

# RUPRI Center for Rural Health Policy Analysis

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## **Rural Enrollment in Health Insurance Marketplaces, by State**

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### **Purpose**

Since passage of the Patient Protection and Affordable Care Act (ACA), much attention has been focused on the functioning of Health Insurance Marketplaces (HIMs). In this brief, cumulative county-level enrollment in HIMs through March 2015 is presented for state HIMs operated as Federally Facilitated Marketplaces (FFMs) and Federally Supported State-Based Marketplaces (FS-SBMs). We provide comparisons between enrollment in urban and rural areas of each state and corresponding percentages of "potential market" participants enrolled. Given differences in populations eligible for HIM enrollment, we analyzed Medicaid expansion states separately. This analysis provides a gauge of how well outreach and enrollment efforts are proceeding in the states.

### **Key Findings**

- Overall, people living in metropolitan areas were more likely to enroll in HIMs than were people in non-metropolitan areas, as 38.9 percent of potentially eligible metropolitan residents in Medicaid expansion states and 47.5 percent in non-expansion states were enrolled in HIMs, compared to 33.9 percent and 37.3 percent in nonmetropolitan areas, respectively.
- Estimated enrollment rates varied considerably across the United States. In particular, estimated enrollment rates in non-metropolitan areas are higher than in metropolitan areas in Illinois, Maine, Michigan, Montana, Nebraska, Nevada, New Hampshire, North Dakota, Wisconsin, and Wyoming.
- The states with the highest rural enrollment percentages were Maine, Michigan, Montana, North Carolina, New Hampshire, South Carolina, and Wisconsin. States with high absolute rural enrollment were about as likely to be Medicaid expansion states to be as non-expansion states, and they were slightly less likely to belong to the South census region.

### **Introduction**

HIMs, established by the ACA, were first implemented in 2014, with individuals enrolling in Fall 2013, leading to an overall enrollment of over eight million Americans into HIM plans in 2014.<sup>1</sup> HIM enrollment, along with Medicaid expansion in a number of states, contributed to a 26 percent reduction in the overall uninsured rate nationally in 2014, from 20.3% to 15.1%.<sup>2</sup> Preliminary estimates using aggregated 2015 enrollment data show that nearly 10.2 million Americans were insured through HIMs in March 2015.

Analysis of 2014 HIM enrollment data at the ZIP Code level released publicly by the Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services indicated that rural populations enrolled at lower rates than urban populations.<sup>3</sup> However, these data were censored for records below 50 enrollees, meaning that approximately 60 percent of all ZIP Codes were censored. Because these ZIP Codes are likely in rural areas, it is difficult to conduct detailed rural analysis with the censored data.



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The analysis presented in this brief is based on newly released uncensored county-level enrollment data for 2015 for all state HIMs operated as FFMs and FS-SBMs and therefore provides a more detailed description of enrollment trends in rural places.<sup>4</sup> Data for State-Based Marketplaces were unavailable for this analysis.<sup>5</sup>

