

Insuring Rural America: Health Insurance Challenges and Opportunities

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TABLE OF CONTENTS

INTRODUCTION	1
BACKGROUND AND THEORY	2
The Role of Insurance	2
Rural Population Characteristics.....	3
The Rural Health Insurance Experience	3
Rural Health Care Delivery Infrastructure.....	4
The Impact of Population Characteristics, Health Care Use, and Provider Prices on the Cost of Care	5
CURRENT POLICY CONSIDERATIONS	6
Policies Related to Rural Insurance Risk	6
Policies Related to Provider Networks.....	10
Health Plan Payment Policies to Address Particular Rural Needs	12
CONCLUSION	14
REFERENCES	16

INTRODUCTION

Purpose: This paper discusses the realities and challenges of designing a market structure that will result in affordable health insurance being offered in rural markets, and reviews the rural implications of policies affecting rural health insurance markets and health systems.

Rural insurance markets face two particular challenges. First, an insufficient number of potential enrolled lives may fail to attract *any* insurance offerings. Health plan administrators and regulators often note the challenges of offering affordable insurance products in rural markets, as small populations create higher administrative costs and do not allow for sufficient risk pooling. Second, characteristics of the health care delivery market may not support competitive plans that are affordable to rural households. Health plan administrators cite the problem of forming provider networks in some rural areas with limited provider supply. In addition to these issues, which both stem from the small populations in many rural settings, the socio-demographics of some rural areas (e.g., higher levels of chronic disease, lower rural incomes, higher unemployment) can also create significant affordability challenges.

The challenges of rural insurance markets often feature prominently in the current policy debate over the stability of the individual insurance market. However, the same challenges are also evident in other insurance markets and policy sectors, including the small group, employer-based health insurance market; the Medicare Advantage (MA) program; the Federal Employees Health Benefits Program (FEHBP); and State-based Medicaid managed care programs.

Affordable health insurance—including premiums as well as out-of-pocket costs incurred before a deductible is met—is critical to rural citizens. Affordability of premiums (adjusted by subsidies for premiums and cost-sharing) is gauged against lower rural incomes. Furthermore, affordability has broad implications for the financial viability of the rural health system. Lack of insurance and/or higher out-of-pocket insurance costs translates to higher uncompensated care costs to providers, which in turn threatens the financial viability of rural hospitals and other providers.

Current public policy regarding health insurance, including health insurance marketplaces (HIMs) created by the Patient Protection and Affordable Care Act (PPACA), assumes that a market-based approach with multiple health plans and multiple providers will be effective and sustainable in providing consumers with choices among affordable plans. This ideal is far from the reality in most rural areas, where only one or two insurers offer plans, and where there are a limited number of available providers with whom to form local provider networks. These limitations can result in health plans having limited ability to negotiate contract terms from these providers to include them in networks. Conversely, it may mean hospitals and other providers are compelled to accept the payments proposed by those

insurers should they want to be in the preferred network. Network adequacy standards that require contracts with higher-cost local providers in order to enroll the local population may create upward pressure on health insurance premiums and/or total out-of-pocket costs for rural consumers. Faced with these complexities, private insurers will tend to choose not to participate in rural markets. At stake are rural consumers' access to affordable insurance and the need for local rural providers to retain market share to sustain the local health care system.

The remainder of this paper includes a background section on the economics of insurance markets, which provides a rural context on the issue of health insurance, followed by a discussion of policy considerations that stem from our analysis. The latter section includes a discussion of the rural implications of policies related to insurance risk and a discussion of policies related to health care delivery system challenges. We conclude with observations on how best to improve the experience of rural people, given the realities of the rural health insurance market.

BACKGROUND AND THEORY

Summary

- The **purpose of insurance** is to pool risk, which by definition means some health care costs will be shifted from those who are healthier to those who are sicker.
- Although premiums may be “risk-adjusted” to compensate insurers if their enrollees are sicker than average, there may be **rural population characteristics** that are not part of this adjustment.
- Rural populations tend to rely more on **public sources** of health insurance coverage, in part because smaller employers in rural areas cannot afford to offer coverage.
- The **infrastructure costs** needed to deliver care in rural places must be spread over fewer patients, resulting in higher average costs per patient.
- Consumers' **insurance costs** in a given region depend directly on the total cost of care in that region, which is a function of health care use, prices, and how much risk can be spread across covered lives in that region.

