

# Affordable Insurance Exchanges and Enrollment: Meeting Rural Needs

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## Introduction

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Many states have begun the planning processes to establish the Affordable Insurance Exchanges (Exchanges), provided for in the Patient Protection and Affordable Care Act (ACA), in order to have plans for Exchanges approved in early 2013 and operational in 2014. Exchanges will manage the health insurance market through which low-income households can purchase individual/family insurance and gain access to tax credits to subsidize premiums. Exchanges will also manage the market for small firms to select health plans and receive tax credits toward premium costs. Given the profile of the currently uninsured in rural America (e.g., unemployed or working in low-wage jobs in small businesses), the characteristics of Exchanges will be especially important to the policy objective of expanding access to affordable health insurance and enrollment into health plans. This paper reviews the principal characteristics of Exchanges that will affect how well they meet the needs of rural residents, including the structure, governance, and process for enrollment.

## Background

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The purpose of Exchanges is to ease the process of purchasing and enrolling in health plans, and increase access to affordable health insurance. Exchanges are integral to achieving two of the main goals of health reform: guaranteeing that health insurance is affordable to individuals at all income levels (including those eligible for federal subsidies), and ensuring that individuals and small businesses can make logical and transparent choices through an organized and sortable health insurance marketplace [1]. Individuals earning up to four times the federal poverty level may be eligible for subsidies on plans offered through an Exchange, depending on state and federal regulations [2]. Exchanges will provide web-based portals for individuals and small businesses to use in selecting among health plan options. Exchanges must include these minimum functions: operating a website and a toll-free hotline, health plan certification and disclosure, and facilitating enrollment and determining eligibility for premium subsidies and cost-sharing subsidies [3].

States have until January 2014 to establish an operating Exchange. However, if a state fails or chooses not to establish an Exchange, Section 1321(c)(1)(B) of the ACA gives the US Department of Health and Human Services (HHS) the power to not only create, but also operate, an Exchange for that state. State plans for Exchanges must be reviewed and certified by the federal government no later than January 2013. If the HHS Secretary determines on or before January 2013 that a state will not have an Exchange operational by 2014, the Secretary may begin action to set up an Exchange for the state. States have the option of creating an Exchange operated solely within the state or collaborating with other states to form a larger Exchange [4]. Alternatively, states may create multiple Exchanges within their state. For example, Illinois could establish one Exchange for the greater Chicago metropolitan area and another Exchange for the rest of the state [5]. States may also create separate Exchanges for businesses with fewer than 100 employees and for individuals.

While definitive information about how Exchanges will be formed and operated in all states is not available, lessons can be gleaned from states presently operating an Exchange system and from previous health policy activities. Most of the research specific to Exchanges has been drawn from experiences in Massachusetts and Utah. The implementation of Medicare Part D can also be instructive since it too expanded access to insurance benefits through private plans by providing publicly funded premium subsidies. Particular attention is given in this paper to the lessons from these experiences that will have implications for improving access to affordable care for rural residents.

## **Key Exchange Characteristics**

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This paper will describe the following key Exchange characteristics affecting rural people and places in the implementation of Exchanges:

- Market function: the state's level of influence over the market
- Governance
- Enrollment
  - Use of navigators
  - Role of providers
  - Medicaid, enrollment periods, and Exchanges
  - Impact of the digital divide
- Access standards
- Insurance plans and Exchange boundaries
- Small Business Health Options Program (SHOP)
- Certification of qualified health plans

The discussion of each characteristic will include a description of decisions that are to be made by each state in designing the Exchanges, and rural implications flowing from those decisions.

### ***Market Function: the State's Level of Influence Over the Market***

States will have to decide how much influence to exert on the insurance market. The current Utah and Massachusetts Exchange programs illustrate the two ends of the influence spectrum. The Massachusetts Connector, on one end of the spectrum, uses the power of certifying health plans to influence directly the nature of the insurance market. The Utah Exchange program, on the other end, uses minimal regulatory and oversight authority, facilitating rather than influencing the insurance market [6]. Massachusetts is an active purchaser of health plans, whereas Utah simply organizes the market.

