

# RUPRI Center for Rural Health Policy Analysis

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## 2016 Rural Enrollment in Health Insurance Marketplaces, by State

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### Purpose

In this brief, cumulative county-level enrollment in Health Insurance Marketplaces (HIMs) through March 2016 is presented for state HIMs operated as Federally Facilitated Marketplaces (FFMs) and for those operated as Federally Supported State-Based Marketplaces (FS-SBMs). Enrollment rates in metropolitan and non-metropolitan areas of each state, defined as the percentage of “potential market” participants selecting plans, are presented. Monitoring annual enrollment rates provides a gauge of how well state outreach and enrollment efforts are proceeding and helps identify states with strong non-metropolitan enrollment as models for other states to emulate.

### Key Findings

- Cumulative enrollment in the HIMs in non-metropolitan counties has grown to about 1.4 million in 2016, representing 40 percent of the potential market in non-metropolitan counties.<sup>1</sup>
- Estimated enrollment rates varied considerably across the United States. In particular, estimated enrollment rates in non-metropolitan areas were substantially higher than in metropolitan areas in Hawaii, Illinois, Michigan, Montana, Maine, Nebraska, Wisconsin, and Wyoming.
- The states that achieved the highest absolute non-metropolitan enrollment totals were Michigan, Georgia, Missouri, North Carolina, Texas, and Wisconsin. Of these, Michigan, North Carolina, and Wisconsin also had non-metropolitan enrollment rates above 50 percent.
- About half of all states, evenly distributed by Medicaid expansion status but mostly concentrated in the Midwestern census region, had higher enrollment growth in non-metropolitan areas from 2015 to 2016, and in fact aggregated non-metropolitan growth was greater than metropolitan growth in both expansion categories.

### Introduction

HIMs, established by the Affordable Care Act (ACA), were first implemented in 2014. HIM enrollment, along with Medicaid expansion, contributed to a 43 percent reduction in the overall uninsured rate for non-elderly adults nationally since 2013, from 20.3 percent to 11.5 percent as of March 2016.<sup>2</sup> Estimates using aggregated 2016 enrollment data show that nearly 12.7 million Americans selected plans through HIMs during 2016 open enrollment.<sup>3</sup>



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Uninsured rates in metropolitan and non-metropolitan areas have historically been similar.<sup>4,5</sup> This similarity is a result of a larger percentage of the metropolitan population having been enrolled in employer-sponsored health insurance (57 percent metropolitan vs. 51 percent non-metropolitan between 2012 and 2013), while at the same time, a larger percentage of the nonelderly, non-metropolitan population has been enrolled in public health insurance (25 percent non-metropolitan vs. 19 percent metropolitan).

## **Data and Methods**

The analysis presented in this brief was based on county-level plan selection data for 2016 for all state HIMs operated as FFMs and FS-SBMs and therefore provides a detailed description of enrollment trends in non-metropolitan areas.<sup>6</sup> Data for State-Based Marketplaces were unavailable for this analysis.<sup>7</sup> Also note that effectuated enrollment rates are lower in general and may differ across geographic areas.

An ideal assessment of HIM success over the past two years would compare enrollment data to county-level measures of potential enrollees. We used Kaiser Family Foundation statewide estimates of the numbers of uninsured citizens whose incomes were above 100 percent of the Federal Poverty Level (FPL) in non-expansion states and above 138 percent of the FPL in expansion states.<sup>8</sup> The numbers exclude people who had offers of employer-sponsored coverage and include people who participated in the non-group (direct purchase) market, as well as children eligible for Medicaid or CHIP at higher FPL percentages.<sup>9</sup> To allocate those statewide totals to metropolitan and non-metropolitan counties, we used the 2014 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. Therefore, these data do not adequately capture the size of the potential market in non-expansion states. Our method assumes that within a given state, the uninsured above 100 percent FPL and the uninsured above 138 percent FPL are distributed proportionally, and that non-group enrollees also follow this distribution.<sup>10</sup> With these assumptions acknowledged, we apportioned the state-level Kaiser estimate of the potential market to each county using the SAHIE uninsured rates above 138 percent FPL. We then aggregated these values according to metropolitan or non-metropolitan county status, and we report both 2015 and 2016 enrollment rates as percentages of these aggregates.