The Role of Insurance

The fundamental economic purpose of insurance is to pool risk (i.e., predicted costs), based on the fact that risks become fairly predictable in large groups, allowing insurers to calculate expected costs of claims. This actuarial predictability is the basis of the premiums charged to insured individuals in a “community-rated” insurance pool, with everyone in the pool paying the same premium based upon average risk. In the individual and small group markets, mechanisms that blend persons at all risk levels normalize premiums such

that persons at high risk will pay below the rate based only on their own risk, while low-risk persons will pay more than the rate based solely on their own risk.

Thus, a key policy issue underlying the distribution of insurance risk within a risk pool is who pays for the risk. By definition, insurance involves sharing the risk of a group through comparable payments by each member of the group, thus shifting higher costs from those who consume more benefits to those who consume less. The more concentrated a risk pool becomes with sicker people who require more health care, the more those higher costs and insurance premiums are shifted to healthier enrollees. Over time, this theoretically could produce what is known as a “death spiral” in the market, in which only the sick purchase insurance and those who are healthier avoid purchasing insurance because of higher average premium costs.

Rural Population Characteristics

The most significant characteristic of any rural population, from the perspective of an insurer, is the small size of the insurance pool (in the county or rating area). However, other significant characteristics include any patterns or behaviors that rural people may have in common that do not factor into the risk adjustment formulas that the Centers for Medicare & Medicaid Services (CMS) uses to compensate insurers when their enrollees are at a higher-than-average risk of incurring large health care costs, based on their medical claims history. For example, if rural populations tend to delay seeking care when a medical issue arises, this could increase the likelihood that medical claims will be high. Rural populations tend to be older, but even with a risk adjustment for age, the greater degree of manual labor in rural populations could make age a *greater* risk factor in rural places, and at an earlier age. Any demographics that are more common among rural populations—but not factored into the risk-adjustment formula—can discourage insurers from offering affordable coverage in rural places.

The Rural Health Insurance Experience

Compared to their urban counterparts, rural people are somewhat less likely to have health insurance.¹ Rural residents who are insured rely disproportionately on public insurance because of lower incomes, older populations, higher poverty rates, and less access to employer-sponsored insurance than urban residents.^{2,3} Before the implementation of the PPACA in 2014, rural populations were more likely to be covered by Medicaid or other public insurance (21 percent and 4 percent, respectively) than were urban residents (16 percent and 3 percent, respectively)⁴, a pattern that continued into 2015⁵ and 2016.⁶ Small businesses, a staple of rural communities,⁷ report that they are less likely to offer employer-sponsored insurance to employees due to high premium costs and generally lower wages.⁸ When private health insurance is offered and taken up, rural employers and employees typically have plans that offer less generous coverage with fewer benefits and higher out-of-pocket costs than plans in urban areas.^{9,10,11} One reason for this differential is likely that the administrative costs of servicing the smaller employers

and fewer individuals in rural areas cannot be spread over many insured lives, as in urban areas.

The difficulties facing rural areas in the individual insurance market also occur in other markets such as MA, FEHBP and Medicaid managed care, for the same reasons that marketplace plans have struggled in rural areas. Rural Medicare beneficiaries are less likely than urban beneficiaries to be enrolled in an MA plan (in a few rural counties because no plan is offered), which may disadvantage rural residents since many MA plans offer more generous benefits at lower cost to the consumer. Moreover, evidence suggests that, compared to urban MA enrollment, a higher proportion of rural MA enrollment is in regional PPOs. In large part because those plans are typically less expensive but have lower Medicare quality ratings,¹² rural MA beneficiaries are also much less likely than urban beneficiaries to have highly rated plans (using Medicare's star rating system). Moreover, they are less likely to have a highly rated plan available in their county and are much less likely to have a "zero premium" MA plan (meaning a plan that charges zero additional premium beyond Part B) available.¹²

The FEHBP, which insures all Federal employees, offers fewer plan options in rural areas than in urban areas. Although FEHBP plans are offered in all U.S. counties, the number of plans offered in rural counties lags those in urban counties, and only Blue Cross Blue Shield plans consistently include local physicians in their networks.¹³ Questions about the number of competing plans in the FEHBP persist, with Blue Cross Blue Shield plans dominating markets and other firms withdrawing, according to an Office of Personnel Management (OPM) briefing paper and as reported in *The Washington Post*.¹⁴

