NOSORH

National Organization of
State Offices of Rural Health

January 25, 2018

Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Subject: Request for Information – Promoting Healthcare Choice and Competition across the United States

To Whom It May Concern:

The National Organization of State Offices of Rural Health (NOSORH) is pleased to have the opportunity to respond to the Request for Information – Promoting Healthcare Choice and Competition across the United States. The input to the report in response to EO 13813 is an important opportunity to address the lack of completion which plagues rural America's access to health care services.

NOSORH is the national, non-profit membership organization of the fifty State Offices of Rural Health (SORH). Our mission is to promote the capacity of State Offices of Rural Health to improve health care in rural America through leadership development, education, and partnerships. The SORH are anchors of rural health activity throughout the nation and have responsibility for information dissemination, coordination, data collection and technical assistance to support rural communities.

The comments attached include an empirical analysis of the current status of health insurer competition in rural counties. It also looks at the impact of lack of competition on health plan premiums. One key finding of the analysis is that about 60% of rural counties in the 39 states face monopoly health insurance markets, with only one health insurer offering health plans.

The comments include several recommendations for changes in Federal policy under the ACA. These recommendations are based upon State policies that have demonstrated effectiveness in improving competition as well as statements from insurers about what would increase their successful participation in the private insurance marketplace.

For clarification, additional comment or questions, please don't hesitate to contact me by email at any time teryle@nosorh.org.

Sincerely,

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NOSORH Comments for DHHS to inform EO 13813

Overview

The National Organization of State Offices of Rural Health (NOSORH) provides these comments to the Department of Health and Human Services (DHHS) in response to its request for information under Executive Order 13813. That Executive Order seeks to promote choice and competition and reduce regulatory burden, throughout healthcare markets. NOSORH has been monitoring the decrease of competition in the health insurance marketplace for rural counties over the last four years. These comments reflect the insights gained from this long term analysis.

In 2018, residents of rural counties in the nation face challenges in the direct purchase of individual/family health insurance on the health marketplace. Rural residents face limited competition from insurers, with resultant higher premiums. Federal and State policy and regulations have a role in the resolution of these issues. In some cases, inappropriate guidance has contributed to the creation of problems. In other cases inadequate guidance has permitted the problems to develop. In these comments NOSORH will identify specific challenges faced by rural residents in the direct purchase of individual/family insurance. The comments will discuss the nature and cause of these problems and suggest specific changes which could improve the situation in Rural America.

Competition Challenges Faced by Rural Residents

Most rural counties face monopoly markets for the direct purchase of individual/family health insurance. A NOSORH analysis of Qualified Health Plan (QHP) offerings for individuals/families on the 2018 Federally Facilitated Marketplace (FFM) shows that ***more than half*** of all rural counties had offerings from just ***a single insurer***. This analysis covered all QHP offerings in the 39 states on the FFM. Monopoly markets exist for Gold, Silver and Bronze/Expanded Bronze offerings. The number of rural counties facing monopoly markets is higher than in any previous year. The percentage of rural counties facing monopoly markets is higher than the similar percentage for urban counties in the 39 states. A summary of the 2018 analysis is attached at the end of NOSORH's narrative comments.

Monopoly markets for health insurance are a serious problem. Residents of rural counties face a 'take it or leave it' situation in these markets – they cannot go to another county to get alternative offerings. This is unlike the market for any other good or service. For example, if a rural county resident was unhappy with the brand or price of flat screen televisions available locally, that resident could travel to another county to get a better product.

Only a small percentage of rural counties are in competitive markets for QHPs. Competitive health insurance markets are generally defined as those with offerings by three or more insurers. NOSORH analysis of the FFM shows that ***fewer than 15%*** of rural counties in the 39 states are ***in competitive markets***. This is the case for Gold, Silver and Bronze/Expanded Bronze offerings. The number of rural counties in noncompetitive markets is lower than in any previous year. The percentage of rural counties in non-competitive markets is significantly lower than the similar percentage for urban counties.

Several states have engaged insurers to identify their reasons for reducing their offerings or for leaving the QHP marketplaces – these decisions being the underlying cause of reduced competition. The main reason cited by insurers in interviews and in public statements has been the uncertainty and confusion related to Federal policy direction for these markets. The changing Federal position related to cost sharing reduction payments for insurers seriously

hampered the ability of insurers to project future costs and revenues. Similarly, Federal decisions and unresolved litigation related to the risk corridor programs authorized by the Affordable Care Act further limited the ability of insurers to assess the total cost of their operations.

There are multiple negative impacts of restricted competition in rural counties. The price of health insurance is a major result of restricted competition. Based on a NOSORH analysis of average 2018 QHP premium levels in the 39 states on the FFM, ***rural counties with only one or two insurers have higher premiums than those with three or more***. This is true for Gold, Silver, and Bronze/Expanded Bronze offerings. ***Monopoly, single issuer counties*** have average ***premiums running about 20% higher*** than counties with 3 or more issuers. ***Counties with 2 issuers*** have average premiums running ***at least 12% higher*** than counties with 3 or more issuers. This demonstrates the important impact of adequate competition on QHP premium levels faced by rural community residents. A summary of these findings is attached at the end of NOSORH's narrative comments.