## Data and Methods

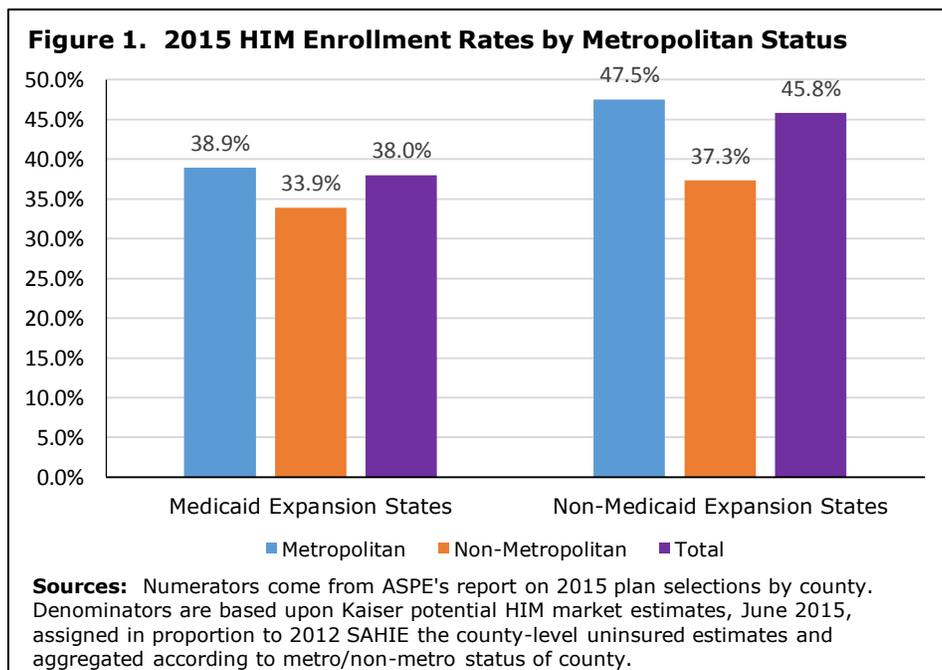
An ideal assessment of HIM success over the past two years would compare enrollment data to county-level measures of potential enrollees. We use Kaiser Family Foundation statewide estimates of the numbers of uninsured citizens whose incomes were above 100 percent of the Federal Poverty Level (FPL) in states without Medicaid expansion and above 138 percent of FPL in states with Medicaid expansion.<sup>6</sup> The numbers exclude people who had offers of employer-sponsored coverage and include people who participated in the non-group (direct purchase) market.<sup>7</sup> To allocate those statewide totals to metropolitan and non-metropolitan counties, we used the 2013 Small Area Health Insurance Estimates (SAHIE), which are county-level estimates of the uninsured by income category. Note that SAHIE data give rates above and below 138 percent FPL; there is no information on numbers of uninsured above and below 100 percent FPL. So, for non-expansion states, these data do not adequately capture the size of the potential market. Our method assumes that within a given state, the uninsured above 100 percent FPL and the uninsured above 138 percent FPL are distributed proportionally.<sup>8</sup> With this assumption acknowledged, we proceeded to apportion the state-level Kaiser estimate of the potential market to each county by using the SAHIE uninsured rates above 138 percent FPL. We then aggregated these values according to the metropolitan or non-metropolitan status of the county, and we report the enrollment rates as percentages of these aggregates.

In some cases, individuals now enrolled in HIMs could have been previously insured but may have switched in 2014 or 2015 to a HIM plan. Also, SAHIE estimates are reported with a margin of error, as high as 10 percent in low population counties. Kaiser data on potential market enrollees are also estimates, the product of a complex simulation. For all these reasons, our constructed data provide only an imprecise estimate of the number of people potentially seeking HIM coverage. By aggregating county-level enrollment and county-level potential enrollee counts to the state level, by metropolitan and non-metropolitan status, we minimize impact of the issues discussed above (since errors are greater for smaller population units, such as counties).

We separated out enrollment rates for Medicaid expansion and non-expansion states because even though the denominators are the same – the Kaiser estimates of the potential market – the composition of the potential market differs significantly between expansion and non-expansion states. Many of the poorest uninsured individuals, those belonging to the 100-138 percent FPL income group, are eligible for the most generous subsidies and cost sharing: annual premiums capped at 2 percent of income, with silver plans required to cover 94 percent of expected costs instead of the standard 70 percent. This group is counted as part of the potential market only in non-expansion states.

## Results

Overall, people living in metropolitan areas were more likely to enroll in HIMs than were people in non-metropolitan areas, as 38.9 percent of metropolitan potential market participants in Medicaid expansion states and 47.5 percent in non-Medicaid expansion states enrolled in HIMs, compared to 33.9 percent in non-metropolitan areas, respectively (Figure 1). Of the 35 states studied that have non-metropolitan counties (excluding Delaware and New Jersey), 25 had higher enrollment rates among their metropolitan populations. As the aggregate differences in Table 1 suggest, metropolitan and non-metropolitan rates in Medicaid expansion states tended to be similar in general, though somewhat lower in non-metropolitan counties.



**Table 1. 2015 Cumulative Enrollment in ACA Marketplaces in Federally-Facilitated Marketplace States, by Metropolitan/Non-Metropolitan Status and as a Percent of the Potential Market**