Most State Medicaid programs have capitated managed care programs, with 37 states contracting with private managed care organizations (MCOs) that serve beneficiaries in both rural and urban areas. Low population volumes and limited numbers of health care providers have challenged states and their MCO contractors in extending their capitated programs into rural areas. In states without capitated managed care programs, Medicaid programs have used fee-for-service-based Primary Care Case Management and Health Homes models to overcome the challenge of launching capitated Medicaid managed care in low-volume rural areas.¹⁵ A combination of sparsely populated areas and low provider availability have led several states to request a waiver—a "rural exception" to the choice requirement.¹⁵

Rural Health Care Delivery Infrastructure

Rural health care infrastructure is anything but monolithic. Historically, rural providers have been characterized as independent entities, including community hospitals and local doctors' offices. However, the landscape is changing, more rapidly in some places than in others, with expansion of regional health systems (most often anchored by urban tertiary centers) and creation of rural provider networks (that may be exclusively rural, as in the case of the Illinois Critical Access Hospital Network). Analysis of American Hospital

Association Survey data shows that as of 2016 nearly 50 percent of rural hospitals participated in systems, including 43 percent of Critical Access Hospitals (CAHs) (unpublished analysis of the RUPRI Center for Rural Health Policy Analysis). Of course, that means that slightly more than half of rural hospitals are not participating in systems.

Rural providers—and particularly rural hospitals—often serve a small population in their service area, resulting in a low service volume. This fundamental reality of a low service volume presents a challenge in rural settings, especially when payment, and therefore a hospital’s or physician’s revenue, is based on the volume of patients. While this is an issue in many professions (e.g., for a lawyer setting up practice in a rural area), it is more challenging in health care for three reasons: (1) services are often needed unexpectedly and urgently, making proximity especially important; (2) increasingly, a significant amount of equipment, staff, facilities, and electronic medical records software is needed to support even a small hospital or practice; and (3) calculation of valid and reliable quality measures is difficult in low-volume settings, at the very time when insurance payments are becoming increasingly based on provider performance on quality measures. In large towns and cities, the up-front investment required to acquire or improve these inputs can be spread over many patients. In a low-volume setting, however, many investments and new technologies will not make financial sense given the high average cost per use. In other words, the “fixed” costs of providing rural health care are relatively high.

The Impact of Population Characteristics, Health Care Use, and Provider Prices on the Cost of Care

The cost of insurance in a given region depends largely on the total cost of care, which is a function of two factors: (1) health care use and (2) the prices insurers pay providers for services in that region. Administrative costs and profits can vary, but only within a narrow range as determined by State regulations (including those implementing the PPACA) that require minimum levels of medical spending, meaning that insurance premiums are nearly directly proportional to the average value of claims incurred. In public insurance systems, participating health plans may receive “risk adjustment” payments to compensate for enrollees whose demographic and health status characteristics and claims history suggest that they will be high-cost. However, the insurers must still absorb all of the substantial risk that cannot be predicted by demographics and prior claims. Those costs may result from previously undiagnosed conditions or emergent needs such as treatment following injuries. Thus, the cost to the insurer of assuming this risk becomes another component of the premium charged to the consumer. This risk-related cost is higher when risk is less predictable, as insurers seek to protect themselves from unanticipated losses. With those two factors in mind, we turn to an analysis of current policy considerations.

CURRENT POLICY CONSIDERATIONS

What are current market and policy landscapes and their implications for rural insurance markets? In this section of this paper the RUPRI Health Panel reviews current policy discussions of options to affect market-based reforms. Broadly, our analysis falls into three categories: the rural implications of strategies and policies for (1) managing insurance risk, (2) satisfying network adequacy requirements, and (3) designing appropriate payment mechanisms, given the characteristics of the typical rural health insurance and health care markets. We explore implications for both affordability of insurance coverage and implications for access to services.