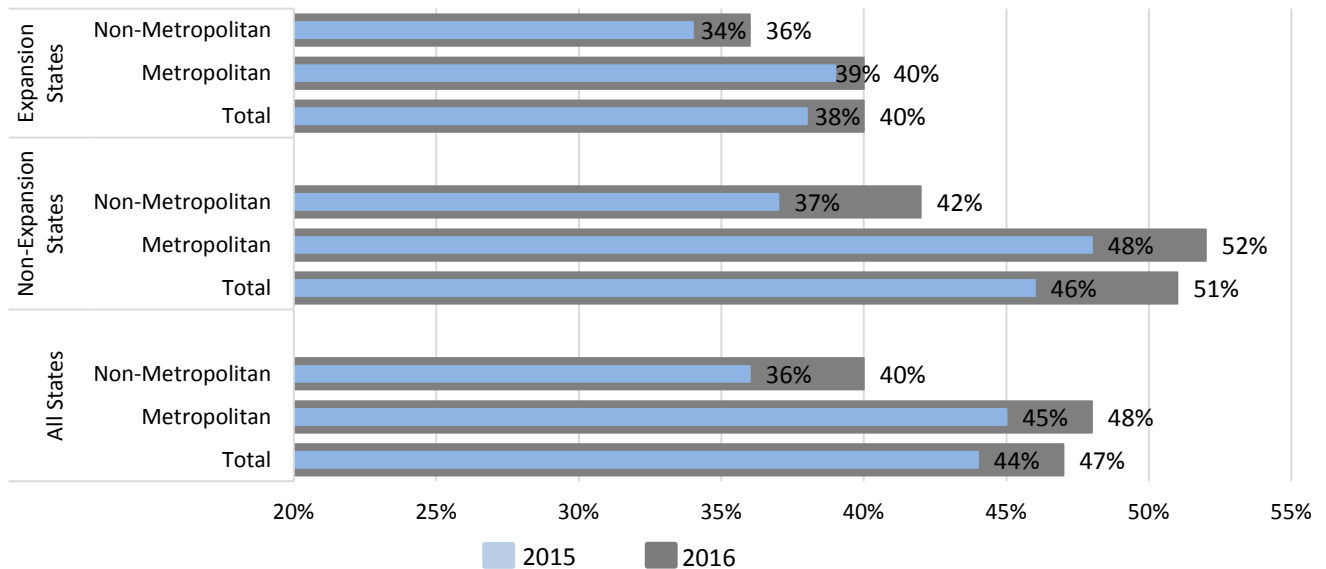
Note that individuals now enrolled in HIMs could have been previously insured but switched in 2014 or later to a HIM plan. Also, SAHIE estimates are reported with a margin of error, as high as 10 percent in low population counties. Kaiser data on potential market enrollees are also estimates, the product 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 enrollment rates for Medicaid expansion and non-expansion states<sup>11</sup> because the composition of the potential market differs significantly between expansion and non-expansion states. A portion of the uninsured individuals with the lowest incomes, those belonging to the 100-138 percent FPL income group, are eligible for the most generous subsidies and cost sharing reductions in the HIM in non-expansion states, but are eligible for Medicaid coverage in expansion states. In addition, this group is eligible for 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, 40 percent of the potentially eligible nonmetropolitan residents were enrolled in the HIMS in 2016, an increase from 36 percent in 2015 (Figure 1). People in nonmetropolitan areas were somewhat less likely to enroll in HIMS, as compared to people living in metropolitan areas (40 percent as compared to 48 percent, respectively) although the gap is smaller in Medicaid expansion states (Figure 1). Of the 36 states studied that have non-metropolitan counties (excluding Delaware and New Jersey), 23 had higher metropolitan enrollment rates (Table 1); in fact, one-half of expansion states showed higher enrollment rates for non-metropolitan counties, while in non-expansion states, the proportion was only one-fourth.