	ALL PERSONS		METROPOLITAN		NON-METROPOLITAN	
<b>MEDICAID EXPANSION STATES</b>						
	Enrolled	Enrolled as a Percent of the Potential Market	Enrolled	Enrolled as a Percent of the Potential Market	Enrolled	Enrolled as a Percent of the Potential Market
Arizona	205,666	32.7%	198,323	33.3%	7,340	22.3%
Arkansas	65,684	25.9%	40,939	25.9%	24,755	25.8%
Delaware	25,036	52.2%	25,037	52.2%	*	*
Illinois	349,487	36.6%	313,242	36.0%	36,241	42.7%
Indiana	219,185	43.3%	173,653	44.7%	45,544	38.7%
Iowa	45,162	20.1%	27,072	21.5%	18,095	18.3%
Michigan	341,183	49.5%	272,557	48.7%	68,628	52.9%
Montana	54,266	44.8%	16,969	41.5%	37,293	46.5%
Nevada	73,596	28.7%	66,850	28.6%	6,746	30.4%
New Hampshire	53,005	51.0%	31,352	49.7%	21,660	53.0%
New Jersey	254,316	43.2%	254,309	43.2%	*	*
New Mexico	52,358	33.6%	36,889	35.1%	15,469	30.3%
North Dakota	18,171	23.3%	7,532	21.9%	10,646	24.4%
Ohio	234,341	25.1%	192,219	26.2%	42,125	21.4%
Oregon	112,024	34.6%	94,421	35.3%	17,601	30.9%
Pennsylvania	472,697	52.6%	430,381	54.3%	42,310	39.6%
West Virginia	33,421	31.5%	20,410	32.0%	13,008	30.8%
<b>TOTAL</b>	<b>2,609,598</b>	<b>38.0%</b>	<b>2,202,155</b>	<b>38.9%</b>	<b>407,461</b>	<b>33.9%</b>
<b>NON-MEDICAID EXPANSION STATES</b>						
Alabama	171,641	38.1%	133,726	39.4%	37,911	34.3%
Alaska	21,260	24.4%	13,796	24.9%	7,460	23.5%
Florida	1,596,296	63.7%	1,564,996	64.5%	31,303	40.1%
Georgia	541,080	49.6%	472,427	51.4%	68,631	39.8%
Kansas	96,197	39.3%	69,370	43.7%	26,821	31.1%
Louisiana	186,277	35.5%	161,926	36.7%	24,335	29.4%
Maine	74,805	60.3%	40,350	58.1%	34,453	63.2%
Mississippi	104,538	36.8%	57,513	43.4%	47,018	31.1%
Missouri	253,430	39.7%	192,180	41.3%	61,252	35.3%
Nebraska	74,152	31.6%	41,073	27.9%	33,068	37.7%
North Carolina	560,357	51.1%	441,489	52.0%	118,856	47.9%
Oklahoma	126,115	31.7%	88,821	34.6%	37,294	26.4%
South Carolina	210,331	47.7%	180,634	48.0%	29,707	46.1%
South Dakota	21,393	21.2%	9,957	21.3%	11,436	21.1%
Tennessee	231,440	40.0%	179,736	40.1%	51,697	39.6%
Texas	1,205,174	39.4%	1,104,246	40.5%	101,287	30.4%
Utah	140,612	37.4%	124,277	37.6%	16,335	36.1%
Virginia	385,154	46.3%	339,172	46.7%	45,987	43.7%
Wisconsin	207,349	43.4%	140,624	40.7%	66,720	50.3%
Wyoming	21,092	32.5%	4,833	26.0%	16,257	35.0%
<b>TOTAL</b>	<b>6,228,693</b>	<b>45.8%</b>	<b>5,361,146</b>	<b>47.5%</b>	<b>867,828</b>	<b>37.3%</b>

Denominator uses Kaiser's state-level estimates of potential market participants, including the uninsured with incomes above 100% or 138% of the Federal Poverty Level(FPL) for non-Medicaid expansion and Medicaid expansion states, respectively. This number is apportioned across counties using SAHIE uninsured data and aggregated across metropolitan or non-metropolitan counties. Kaiser potential market estimates include those previously enrolled in non-group, direct purchase coverage. Additionally, estimates are subject to sampling and statistical error.

\* Note that Delaware and New Jersey have no non-metropolitan counties.

In fact, about two-fifths of expansion states showed higher rates of enrollment for non-metropolitan counties, while in non-expansion states, the proportion was only one-fifth. Furthermore, four of the five states with the highest differentials (states in which metropolitan enrollment significantly outpaced non-metropolitan enrollment) were non-expansion states: Florida, Georgia, Kansas, and Mississippi all show large enrollment differences, as did Pennsylvania in the Medicaid expansion group.

Certain states in both the Medicaid expansion and the non-expansion groups did relatively well enrolling non-metropolitan residents. Illinois, Maine, Michigan, Montana, Nebraska, New Hampshire, North Dakota, Wisconsin, and Wyoming all posted significantly higher rates in non-metropolitan areas. Six of these states have rural populations greater than one-third of their total population, and the four states with the highest percentages of rural noncore (non-metropolitan) populations are all among this group. Since enrollment is partially probably dependent on outreach efforts, and these efforts are more likely to be tailored to reach rural residents if they are deployed in a state that is predominately rural, it makes sense that the results exhibited this trend. This hypothesis warrants further examination.