Policies Related to Rural Insurance Risk

Summary

- In general, **larger geographic regions** for risk rating produce more stable, predictable costs and premiums and therefore are preferred as rating and service areas.
- High-deductible, “bare bones” plans, offered through short-term, association, or other plans, which are all forms of **product differentiation**, are designed to offer consumers plans with lower premiums in exchange for more limited benefits and higher cost sharing. This tradeoff is acceptable for healthier and higher-income individuals but may create a cost burden for lower and middle-income consumers.
- Allowing a wider array of plan offerings will increase **market segmentation** and create more expensive coverage categories that require additional subsidy funding to enable rural consumers to afford products offered in any market-based program. Moreover, successfully separating out the healthiest consumers drives up the premiums for plans covering more conditions with lower deductibles. For those who qualify for premium subsidies under the PPACA, higher premiums may not affect the affordability (to them) of their PPACA-compliant insurance. However, for less-healthy individuals who do not qualify for premium subsidies, the higher premiums may be prohibitive. A further spillover effect from both scenarios may be an increase in uncompensated care, as individuals with high deductibles and/or uncovered conditions are more likely to be unable to pay balance bills.
- Increasingly, states are using the 1332 waiver authority under the PPACA to create **risk reinsurance** programs that subsidize the cost of predetermined high-cost individuals with State premium tax dollars. Prior to the PPACA, state-level **high-risk pools (HRPs)** sought to contain premium growth for the majority by removing the most expensive claimants from the common risk pool. Where tried, HRPs have faltered on high premium costs and unsustainable public subsidies.

Size of the Risk Pool. For insurers, costs of covered health care services must be predictable in the aggregate across the geographic rating area. Rating areas are typically set by law and/or by Federal or State regulations. In the case of MA, insurers contract with CMS at

the county level, effectively making the county the rating area. In the case of the HIMs, rating areas are set by the states. States have taken different approaches to setting HIM rating areas. Some rating areas are as small as one county while others encompass the entire state. Many HIM rating areas encompass groups of contiguous counties, often but not always a mix of urban and rural. The key point is that insurers must charge the same premium to similar individuals everywhere the plan is offered within the same rating area. Rating areas with small populations of enrollees, such as many rural populations and rural counties, are less likely to meet the standard of aggregate cost predictability, which either discourages insurer participation in such areas or increases the premiums charged. In general, across all public and private insurance systems, larger rating areas are preferable because they produce more stable, predictable total costs and premiums for rural and urban consumers. This relationship between rating area size and costs is illustrated in the Medicare Part D program's regional rating areas, each of which encompasses multiple states. With this design, policymakers deliberately created larger risk pools to combat the problems of small risk pools. Part D has been successful in producing relatively stable premiums across larger populations, thereby reducing disparities between rural and urban populations.¹⁶

In another rural insurance market, MA plans have always had a lower penetration in rural areas as compared to urban areas, meaning that the risk pools are smaller, creating challenges for insurers. In part this is because HMOs have always had a stronger presence in urban areas, as Medicare HMOs were the only plans allowed to offer Medicare private plans until 1997. Also, HMO and Local PPO plans, which are both more prevalent in urban areas, have stronger quality ratings that qualify them for a higher payment rate under legislation enacted more recently.

Product Differentiation. In response to market instability associated with small populations and the unpredictability of expected costs (and in lieu of reconfiguring rating areas), State and Federal policymakers have looked to giving more flexibility to insurers' product development to encourage participation of healthier individuals and those with moderate incomes (low, but above eligibility for subsidies) in the market. For example, policies can allow the sale of plans that "meet consumers' needs," offering a variety of non-standardized plans with varying benefits, plan designs, and premium prices. To the extent that these plans attract healthier consumers looking for lower premiums, they have the potential for segmenting the risk pool into subgroups, with the risk associated with each assessed separately, which effectively creates a small risk pool issue.

In the individual market, insurers may offer a menu of plans that varies tradeoffs between premium costs, services covered, and deductibles/copayments and includes so-called "bare bones" insurance plans with lower premiums and higher cost sharing. These bare bones plans tend to have lower premiums that bring healthier consumers into the market, but they are likely to segment the risk pool, contributing to market instability. Likely

consumers of these lower-premium plans include individuals and households wishing to insure against steep financial losses (often to protect fixed assets) at what they deem to be an affordable premium for such limited coverage. Given that rural households rely more heavily on the individual market, and that asset protection is critical for households that are asset-rich but have only moderate incomes, such as small farmers and ranchers, this rationale may apply more commonly in rural places.

