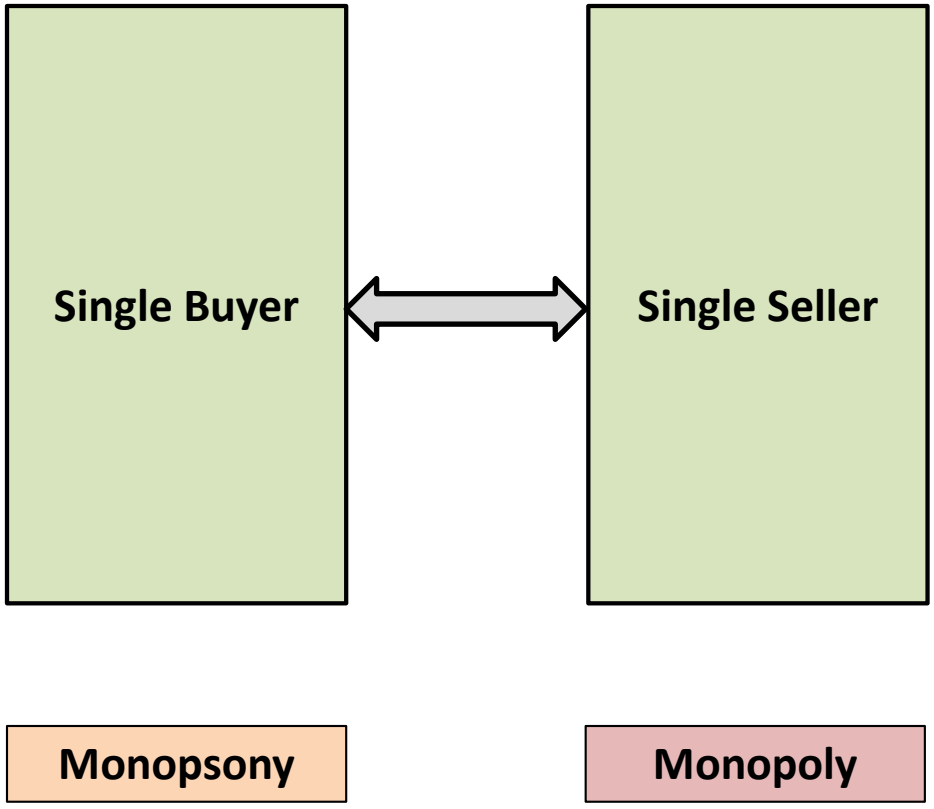
Types of Policy Impact on Rural Health Systems

- **Changes in payor/contracting environment: State policy decisions can affect the insurer mix in a rural county. They can also change the benefit packages contained in offered health plans. Providers must be aware of these changes and respond accordingly.**
- **Changes in uncompensated care: State policy decisions can change the overall levels of uncompensated care facing rural providers. Providers must understand how uncompensated care levels will vary based upon policy decisions.**
- **Changes in revenues: State policy decisions can lead to significant changes in rural provider revenues. Providers must anticipate how decisions will affect their revenue picture.**
- **Changes in provider responsibilities for collecting patient co-pays: State policy decisions can change patient co-pay and co-insurance responsibilities. Providers must be aware of these changes might require billing modifications and influence collections.**

Policy Goals for the Direct Purchase Market

- **Targets for State policy:**
  - **Increase insurer competition – number of insurers and offered plans.**
  - **Assure affordable premium levels.**
  - **Assure key pre-deductible benefits for rural residents.**
  - **Assure provider network adequacy in rural areas.**
  - **Assure rural provider viability.**
- **States can help offset free market failures in the low-volume rural market.**
  - **They can influence monopoly and oligopoly situations for rural consumers.**
  - **They can influence monopsony and oligopsony situations for rural providers/facilities.**
- **States can also establish restrictive waivers, stabilizing the market but reducing access and affordability.**