State designs for Exchanges will have to balance providing effective consumer protections, through the conditions necessary for plans to be certified as Exchange participants, with attracting multiple insurance carriers/plans [6]. States will review submissions from Qualified

Health Plans (QHPs) and certify them as participants in Exchanges based on meeting requirements detailed in state plans.

The approaches taken by California and Colorado to structuring Exchanges and contracting plans also illustrate the spectrum of choices facing states. California decided to take the role of an active purchaser, while Colorado decided to take the role of a clearinghouse [7]. California's Exchange board will selectively contract with health plans to be offered through the Exchange, to ensure that all plans offered have the optimal combination of quality, value, service, and choice [7]. Colorado will not actively purchase or solicit bids for insurance plans, and all insurance providers who conduct business within the state will be eligible to participate within the Exchange [7].

States should be expected to align themselves within the spectrum consistent with their political culture. States that prefer little government oversight will likely develop Exchanges that are closer to Utah and Colorado on the spectrum, and states that prefer greater governmental control will likely align themselves with the Massachusetts or California model.

In offering Exchanges, states will be creating insurance markets in rural places that heretofore have seen limited if any coverage competition among insurance plans. The number of plans is expected to rise, and facilitating consumer choice will be especially critical in rural America. The proportion of persons entering the market for the first time is likely to be higher in rural areas than in urban areas, based on the characteristics of the currently uninsured [19]. In addition, greater challenges may exist in disseminating information to rural consumers because of fewer opportunities in rural areas to reach individuals through places where they are likely to congregate. State certification of QHPs creates an opportunity to require outreach to rural residents and access to local providers.

### ***Governance***

Exchanges can be operated by a state government, the federal government, a quasi-public agency, or a private nonprofit group [3]. Private groups may experience difficulty working with government agencies or retrieving data unless called for by law. However, private groups may have some advantages, such as separation from political influence; stronger relationships with private health plans, businesses, and brokers; having the resources to pay for more highly qualified staff; and adaptability [3]. Currently, the only Exchange operated by a nonpublic entity is the Connecticut Business and Industry Association (CBIA) Health Connections [3]. If a state decides to have an Exchange run by a nonprofit or independent agency, stipulations must be put in place to ensure that conflicts of interest do not arise and that financial disclosure and ethical standards are followed [8].

In the proposed rule to implement Exchanges, CMS acknowledges the need for inclusivity in membership on governing bodies and among key stakeholders consulting to the governing bodies. Thus, there will be opportunities to consider input from rural stakeholders in decisions made by Exchanges.

## **Enrollment**

### *Use of Navigators*

The Exchange will provide grant programs for organizations to act as consumer navigators, helping consumers understand the subsidy options and health plan choices within the Exchange [1]. Navigators should ensure outreach efforts are as extensive as possible and should ease the enrollment process for individuals who encounter complications with the online web portal. Navigators will also facilitate enrollment, provide referrals for grievances, provide public education outreach and awareness programs, and respond to questions and complaints [2]. Navigators could include industry, professional, and trade associations; chambers of commerce; small business development centers; unions; consumer- and community-focused nonprofit groups; brokers; and licensed insurance agents (Section 1311 (i)(2)(B) of the ACA).

The roles and duties of navigators include the following:

- Provide public education opportunities and programs to raise awareness about the Exchanges and their benefits [8].
- Provide information about enrollment, tax credits, and cost sharing that is fair and impartial [8].
- Help consumers select QHPs that best meet their needs [8].
- Ensure that all information provided is linguistically and culturally appropriate [8].
- Direct consumers to an ombudsman or consumer assistance program if a complaint, grievance, or question about plans or coverage needs to be addressed [8].