Although bare bones products are likely to attract healthier consumers who expect to use fewer services, they may have negative consequences for those who are less healthy. For those who qualify for premium subsidies under the PPACA, higher premiums may not affect the net affordability of their PPACA-compliant insurance. However, for less healthy individuals with incomes too high to qualify for premium subsidies (and for those who buy insurance outside of the HIMs), the higher premium costs may be prohibitive. The continued availability of “off market” individual insurance plans, available directly from insurers, has been one of the reasons why the HIMs have been less than stable since they were implemented in 2014.¹⁷

These challenges apply in other insurance markets, such as the small group market, where employers have historically sought ways to create larger risk pools by aggregating into larger groups. For example, association plans, which pool employer-based groups that have natural affiliations (e.g., occupation, employer type) are designed to create more sustainable risk pools, thereby lowering premiums (often in conjunction with high-deductible, high-cost-sharing plan designs). As in the case of the individual market, these approaches will only succeed to the extent that there is a large enough risk pool to make costs predictable over time, overcoming the challenges of large claims. In addition, these plans can contribute to market instability if healthier groups are drawn out of the small-group risk pool. And finally, high-cost-sharing benefit designs can create problems of affordability for individual households and unintended fiscal challenges for rural providers faced with unpaid patient bills.

Risk Reinsurance and HRPs. Risk reinsurance and high risk pools (HRPs) are both strategies for addressing problems of risk distribution in insurance markets. One approach to address the same underlying goals of affordability and access while avoiding too-small risk pools is through subsidized risk reinsurance programs. Building on Maine’s concept of “invisible risk pools,” many states are using the 1332 waiver authority to develop risk reinsurance programs.¹⁸ The pools can lower the risk for unanticipated expenditures, generally by sharing the costs of claims above a “trigger” amount, up to a ceiling. In Minnesota’s program, for example, reinsurance reimburses for claims between \$50,000 and \$250,000.¹⁹ The health plan resumes full liability above the ceiling, but is likely to purchase additional reinsurance at those levels. Subsidizing a system of risk reinsurance to limit insurers’ liability for large claims can lower premiums charged to consumers while removing the disincentive on the part of risk-averse insurers to participate in small markets

in order to avoid exposing themselves to the possibility of outlier claims. In most cases subsidy costs for the reinsurance pool are covered by an assessment on health insurance premiums.

In the 1990s and leading up to passage of the PPACA, some states implemented HRPs in an effort to stabilize their individual insurance markets. The goal was to contain premium growth in the individual market by removing the most expensive claimants from the common risk pool and allowing them to buy an HRP plan with subsidies scaled to income. In most cases, HRPs had strict eligibility criteria based on applicants having one or more expensive, chronic health conditions and/or having medical costs exceeding some threshold. HRPs suffered from several problems, the most challenging being that premiums tended to be very high, often set at some multiple of average premiums in the individual market (e.g., 125-150 percent). Premium costs were largely a function of the level of State subsidy provided, with few states able to provide the level of subsidy needed to bring premiums into an affordable range for many applicants. This, in turn, meant that HRPs often had few enrollees. In addition, states found it difficult to sustain appropriations (and/or taxes) needed for HRP subsidies.²⁰ HRPs in many rural states would be very small and would therefore face the problem of small risk pools compounded by high average costs that would require very high subsidies.

Summary. In the final analysis, policies or market strategies determine who pays for the higher costs of individuals or employers whose health needs and use exceed those of, healthier individuals or groups. Costs can be shared across a risk pool, but as the costs of higher cost individuals are shared across the pool, premiums may become unaffordable, especially to those with low incomes. At that point, subsidies are needed to reduce costs to those individuals or groups. By increasing market segmentation, policies allowing a wider array of plan offerings will likely create more expensive coverage categories that require additional subsidy funding to enable rural consumers to afford products offered in any market-based program.

Policies Related to Provider Networks

Summary

- **Network adequacy standards** for rural areas must balance the need to ensure access to care with the possibility that stricter standards are likely to cost more.
- **Price competition** among providers in rural areas becomes more challenging where there are fewer providers, and excluding rural providers from provider networks can, in certain areas, threaten the availability and sustainability of local rural health services.
- **Federal and State network adequacy policies** play an important role in balancing the desire of public and private insurers to secure prices from providers that will maintain affordable insurance products with the realities of small, low-volume rural providers who have limited capacity to lower their fixed or operating costs. Other policies may also influence negotiation power by specifying what prices will prevail in the absence of a contractual agreement.

As noted earlier, the challenges of forming adequate rural provider networks and negotiating payment rates influence (1) insurers' decisions to offer plans in rural areas and (2) health plan premiums. On the one hand, insurers need to form provider networks that offer consumers access to the full range of primary care, hospital, and specialty services. On the other hand, insurers expect to negotiate discounted payment rates with providers to minimize (control) premium costs. Many nuances in the negotiation process in rural areas may differ from those in urban areas. We will discuss some of these differences below and then analyze the implications for rural policy development in a later section.