**Figure 1. 2015-16 HIM Enrollment Rates as a Percent of the Potential Market, by Metropolitan and Expansion Status**



Furthermore, six of the eight states with the highest differentials (states in which metropolitan enrollment substantially outpaced non-metropolitan enrollment) were non-expansion states: Florida, Georgia, Kansas, Mississippi, Oklahoma, and Texas all showed large enrollment differences, as did Pennsylvania and Arizona in the Medicaid expansion group.

Certain states in both the Medicaid expansion and the non-expansion groups did well in enrolling non-metropolitan residents. Hawaii, Illinois, Michigan, Montana, Maine, Nebraska, Wisconsin, and Wyoming all posted substantially higher rates in non-metropolitan areas.

The states that achieved the highest absolute non-metropolitan enrollment totals were Michigan, Georgia, Missouri, North Carolina, Texas, and Wisconsin. Of these, Michigan, North Carolina, and Wisconsin also had non-metropolitan enrollment rates above 50 percent. There seems to be no particular pattern in terms of the degree of rurality of the state being associated with high or low performance. Of these states, three are Medicaid expansion states, which is proportional. None of the six are from the South census region, even though 14 of the 38 states in the sample are in that census region. Also noteworthy is the fact that growth between 2015 and 2016 was greater overall in non-metropolitan than metropolitan areas in both expansion and non-expansion states.