To ensure that the navigator program is sustainable, states must decide how the program will be designed and funded. The proposed rule calls for states to select a minimum of two organizations from a list of potential navigators [8].

States can be specific in requiring Exchanges to make information available to rural residents, by specifying particular means of communication or demanding that QHPs present specific strategies to reach rural residents. Rural-oriented groups will be essential in aiding the enrollment of hard-to-reach individuals [9].

To be successful, an Exchange must facilitate communication in a simple and meaningful way to all parties involved [10], including extensive outreach efforts to rural populations. Navigators selected by Exchanges must have the knowledge and contacts to provide outreach to rural residents. Rural organizations (e.g., local civic organizations) are already familiar with potential outreach challenges that will be present and are knowledgeable in techniques to address them [2]. Rural people are more likely to use information provided to them by rural organizations in making choices among QHPs [2].

Alternative, “outside the box,” strategies may be needed to ensure that demographic groups that are least likely to have insurance are targeted. Young, single males; racial and ethnic minorities; and those whose first language is not English are disproportionately represented among the uninsured [11]. States will have to use a variety of strategies to ensure that as many uninsured individuals as possible are enrolled within the Exchanges. For example, reaching migrant workers may require partnering with farm worker organizations, and reaching the unemployed may require partnering with local human service organizations.

Efforts by the navigators should continue for several years after the Exchanges are in place. Massachusetts’ experience with the Connector program, which is now several years old, shows that despite a potential penalty, many individuals will wait to enroll until they have an immediate health care need or are at a clinic or hospital [6]. Massachusetts has had difficulty getting such individuals to re-enroll a year later once they are again healthy and have little need for health insurance [6]. Not only do navigators have to work to get individuals enrolled, but they also must find ways to encourage individuals to stay enrolled, including helping them renew or choose a different plan in each open enrollment period.

Rural considerations about the navigator programs include the following:

- Conducting outreach in rural areas may be different than conducting outreach in urban areas.
- At least one navigator entity should be a community- and consumer-focused nonprofit organization.
- Standards should be in place relating to information sharing and referral strategies among navigators.
- Navigators should be required to demonstrate efforts that focus on rural residents.

Section 155.220 of the proposed rule details issues surrounding brokers acting as navigators. Brokers and agents in rural areas are likely to have already built trusting relationships with individuals, which could be key to getting those individuals enrolled in the Exchange. Rural individuals have often worked with the same insurance broker for years and rely on them for advice on selecting plans [20]. These brokers and agents could also assist many rural employers in getting their employees enrolled and could assist individuals with applications for advance payments of their premium. The challenge for states will be distinguishing between the brokers’ role as navigators and their role as private insurance brokers, which could create a conflict of interest. As navigators, brokers would receive grants from Exchanges, while as private insurance brokers operating outside of Exchanges, they would receive commissions on plans sold.

#### *Access Standards*

The final rule for Exchanges will include guidance for states to develop and implement standards requiring QHPs to provide reasonable access to essential health care services through

providers in networks with which the QHP contracts. Section 155.1050 of the ACA states, “An Exchange must ensure that the provider network of each QHP offers a sufficient choice of providers for enrollees.” The CMS discussion of the proposed rule calls for network adequacy standards to be responsive to a state’s particular needs, including demographics, geography, or market conditions [12]. Network adequacy standards could include requiring QHPs to contract with rural health safety net providers, such as Critical Access Hospitals, rural health clinics, and Federally Qualified Health Centers [13]. States should promulgate rules that ensure QHPs provide for access to essential services, including primary care and short-term hospitalization.

In order to ensure adequate access to primary care, rules regarding access standards must account for the challenges of delivering health care in rural America. QHPs should contract with as many rural providers as possible to ensure that local physicians are included within an individual’s network. Individuals should also be able to determine which QHPs have a preferred network that includes their current primary care physician and preferred hospitals and pharmacies and whether other local providers (such as hospitals and pharmacies) are included.