Network Adequacy: Federal and State programs such as FEHBP, MA, Medicare Part D, and Medicaid Managed Care all have explicit standards health plans must meet to ensure enrollees have access to essential services. In the case of plans offered in the HIMs, states have each established, through regulation, network adequacy requirements. In the case of private, employer-based plans, the employer and the health plan work together to define in-network and out-of-network providers. Increasingly, public and private employers are providing incentives to consumers by offering lower cost sharing to those who use high-quality, low-cost providers according to certain performance metrics or standards. In the case of rural providers, the ability to demonstrate such standards can be challenging. Smaller low-volume providers, such as smaller rural hospitals, have had difficulties with public reporting of many quality measures.²¹ They also may not satisfy the "low cost" criterion for reasons discussed throughout this paper.

A key aspect of network adequacy is whether standards require local access to services or access within a specific mileage or travel time standard. For example, states vary in how tightly they regulate network adequacy requirements in their Medicaid managed care programs. Some states offer health plans greater latitude to exclude providers from their networks. Others make such exclusions more difficult. States' Medicaid programs monitor

the issue of network adequacy closely—auditing health plans’ provider network lists—to ensure that plans are meeting contracted levels. For FEHBP, OPM reviews applications of health plans for “evidence of a plan’s ability to provide reasonable access to and choice of quality primary and specialty medical care throughout the service area.”²² For the MA program, CMS produces annually a 75-page document describing network adequacy criteria, including explicit quantitative standards and a review process but also allowing for plans to request exceptions to travel distance maximums and to policies against insuring a partial county.²³ In some cases, health plans can meet federal network adequacy standards for residents of a particular community without contracting with a rural provider in that community.²⁴

Many considerations underlie the issues of network adequacy standards, rural access to care, and the impact of standards on local providers and the rural health system.²⁵ On the one hand, standards that are too stringent will discourage health plans from offering coverage in rural communities if they face difficulties meeting those standards or will put upward pressure on premiums if health plans are able to meet them. On the other hand, without meaningful access, cost, and quality standards, health insurance products will not meet most consumers’ needs and are less likely to be purchased. Either situation threatens the stability of the local insurance market. Network adequacy standards also have implications for the local rural health system. Standards that are too flexible could result in essential community providers being excluded from plans that would otherwise offer an important source of revenue, potentially threatening the financial viability of the local health care infrastructure.

The Challenge of Forming Rural Provider Networks. One element influencing both a health plan’s ability to form provider networks and subsequent costs to consumers (in the form of either premiums or cost-sharing mechanisms such as co-pays) is the ability to negotiate favorable prices with providers. Theoretically, a well-functioning market requires multiple purchasers (health plans as purchasers) and providers (local health care organizations, including hospitals and clinics). Where that is not the case, we can expect claims of market power causing one or both sides (health plans and providers) to opt out of negotiations, faulting the other side for being arbitrary (“take it or leave it”) in their negotiating posture. Such has been the case vis à vis health plan entry into rural areas. The debate regarding appropriate pricing surfaced in media and other outlets in the context of concern that many rural counties would be without any HIM or MA plan offerings or at best only one choice. Direct comments from insurance executives and a report showing higher medical costs associated with rural residents were featured in a *Wall Street Journal* story in 2016.²⁶ But a subsequent story in *Modern Healthcare*²⁷ countered with statements from hospital executives in the state of Washington indicating they were able to negotiate with the dominant health insurance firm on price, speculating that the insurance firm was leaving the local market for other reasons. The issue is summarized by Brandt and Rivlin of the Brookings Institute: “In rural counties with few providers, it was inherently difficult for

insurers to form networks and to negotiate lower prices with providers who were often the only providers in the area.”²⁸