Limits to Competition – Provider Contracts



Increase Insurer Competition - 1

- **Design appropriate QHP Rating Areas: States can establish insurance rating areas which improve the offerings of insurers in rural counties.**
  - **CA regional Rating Areas combining urban and rural counties in single areas.**
  - **CO redesign of Rating Areas shifting frontier counties from rural-only Rating areas to Rating Areas including urban counties.**
  - **NH, VT, HI, NJ, RI have a single statewide Rating Area.**
- **Mandate wide or statewide provision of plans: States can establish rules which require that plans on the exchange be offered in more than the one county federal requirement.**
  - **NM QHP regulations require insurers offer plans in at least two metal levels. NM also requires at least one statewide plan for any metal level plan offered on a sub-state basis.**

Increase Insurer Competition - 2

- **Prevent rapid, unpenalized, exit/re-entry into market: States can add rules establishing Federal penalties for insurers who leave the exchanges. These rules could extend the waiting period before marketplace re-entry.**
- **Link participation in exchange to participation in other markets: States can establish policies which make successful participation in other, larger markets contingent upon participation in health insurance exchanges.**
  - **NY denial of Medicaid managed care contracts to companies exiting exchange.**
  - **NV provision of Medicaid contract preference to companies on exchange.**
- **Establish a public option: States can establish a public option alternative to private insurers, at a minimum in local areas without competition.**
  - **The NV Legislature passed a bill seeking to modify the Medicaid Program to permit individuals to buy-in.**

Assure Affordable Health Plan Premiums in Rural Areas

- **Establish public high risk mechanism: States can create high risk financing mechanisms to assume costly claims/patients that would otherwise drive up the rates of insurers.**
  - **AK established a State-funded high risk reinsurance program to support high cost patients. AK is seeking partial Federal offset for the costs of this program.**
  - **ME previously had a similar State-funded invisible high risk pool.**
- **Establish Rating Area premium differential maximums: States can establish a maximum premium ratio between highest and lowest Rating Areas. This would be similar to the age ratio maximums established under the ACA.**
- **Establish State-funded tax credits and cost-sharing reductions.**
- **Design appropriate QHP Rating Areas: See previous discussion.**

Assure Key Pre-Deductible Benefits

- **Establish schedule of pre-deductible plan benefits: State can establish a pre-deductible benefits schedule, including a detailed cost-sharing breakout, for plans at all metal levels. All key categories of health service can be part of the schedule – primary care, specialty care, behavioral health care, hospitalization, pharmacy services, laboratory services and emergency care.**
  - **Several states have established these requirements. NY has one of the most developed schedules of coverage.**

Assure Provider Network Adequacy

- **Establish supplemental network adequacy standards: States can establish their own standards for qualified health plan provider networks as a supplement to the Federal guidance.**
  - **NM has established standards, including population to provider ratios, maximum distance requirements and maximum wait time requirements.**
  - **CA has established standards and has an extensive effort for monitoring and enforcing compliance.**
- **Establish supplemental standards for Essential Community Provider contracts: States can establish their own standards for guaranteed contracting with ECPs, either in all areas or in shortage areas. This would supplement Federal guidance.**

Assure Rural Provider Viability

- **Establish default reimbursement schedule for underserved areas: States can establish default reimbursement standards to assure that participating providers in underserved areas can get reasonable levels of service reimbursement. Federal standards can be used for this baseline including the Medicare Inpatient/Outpatient Payment Schedules and Prospective Payment System rates. Providers will be free to negotiate lower rates.**

- **Establish payment incentives for underserved areas: States can establish payment incentives to be applied on top of negotiated reimbursement rates for providers in underserved areas. This would be similar to Medicare bonus payments in underserved aras.**

Summary

- States can have substantial policy impact on the direct-purchase health insurance market in their rural counties. The net impact of policies can either improve or restrict access to health services for rural residents.
- There are multiple tools that can be employed. New approaches are being developed by states.
- Medicaid policy, although shared with the federal government, can have a similar impact on the Medicaid market.

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