**Table 1: 2016 Cumulative Enrollment and Enrollment Growth 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		
	Enrolled in 2016	Enrolled as a Percent of the Potential	Percent Change in Enrollment, 2015-16	Enrolled in 2016	Enrolled as a Percent of the Potential	Percent Change in Enrollment, 2015-16	Enrolled in 2016	Enrolled as a Percent of the Potential	Percent Change in Enrollment, 2015-16
<b>MEDICAID EXPANSION STATES</b>									
Arizona	203,064	32.3%	-1.3%	195,506	32.9%	-1.4%	7,558	23.0%	3.0%
Arkansas	73,643	29.0%	12.1%	45,737	28.9%	11.7%	27,906	29.1%	12.7%
Delaware	28,256	58.9%	12.9%	28,256	58.9%	12.9%	*	*	*
Hawaii **	14,564	28.0%	n/a	10,332	25.6%	n/a	4,232	36.5%	n/a
Illinois	388,176	40.7%	11.1%	346,545	39.9%	10.6%	41,631	49.0%	14.9%
Indiana	196,241	38.8%	-10.5%	155,104	39.9%	-10.7%	41,137	35.0%	-9.7%
Iowa	55,088	24.5%	22.0%	32,142	25.5%	18.7%	22,946	23.2%	26.8%
Michigan	345,804	50.2%	1.4%	274,176	49.0%	0.6%	71,628	55.2%	4.4%
Montana	58,112	48.0%	7.1%	17,701	43.3%	4.3%	40,411	50.4%	8.4%
Nevada	88,142	34.4%	19.8%	80,198	34.3%	20.0%	7,944	35.8%	17.8%
New Hampshire	55,183	53.1%	4.1%	32,819	52.0%	4.7%	22,364	54.7%	3.3%
New Jersey	288,571	49.0%	13.5%	288,571	49.0%	13.5%	*	*	*
New Mexico	54,863	35.2%	4.8%	38,838	37.0%	5.3%	16,025	31.4%	3.6%
North Dakota	21,604	27.7%	18.8%	9,046	26.3%	20.1%	12,558	28.8%	18.0%
Ohio	243,714	26.1%	4.0%	198,462	27.0%	3.2%	45,252	23.0%	7.4%
Oregon	147,108	45.4%	31.3%	123,997	46.4%	31.3%	23,111	40.6%	31.3%
Pennsylvania	439,235	48.9%	-7.1%	397,995	50.2%	-7.5%	41,240	38.6%	-2.5%
West Virginia	37,284	35.2%	11.6%	22,675	35.6%	11.1%	14,609	34.6%	12.3%
<b>SUBTOTAL</b>	<b>2,738,652</b>	<b>39.6%</b>	<b>4.9%</b>	<b>2,298,100</b>	<b>40.3%</b>	<b>4.4%</b>	<b>440,552</b>	<b>36.3%</b>	<b>8.1%</b>
<b>NON-MEDICAID EXPANSION STATES</b>									
Alabama	195,047	43.3%	13.6%	151,745	44.7%	13.5%	43,302	39.2%	14.2%
Alaska	23,028	26.5%	8.3%	15,084	27.3%	9.3%	7,944	25.1%	6.5%
Florida	1,742,806	69.6%	9.2%	1,706,920	70.4%	9.1%	35,886	46.0%	14.6%
Georgia	587,833	53.9%	8.6%	510,741	55.6%	8.1%	77,092	44.7%	12.3%
Kansas	101,553	41.5%	5.6%	71,285	44.9%	2.8%	30,268	35.2%	12.9%
Louisiana	214,143	40.9%	15.0%	184,929	41.9%	14.2%	29,214	35.3%	20.0%
Maine	84,059	67.8%	12.4%	45,170	65.0%	11.9%	38,889	71.3%	12.9%
Mississippi	108,668	38.3%	4.0%	57,206	43.2%	-0.5%	51,462	34.0%	9.5%
Missouri	290,197	45.4%	14.5%	220,409	47.4%	14.7%	69,788	40.2%	13.9%
Nebraska	87,824	37.4%	18.5%	47,575	32.3%	15.8%	40,249	45.9%	21.7%
North Carolina	613,477	55.9%	9.5%	489,250	57.6%	10.8%	124,227	50.1%	4.5%
Oklahoma	145,328	36.5%	15.2%	101,942	39.7%	14.8%	43,386	30.7%	16.3%
South Carolina	231,845	52.6%	10.2%	200,629	53.3%	11.1%	31,216	48.4%	5.1%
South Dakota	25,994	25.7%	21.5%	11,644	24.9%	16.9%	14,350	26.4%	25.5%
Tennessee	268,860	46.4%	16.2%	210,915	47.0%	17.3%	57,945	44.4%	12.1%
Texas	1,306,189	42.7%	8.4%	1,191,803	43.7%	7.9%	114,386	34.4%	13.3%
Utah	175,633	46.7%	24.9%	155,972	47.1%	25.5%	19,661	43.5%	20.4%
Virginia	421,892	50.8%	9.5%	372,307	51.3%	9.8%	49,585	47.1%	7.8%
Wisconsin	239,031	50.0%	15.3%	164,237	47.5%	16.8%	74,794	56.4%	12.1%
Wyoming	23,770	36.6%	12.7%	5,460	29.4%	13.0%	18,310	39.5%	12.6%
<b>SUBTOTAL</b>	<b>6,887,177</b>	<b>50.6%</b>	<b>10.6%</b>	<b>5,915,223</b>	<b>52.4%</b>	<b>10.3%</b>	<b>971,954</b>	<b>41.7%</b>	<b>12.0%</b>
<b>TOTAL</b>	<b>9,625,829</b>	<b>46.9%</b>	<b>8.9%</b>	<b>8,213,323</b>	<b>48.3%</b>	<b>8.6%</b>	<b>1,412,506</b>	<b>39.9%</b>	<b>10.8%</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. \*\* Enrollment data for Hawaii are available in 2016 only.

## Discussion

Overall, this analysis shows that in the aggregate, enrollment in HIMs in nonmetropolitan areas has grown in both expansion and non-expansion categories between 2015 and 2016. On average, HIM enrollment has been more robust in metropolitan areas, but this average masks a wide degree of variability. This geographic differential has occurred in other recent policies that implement private plan choices – in particular, the Medicare Advantage program – but enrollment rate differential is of lesser magnitude.<sup>12</sup> Furthermore, in expansion states, non-metropolitan enrollment better kept pace with metropolitan enrollment when states were analyzed both individually and in the aggregate. This finding could be a result of greater outreach, more positive attitudes towards the ACA, political leanings, and/or demographic differences in non-metropolitan areas between expansion and non-expansion states. Differences in prices and other market characteristics could also play a role. Reaching extremely low-income populations and convincing them of the value of private health insurance (even when heavily subsidized) may pose special challenges.