NOSORH's analysis of average 2018 QHP offerings in the 39 states on the FFM has also shown that ***average premiums in rural counties are higher than average premiums in urban counties***. This is true for Gold, Silver and Bronze/Expanded Bronze offerings. In part, this reflects the way in which insurance rating areas are structured within the states. Federal guidance establishes a default rating area system for states which assigns each urban Metropolitan Statistical Area (MSA) its own rating area and isolates all rural counties into a single, separate rating area. This MSA+1 approach, used by many states, isolates high volume, high profit health markets from low volume, lower profit markets. It creates a situation where ***rural residents will pay substantially more for the same coverage*** than do urban residents in the larger MSAs. In comparison, several States have established a single rating area for all counties, assuring all state residents ***equal premium levels for equivalent plans***.

It should be noted that some insurers offer QHPs in some counties, but not others. When insurers limit their offerings, it is often rural counties which are excluded. For example, in the 39 of the FFM, ***14 rural counties are not offered any Gold plans or any Bronze/Expanded Bronze plans***. This results, in part, from Federal guidance permitting insurers to limit their offerings to coverage areas as small as one county. This regulatory approach is inappropriate and permits insurers to cherry pick the counties in which they do business. Several states have established guidance requiring insurers to make any QHP offerings statewide. This has helped assure competition in rural counties. It is a reasonable model for how appropriate Federal guidance could assure competition in Rural America.

Recommendations

NOSORH has several specific recommendations for DHHS identifying ways in which Federal policy and regulation can improve health insurance competition in Rural America. They are detailed below:

> **Establish a High Risk/High Cost Patient Coverage Infrastructure**: NOSORH recommends that DHHS create a program to assume the costs of high risk/high cost patients or support state efforts to create local programs. The use of 'invisible risk pools' has shown itself to be an effective means of assuring QHP offerings. Federal support, with or without State cost-sharing, is important in making this approach work. The current effort of the State of Alaska in undergirding the private market is an example of how such efforts can be effective. States funding for these efforts, combined with Federal premium support payments have helped stabilize the health insurance market – even in

the remote rural parts of that state. The proposals included in the Alexander/Murray bipartisan bill would be a useful starting point for this approach.

Establish Cost-Sharing Reduction Support for Insurers: The Affordable Care Act mandates insurers to make cost-sharing reduction available for eligible enrollees. Up until last year there was Federal financial support available to insurers to defray this required cost. Insurers have indicated that the discontinuance of this support program added a significant additional cost to their operations. Elimination of the Federal support was a major factor in their decisions to reduce offerings and increase premiums. NOSORH recommends that DHHS provide renewed support for these mandated costs. This will increase competitive offerings and reduced premiums in Rural America.

Revise Federal Rating Area Requirements: The MSA+1 default approach to health insurance rating areas established in DHHS guidance codifies policy which places rural counties at a disadvantage. NOSORH recommends that DHHS revise Federal rating area guidance to establish a single statewide rating area as the default for all QHP offerings.

Revise Federal Minimum Offering Area Requirements: Current DHHS guidance permits insurers to limit the areas in which they offer QHPs to markets as small as a single county. This creates a disadvantage for some rural counties – they do not receive the same QHP offerings as urban counties. NOSORH recommends that DHHS revise its minimum offering requirement for insurers to assure that at least one QHP product is offered statewide at each metal level. This approach has been used in New Mexico to assure adequate insurer participation and QHP offerings in rural counties.

Number of Insurers Offering Qualified Health Plans
-- 39 States on the Federally-Facilitated Marketplace
-- Bronze/Expanded Bronze Plans - Rural Counties - 2018

Insurers	Counties	PCT Rural Counties
1	1,047	60.2%
2	463	26.6%
3	184	10.6%
4	27	1.6%
5	19	1.1%
Total	1,740	100.0%

-- Note that 14 rural counties have no Bronze/Expanded Bronze offerings.

Number of Insurers Offering Qualified Health Plans
-- 39 States on the Federally-Facilitated Marketplace
-- Silver Plans - Rural Counties - 2018

Insurers	Counties	PCT Rural Counties
1	1,050	59.9%
2	466	26.6%
3	125	7.1%
4	94	5.4%
5	19	1.1%
Total	1,754	100.0%

-- Note that all rural counties have Silver offerings.

Number of Insurers Offering Qualified Health Plans
-- 39 States on the Federally-Facilitated Marketplace
-- Gold Plans - Rural Counties - 2018

Insurers	Counties	PCT Rural Counties
1	1,037	59.6%
2	465	26.7%
3	125	7.2%
4	94	5.4%
5	19	1.1%
Total	1,740	100.0%

-- Note that 14 rural counties have no Gold offerings.

Qualified Health Plan Premium - Individual Age 30
-- 39 States on the Federally-Facilitated Marketplace
-- Bronze/Expanded Bronze Plans - Rural Counties - 2018

Insurers	Mean Premium	Difference - 3 or More Insurers	PCT Difference
1	$419.32	$77.54	22.7%
2	$387.40	$45.62	13.3%
3 and More	$341.78		

Qualified Health Plan Premium - Individual Age 30
-- 39 States on the Federally-Facilitated Marketplace
-- Silver Plans - Rural Counties - 2018

Insurers	Mean Premium	Difference - 3 or More Insurers	PCT Difference
1	$513.35	$84.55	19.7%
2	$501.55	$72.75	17.0%
3 and More	$428.80		

Qualified Health Plan Premium - Individual Age 30
-- 39 States on the Federally-Facilitated Marketplace
-- Gold Plans - Rural Counties - 2018

Insurers	Mean Premium	Difference - 3 or More Insurers	PCT Difference
1	$596.96	$106.08	21.6%
2	$549.95	$59.07	12.0%
3 and More	$490.88		