#### *Role of Providers*

During the Medicare Part D implementation, many beneficiaries relied on their pharmacist to help them select a plan. Similarly, people seeking to enroll in an Exchange may rely on their primary care providers to help them select a plan. Approximately 30% of beneficiaries enlisted their pharmacist’s help when selecting a Medicare Part D plan [14]. On average, it took these pharmacists a minimum of 30 minutes to help the beneficiary select the best plan for their needs [15]. The navigator program could help by providing a well-publicized and readily accessible source of assistance for beneficiaries. It will be important for the navigators to work with individuals who are eligible to enroll within the Exchange before these individuals seek medical services or, in the absence of a navigator, for local provider offices (e.g., clinics and hospitals) to offer outreach services.

#### *Medicaid, Enrollment, and Exchanges*

Section 155.410 of the proposed rule details parameters and time frames for open enrollment periods. The initial open enrollment period proposed by HHS will be from October 1, 2013, to February 28, 2014. This extended enrollment period will allow for sufficient education and outreach efforts to take place [12]. HHS is seeking comment on future annual enrollment periods. Currently, for subsequent years, HHS is proposing October 15 through December 7, with November 1 through December 15 as the alternative [12]. Section 155.420 details the proposed rules on special enrollment periods. Certain events, such as change in citizenship or immigration status, loss of minimum essential coverage, change in eligibility for cost sharing or premium tax credits, or other circumstances, may trigger an individual’s eligibility for a special enrollment period [12].

In the Exchange Eligibility and Employer Standards proposed rule, standards are placed on how Exchanges must interact with state Medicaid and CHIP programs. Exchanges must coordinate with CHIP and Medicaid to ensure that beneficiaries encounter a seamless experience during the eligibility and enrollment process as they transition from Medicaid or CHIP to private

insurance through the Exchange. This seamless transition must occur regardless of when an individual submits an application. Data must be shared between the Exchange, Medicaid, and CHIP to ensure that individuals are enrolled in the appropriate program.

States should also consider the differences in benefits between their Medicaid plan and the lower tier Exchange plan. Benefits should be the same or greater for the lower tier Exchange plan than for the state Medicaid plan. States may also roll their Medicaid beneficiaries into the Exchange. These considerations are particularly important in rural areas because of the higher relative enrollment in Medicaid [19] and, based on experience with Medicare Advantage, greater complexity and volatility in the private insurance marketplace [21, 22].

### *Impact of the Digital Divide*

One of the chief concerns in designing a web-based portal to access QHPs through the Exchanges is the availability of broadband Internet access in rural America. Rural infrastructure development lags urban areas due to the high cost of providing Internet services across a more dispersed population area [16]. Not only is the cost higher, but the resources needed to expand these services rapidly are not present in many rural areas. Not surprisingly, studies have shown that rural residents are less likely than their urban counterparts to use the Internet [16]. The lack of broadband Internet services in rural America will create a greater need for physical outreach and enrollment strategies by navigators. Print material should also be provided, so that consumers can make educated choices about health plans [13]. Print materials will have to be tied to physical outreach and enrollment strategies to ensure that those with and without Internet access have the same tools to easily compare and sort through health plans [13]. Seek-and-enroll strategies will be critical to getting as many people enrolled in Exchanges as possible, but will be especially important for rural Americans due to limited Internet service and use.

### ***Insurance Plans and Exchange Boundaries***

While the process of choosing plans is generally the same for both rural and urban residents, some issues might hinder a rural resident's ability to select an appropriate plan [17]. As noted during the implementation of Medicare Part D, rural residents are not accustomed to selecting from multiple plans [17]. This may mean that navigators will have to spend more time with rural consumers to help them select the best plan for their health care needs.

States have the authority to create multiple Exchanges that cover different areas of the state [5] or to operate an Exchange in partnership with other states [8]. Separate Exchanges may also be created for small businesses with fewer than 100 employers opting to participate [2]. Each of these situations, or a combination of them, can have multiple implications for enrollment and premium prices. States may consider partnering with other states to collaborate on an Exchange in order to create larger pools of purchasers, which may moderate costs. However, creating multiple Exchanges within a state can increase premium prices if the result is small insurance pool numbers.