The states that achieved the highest absolute enrollment rates for rural populations were Maine, Michigan, Montana, North Carolina, New Hampshire, South Carolina, and Wisconsin, all of which had non-metropolitan enrollment rates above 45 percent. There is no particular pattern in terms of the degree of rurality, as Maine and Montana are the two states with the greatest percentage of rural noncore populations, while the others vary widely in this regard. Three are Medicaid expansion states, which is proportional. Only two of the seven are from the South census region, which is slightly low representation, considering that 14 of the 37 states in the sample are in that census region. Other than these tentative patterns, this analysis shows that there is wide variation in non-metropolitan enrollment rates across the FFM states; thus each state must be studied individually to determine causes for its success or lack of success in enrolling non-metropolitan residents.

## Discussion

The data and analysis presented here indicate that, state by state, non-metropolitan enrollment in HIMs is keeping pace with metropolitan enrollment in about half the states, and that states with larger non-metropolitan populations may have an advantage in this regard, possibly due to outreach strategies in effect in those places. The effect of Medicaid expansion on proportions of non-metropolitan and metropolitan HIM enrollment is mixed, with several Medicaid expansion states showing roughly equal results between metropolitan and non-metropolitan populations, but with some non-Medicaid expansion states showing the best enrollment rates in absolute terms. This finding is likely due to the intrinsically different pools of potential enrollees across these categories, especially the differing effective costs they face as they consider enrolling in an HIM plan. Given that individuals with incomes right above the poverty line are potentially eligible for some of the highest subsidies, there are more potential eligibles who would receive the most generous level of premium assistance in the non-Medicaid expansion states, which suggests that outreach efforts targeting these individuals and helping them calculate how low their costs might be is a strategy that could relatively easily boost enrollment. In states where non-metropolitan enrollment has lagged substantially behind metropolitan enrollment, such as in Florida, Georgia, Kansas, Mississippi, and Texas, such efforts could be intensified in non-metropolitan areas.

Overall, these data help identify places that may benefit from rural-specific outreach, as well as places that may have implemented successful strategies already. In particular, these findings could be used in research pairing states whose unbalanced enrollment rates suggest a rural disparity with geographically similar and proximate states that have more balanced enrollment rates in order to study the differences in demographics, health insurance literacy, and outreach efforts that may be driving the results. Approaches could then be replicated to achieve more equal levels of enrollment.

## Notes

<sup>1</sup> [http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib\\_2014Apr\\_enrollment.pdf](http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf)

<sup>2</sup> [http://aspe.hhs.gov/health/reports/2014/InsuranceEstimates/ib\\_InsuranceEstimates.pdf](http://aspe.hhs.gov/health/reports/2014/InsuranceEstimates/ib_InsuranceEstimates.pdf)

<sup>3</sup> Holmes, M. et al., "Geographic Variation in Plan Uptake in the Federally Facilitated Marketplace." NC Rural Health Research Program. September 2014. Available at [http://www.shepscenter.unc.edu/wp-content/uploads/2014/09/EnrollmentFFMSeptember\\_rvOct2014.pdf](http://www.shepscenter.unc.edu/wp-content/uploads/2014/09/EnrollmentFFMSeptember_rvOct2014.pdf)

<sup>4</sup> Data available at <http://aspe.hhs.gov/basic-report/2015-plan-selections-county-health-insurance-marketplace>

<sup>5</sup> SBMs operate in California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont, and Washington.

<sup>6</sup> Accessed June 3, 2015 at <http://kff.org/health-reform/state-indicator/marketplace-enrollment-as-a-share-of-the-potential-marketplace-population-2015/>

<sup>7</sup> For more details on Kaiser's methodology, see <https://kaiserfamilyfoundation.files.wordpress.com/2014/11/8509-methodology-for-estimating-subsidy-eligible-individuals.pdf>.

<sup>8</sup> In other words, there will be little difference in the distribution of who are uninsured and below 138 percent FPL across counties and the distribution of those who are uninsured and below 100 percent FPL across counties. If a particular county contains 5 percent of the statewide uninsured with incomes below 138 percent FPL, then we assume that county contains 5 percent of the statewide uninsured with incomes below 100 percent FPL.