Furthermore, non-expansion states were less likely to have experienced enrollment decreases and had higher percent change overall than expansion states. This finding is likely the result of individuals in non-expansion states between 100 and 138 of the FPL being eligible for larger subsidies to enroll in HIMs instead of enrolling in Medicaid, and having fewer opportunities for coverage outside the HIMs. In addition, states with high non-metropolitan enrollment growth (relative to metropolitan) were proportionally allocated between expansion and non-expansion states, but concentrated more heavily in the Midwest census region. It is also worth noting that in general, a county in which income is concentrated between 100 and 200 percent FPL is more likely to have strong enrollment because the subsidized price is so low, while the benefits are more generous than what could be purchased in the absence of the subsidy.

The data presented in this brief could help target increased non-metropolitan outreach efforts in specific states with low non-metropolitan HIM enrollment. In addition, lessons may be learned from states with successful non-metropolitan enrollment programs that have more balanced metropolitan and non-metropolitan enrollment rates.

## Notes

<sup>1</sup> These results use a county-based definition of rural places (see Note 4). Using a zip-code based definition of rural places, ASPE reports cumulative rural enrollment as 1.7 million as of the same period. See Avery K, Finegold K, Xiao X, *Impact of the Affordable Care Act Coverage Expansion on Rural and Urban Populations* (Issue Brief). Washington, DC: Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. <https://aspe.hhs.gov/sites/default/files/pdf/204986/ACARuralbrief.pdf>

<sup>2</sup> Uberoi N, Finegold K, Gee E. *Health Insurance Coverage and the Affordable Care Act, 2010-2016* (Issue Brief). Washington, DC: Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. <https://aspe.hhs.gov/sites/default/files/pdf/187551/ACA2010-2016.pdf>

<sup>3</sup> *Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report, March 11, 2016* (Issue Brief). Washington, DC: Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. <https://aspe.hhs.gov/sites/default/files/pdf/187866/Finalenrollment2016.pdf>

<sup>4</sup> Metropolitan status was defined as 2013 Urban Influence Codes of 1 or 2; non-metropolitan status was a UIC of 3 or greater.

<sup>5</sup> Newkirk V, Damico A. *The Affordable Care Act and Insurance Coverage in Rural Areas* (Issue Brief). Menlo Park, CA: Henry J. Kaiser Family Foundation; May 2014. <http://kff.org/uninsured/issue-brief/the-affordable-care-act-and-insurance-coverage-in-rural-areas/>

<sup>6</sup> Data available at <https://aspe.hhs.gov/basic-report/plan-selections-zip-code-and-county-health-insurance-marketplace-march-2016>

<sup>7</sup> In 2016, SBMs were operated in California, Colorado, Connecticut, District of Columbia, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont, and Washington.

<sup>8</sup> Marketplace Enrollment as a Share of the Potential Marketplace Population. Menlo Park, CA: Henry J. Kaiser Family Foundation. <http://kff.org/health-reform/state-indicator/marketplace-enrollment-as-a-share-of-the-potential-marketplace-population-2015/>

<sup>9</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>10</sup> In other words, there will be little difference across counties in the distribution of uninsured and below 138 percent FPL and the distribution of uninsured and below 100 percent FPL. 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.

<sup>11</sup> Expansion status is as of January 1, 2016. Louisiana subsequently expanded Medicaid in July 2016.

<sup>12</sup> In March 2016, 33.6% of metropolitan and 21.8% of non-metropolitan residents eligible for Medicare enrolled in Medicare Advantage. See Ullrich, F. and Mueller, K. Medicare Advantage Enrollment Update, September 2016, available at <http://www.public-health.uiowa.edu/rupri/publications/policybriefs/2016/Medicare%20Advantage%20Enrollment%20Update%202016.pdf> for details.