Multi-state insurance plans will be offered as a result of contracts between the federal Office of Personnel Management and insurance plans [18]. According to the OPM, multi-state plans can

be offered through a specific Exchange without having to collaborate with a neighboring state's Exchange program. Multi-state plans must meet all of the same requirements as single-state QHPs [18].

Statewide or multi-state Exchanges could ensure that urban and rural premium differences are minimized, the potential for adverse selection is reduced, and an adequate number of individuals are insured within the Exchange [13]. Numerous challenges are present in creating insurance markets in rural areas, mainly due to smaller employers having less purchasing power and the increased risk for adverse selection [13]. Merging the urban and rural insurance markets within the same Exchange may help compress differences (there may still be separate rating areas within an Exchange).

### ***Small Business Health Options Program (SHOP)***

In 2014, the Small Business Health Options Program (SHOP) will be offered through Exchanges [8]. This program allows employers to give their employees new health insurance choices while also allowing employers to make contributions toward their employees' coverage. Employees could have the flexibility to choose the plan that best fits their needs.

States have the option to limit the size of employers that are eligible to participate in SHOP. The program is intended for employers with up to 100 employees, but states have the option of limiting the program to employers with 50 or fewer employees until 2016 [8]. The larger the size of the employer that the state allows to participate in the program, the easier it will be for more individuals to access affordable health insurance. States should be careful when determining the limits on employers, because they must ensure that the insurance pool will be sufficient to help keep premium prices affordable. States also have the option, starting in 2017, to allow larger employers to buy coverage through the program [8].

Small employers have incentives for participating in SHOP rather than finding their own group health plan for their employees or not offering insurance. Beginning in 2014, employers with fewer than 25 employees who pay at least 50% of the premium cost, offer all full-time employees coverage, and pay annual wages less than \$50,000 may be eligible to receive tax credits to cover up to 50% of premium payments used to purchase insurance for their employees [8]. These tax credits help make health insurance a more affordable benefit option to offer employees while also increasing access to health insurance for individuals not previously able to afford it.

Small businesses in rural areas could benefit greatly from this program. Rural businesses have been less likely than their urban counterparts to offer insurance to employees [19]. Therefore, the ease of using SHOP to identify and enroll in affordable plans will be especially critical to rural employees. SHOP should be readily accessible, and outreach/education efforts should target rural firms.

### ***Certification of Qualified Health Plans***

Exchanges will certify QHPs to offer their choices to the individuals and small businesses securing health insurance through Exchanges. QHPs will have to abide by federal minimum standards based on the ACA provisions regarding benefits required, with latitude for states to impose additional standards or requirements, including how plans will meet minimum quality requirements.

Section 155.200 of the proposed rule details the role of Exchanges in overseeing the quality of QHPs. Exchanges would include an evaluation process that monitors quality improvement strategies developed and used by QHPs. Enrollee satisfaction surveys will be used, along with assessment of health quality and outcomes, and monitoring of enrollee satisfaction.

### **Conclusion**

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Creating Exchanges that work for rural America requires consideration of uniquely rural concerns. A state must first determine the extent to which it will influence the insurance market through the functions of an Exchange. That determination could influence the state plan specifications of the governance structure, including the types of persons and/or organizations included on governing boards. Special consideration should be given to the state's beliefs and values when designing these aspects of the Exchange in order to ensure public acceptance. Navigators are essential to enrolling thousands of individuals. Targeted outreach efforts should be designed to engage rural residents in order to ensure as many individuals as possible are enrolled. However, rural individuals must not only be enrolled, but enrolled in plans addressing their needs. Ensuring rural America will not be left behind as our nation takes a step toward improving our health care system requires meeting the particular considerations described in this paper.

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