How Policies Impact Negotiation Power. The challenges to both providers and insurance plans in negotiating payment rates is evident in the MA program. Rural providers, including CAHs and Medicare Dependent Hospitals (MDHs), may not be deemed essential community providers with whom MA plans must contract to serve beneficiaries in rural areas. Where that is true, MA plans often demand discounts to payment rates below traditional Medicare, leaving those hospitals with the choice of accepting that payment or being “out of network.” If the latter, then the hospital will receive the Medicare FFS/PPS rate in payment, which is below what a CAH would receive under cost-based reimbursement. An MDH in New Mexico was recently dropped from the provider network in a UnitedHealthcare plan in such circumstances.²⁹ Some research suggests that MA plans may be avoiding rural places where they would need the local provider in network, in part due to providers demanding higher payment than the MA plan is willing to pay: there are 148 counties with no plans offered in the MA program, all of which are rural.³⁰ In the end, the issue of negotiated rates between rural providers and insurance plans influences affordability of insurance plans (i.e., premiums being higher, as subsidized or paid by the consumer) and availability of plans in the rural market. This situation has led some commentators to blame market failure on rural hospitals in particular as monopolistic actors³¹ or on providers unable to spread fixed costs across a sufficient patient base, driving up cost of care.³² However, the previous discussion may show that the MA plans’ decisions not to enter some rural markets are based on a range of factors, including the sociodemographics of the residents, for example. In a world where all prices must be negotiated in a complex, multifaceted environment, public policies play a role in setting context, as is the case with requirements for network adequacy and payment to out-of-network providers. Further, policies may change the context if means are found to pay for at least some portion of fixed costs rather than expecting full recovery from reimbursements for patient care.

Health Plan Payment Policies to Address Particular Rural Needs

Summary

- Most private health plans seek to negotiate payment arrangements with rural hospitals without regard to the cost structure of those hospitals. Public policy that recognizes the different cost structures must adjust for **different payment arrangements**.
- An efficient alternative to allowing market-based and administrative pricing arrangements to “subsidize” rural providers in an *ad hoc*, untargeted manner is to **allocate public funding** to defer some of the fixed costs of sustaining essential rural health services.

Basis of Payment. As noted above, rural providers and especially rural hospitals often have a very different cost structure resulting from the spreading of essential fixed costs over a

small volume of patients. Public payers such as Medicare and Medicaid fee-for-service programs (and MCOs, if they start with standard Medicare rates) have adopted reimbursement policies that take this cost structure into account. For example, many smaller rural hospitals, including CAHs, are paid on a cost basis, which allows providers to spread their costs across a smaller patient volume. The implicit assumption is that cost-based payment (for allowed costs allocated proportionately to Medicare, and in a majority of states to Medicaid), will be sufficient to sustain essential services in the area. However, most private health plans negotiate their payment arrangements with CAHs and other rural hospitals without regard to the hospital's cost basis.

The MA program (under different names, including Medicare+Choice) has experienced numerous modifications related to payment rates and structures over its history, some of which illustrate the problems inherent in rural provider payments. Payments being made under the program are still, to some extent, bound to this history. Particularly notable was the introduction of a "rural floor payment" in 1997, which was increased significantly in 2000. As mentioned previously, the county is the geographic unit for bidding and contracting in MA. This means that in theory, health plans had some cushion for paying rural providers extra to cover their higher average fixed costs due to the rural payment floor. But given the current bidding structure—insurers bidding against a benchmark, keeping a portion of any underbid amount, and able to charge a premium if their bid exceeds the benchmark—there is a strong incentive to negotiate the lowest possible rates with providers. Thus, the "rural" policy accommodation of the floor is not the most targeted way to address the differing cost structure among rural providers, as it fails to address the reality of high fixed costs in low-volume rural settings. The same can be said for the PPACA benchmark approach that sets higher levels for lower-cost fee-for-service counties (i.e., 115 percent of previous Medicare expenditures in the lowest quartile of counties).

In the MA program, payment policy favors plans with higher quality ratings, and these are predominantly HMO and Local PPO plans, which are more likely to be in urban areas, as opposed to rural areas.³³ This policy is one of the reasons why Medicare HMOs continue to maintain their stronger foothold in urban areas.

Paying for Health System Sustainability and Access. How to sustain a viable rural health system in a market that is increasingly competitive on price and quality is a core policy issue underlying rural hospital payment. The Panel has previously argued that three services—primary care, emergency care, and population health—are essential anchors in a high-performing rural health system. In the context of the current discussion, public and private insurance payment systems have been the primary funding source for these services. As our national policy focus shifts toward an increased reliance on private markets within Medicare and Medicaid, the resulting payments to rural providers may

impact the financial sustainability and hence availability of essential services in rural communities.

Payment policies that may mitigate the problem include the following: paying explicitly for certain services to be included in MA plans (such those included in the Chronic Care Act in the Bipartisan Budget Act of 2018, e.g., in-home services and telehealth); revisiting how the Medical Loss Ratio is determined to allow plans in rural areas to count population-based social services such as meals and transportation as direct medical spending (supporting the health system in part by diversifying paid services while also improving health outcomes and potentially improving access through lower premiums); and Medicaid and Medicare mandating cost-based reimbursement in very specific situations (e.g., in remote locations) to sustain access to essential services. However, it is also worth noting that reliance on cost-based payment, while supporting the rural provider's need to cover fixed costs, also makes value- and incentive-based payment arrangements such as shared savings and linkages to quality outcomes more challenging in rural areas. A policy response to this reality could be payment that helps rural health providers and their community partners transition to services and strategies that promote population health. One such approach gaining momentum is to transition from episode-based reimbursement to global budgeting. More specifically, demonstrations underway in Maryland and Pennsylvania are moving in the direction of all-payer global budget payments to hospitals, and, in the case of Maryland, the demonstration is now expanding to include ambulatory sites under the same umbrella budget.^{34,35} These budgets could be set at levels that encompass all costs, fixed and variable, with sufficient flexibility to adapt revenue streams to the circumstances of particular communities.

An alternative to allowing market-based and administrative pricing arrangements to "subsidize" rural providers could be to allocate public funding to defer some of the fixed costs of sustaining essential rural health services. This approach would be a more efficient way to allocate resources, since it would not rely on funds being passed through a complex web of market transactions to be received by the right entities in the right amounts. It would do much to ensure the continued presence of such services in local rural communities. Subsidizing points of access (e.g., taxing authority for hospital districts, direct grants) could be considered. Creating payments that reward improvements in population health at the community level may also be feasible.

CONCLUSION

The fundamental question the RUPRI Panel considers here is how insurance markets can be better structured to enhance rural access to affordable insurance and thus affordable health care. A key part of the question is how to sustain essential local services, recognizing that doing so may mean a different configuration of services than is currently in place.

Whether this difference means modifying contract arrangements and payments to private plans so that they are incentivized or required to help sustain essential local services, or developing a different system of direct payment to communities, it is critically important that the question be answered.

In this paper, the RUPRI Panel categorizes the policy issues into three main types: (1) those related to rural insurance risk, (2) those related to provider networks, and (3) those related to rural payment rates and structures. Policy approaches addressing risk include requiring larger geographic rating areas, preventing segmentation of the risk pool, and using risk reinsurance programs. Policy approaches addressing provider networks and payment structures include strengthening network adequacy standards in an environment where local access has been ensured through targeted payment that sustains access to local providers. In other words, to avoid the tradeoff discussed above, whereby strong network adequacy standards diminish affordability for rural consumers, this policy should be paired with a payment policy change that offsets the higher average fixed costs in many rural areas.

Rural places vary a great deal in terms of the severity of the issues we have enumerated in this paper. News headlines about the lack of functionality of market-based programs sometimes imply that it is a “rural” problem, but in fact, it is always a matter of degree of rurality. Because so much of the challenge comes from low population and provider density, these problems are more likely to be manifested in sparsely populated rural counties not adjacent to metropolitan areas. Other factors, including State policies (e.g., insurance regulations, Medicaid managed care and Medicaid expansion status), regional differences, cultural differences, and local health care system history may also play roles in mitigating or aggravating the problems described above.

The most immediately achievable policy successes would probably come from (1) risk reinsurance programs designed at least in part to encourage insurers to operate in low-population, rural areas; (2) changes to the structure and regulation of geographic rating areas, with better attention to the challenges faced by low-population areas; and (3) targeting any available “rural development” funds (e.g., U.S. Department of Agriculture, State economic development programs) to offset certain fixed health care costs such as infrastructure, thereby supporting and strengthening local community providers.

Beyond those immediate changes, lessons learned from the demonstrations underway in global budgeting (Maryland, Pennsylvania, Washington, Vermont) and other payment redesign demonstrations as they arise, may lead to payment arrangements that both stabilize the local health care infrastructure and create a more favorable context for contract negotiations between insurance plans and local providers. Other State or Federal policies could be developed that would affect the context for insurance markets, including payment reform and changes to rating area design and network adequacy regulations. It

would also likely take time to determine whether other approaches, such as invisible risk sharing, could be effective, and if so to create the policies that would implement them.

Ultimately, it is critical to continue this dialogue, informing it with timely research and providing “real time” analysis of options brought forward by policymakers and other stakeholders. Evaluating the options will require a rural-specific lens to determine whether they would successfully address rural needs.

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