



How Will Health Reform Impact Rural Communities?

Assessing challenges and opportunities of implementing health reform in rural America

SUMMARY

From 2010 to 2012, researchers at the University of Southern Maine's [Muskie School of Public Service](#), in Portland, examined the potential impact of the 2010 Affordable Care Act (ACA) on rural communities, and suggested strategies for ensuring that they benefit from expanded health insurance options and mechanisms for financing them.

The project was part of [State Health Access Reform Evaluation](#) (SHARE), a Robert Wood Johnson Foundation (RWJF) national program that initially examined state-level health reform, and now investigates the successes and challenges of state implementation of the ACA. (For more information, see [Program Results Report](#) which describes the program's strategies and provides links to other projects funded under the program.)

Key Findings and Recommendations

The research team published these key findings and recommendations in a peer-reviewed article and two issue briefs (see the [Bibliography](#) for titles):

- State regulators could allow health plans to include midlevel clinicians in patient-provider ratios and rely on innovative delivery systems to make care more accessible to rural residents.
- To reduce market segmentation and fulfill the ACA's intent to broadly distribute risk, state and federal regulators could limit the degree to which health plans can vary premiums by geographic area.
- Nonprofit organizations will need significant administrative and financial capacity to develop health plans for state insurance exchanges. Integrated health care delivery systems that already serve rural areas may be best positioned to overcome these challenges.

Funding

RWJF funded this project with a grant of \$117,476 from September 2010 to February 2012 as part of its *State Health Access Reform Evaluation* program.

CONTEXT

Access to affordable health insurance coverage has been an enduring problem in rural America. According to Andrew Coburn, PhD, project director, recent research has shown that rural residents are more likely than their urban counterparts:

- To be uninsured due to factors such as low income, health status, and type of employment (such as self-employment, part-time and seasonal employment, and employment at small firms)
- To be underinsured, and therefore to spend a larger share of their income on health care
- To depend on publicly funded health insurance

Chronic shortages in the rural health care workforce, and the difficulty of providing a full range of coordinated services over large, sparsely populated areas, also prevent rural residents from gaining easy access to care.

Rural areas could benefit from the ACA's innovations in health care delivery and financing. However, expanded coverage and financing could also bypass rural residents and providers without specific provisions that consider their unique circumstances.

RWJF's Interest in This Area

Since the passage of the ACA, RWJF has been investing in helping states implement its provisions. The *State Health Access Reform Evaluation* program changed its focus in September 2010 from working with states on their state-based efforts at reform to focusing on research and evaluation of implementation of the ACA at the state level. The project described in this report was funded under this new focus.¹

¹ In October 2011, the RWJF Board of Trustees approved a re-authorization of the program with this new focus. The goal is to develop an evidence-based resource for policy-makers seeking to learn about the successes and challenges of the implementation process. A call for proposals was issued in March 2012. It states: "The program seeks to identify and fill gaps in research on health reform issues, especially related to state-level implementation of the Affordable Care Act (ACA), with a focus on provisions that are designed to increase access and coverage. SHARE-sponsored research will provide timely guidance on implementation issues as states consider their unique responsibilities in executing the ACA, and will contribute to the evidence base for future state and national health reform efforts."

THE PROJECT—KEY FINDINGS AND RECOMMENDATIONS

From 2010 to 2012, researchers at the University of Southern Maine’s [Muskie School of Public Service](#) examined the potential impact of the ACA on rural communities, and suggested strategies for ensuring that they benefit from expanded health insurance options and mechanisms for financing them.

With guidance from a national advisory committee (see the [Appendix](#) for a list of members), the project team focused on three key areas:

Standards for Access to Care Through Insurance Exchanges

Under the ACA, state health insurance exchanges set standards for ensuring that the provider networks developed by qualified health plans have enough size and scope to ensure that enrollees can obtain a full range of services in a timely manner.

Stringent standards could discourage health plans from offering insurance to rural residents—given the shortages of medical practitioners in rural areas. Yet allowing health plans to rely on lower-cost, urban providers could erect barriers to care for rural areas and shortchange rural providers.

Recommendations

In the *Journal of Rural Health*², the researchers suggested strategies for protecting rural constituencies while enabling health plans to adapt to rural conditions:

- **Allow patient-provider ratios—and the distances that enrollees must travel for health care—to vary with an area’s “rurality.”** States could use Medicare Advantage’s system of classifying counties as “large metropolitan,” “metropolitan,” “micropolitan,” “rural,” and “extreme access challenges,” and give plans more flexibility in more rural areas.
- **Allow health plans to include midlevel clinicians in patient-provider ratios.** For example, some states allow Medicaid managed care plans to count nurse practitioners and physician assistants in patient-provider ratios for primary care.
- **Allow health plans to rely on innovative delivery systems to make care more accessible to rural residents.** These approaches could include:
 - *Telehealth systems*, which allow urban-based specialists to consult with rural patients, and rural providers to sustain contact with patients in remote areas
 - *Mobile clinics*, which can offer dental, vision, and specialty care in rural areas

² Talbot JA, Coburn AF, Croll Z and Ziller E. “Rural Considerations in Establishing Network Adequacy Standards for Qualified Health Plans in State Health Insurance Exchanges.” *Journal of Rural Health*. Online edition Feb. 22, 2013. Abstract available [online](#).

Accounting for Geography in Setting Health Insurance Premiums

Most states allow insurers to adjust premiums to reflect differences in the cost of medical care across geographic areas. National research suggests that rural residents pay higher premiums than urban residents for a given package of health benefits. However, whether this difference reflects higher administrative costs, unhealthier rural populations, geographic rating of health premiums, or some combination is unclear.

Under the ACA, states can continue allowing health plans to consider geography in setting rates, subject to review by the U.S. Department of Health and Human Services.

To consider the impact on rural areas, the project team searched state websites and contacted state insurance departments to obtain the factors that 39 health plans in eight states used to rate coverage in individual and small group markets from 2005 to 2011. The team reported these findings and recommendations in an [issue brief](#)³:

Findings and Recommendations

- **Geographic rating does not clearly favor rural or urban areas.** That finding suggests that health plans use such rating for reasons other than differences in the cost of care. For example, plans may adjust ratings to gain market share in a given area.
- **To reduce market segmentation and fulfill the ACA's intent to broadly distribute risk, regulators could limit the degree to which premiums can vary based on geographic area.** Some states already set such limits, called rate bands, and the Department of Health and Human Services expects them to review those standards. However, the department cannot set a federal standard unless Congress amends the ACA.
- **Technical assistance from the Department of Health and Human Services will be critical in enabling states to review geographic rating standards.** The ACA authorized \$250 million to help states to develop “fee schedules and other database tools that fairly and accurately reflect market rates for medical services and the geographic differences in those rates,” among other uses.

Ensuring that states create fully staffed and funded data centers on medical reimbursement will be essential in limiting distortions in insurance premiums and other adverse effects of geographic rating.

Are Insurance Co-Ops a Realistic Option for Rural Areas?

The ACA's Consumer Operated and Oriented Plan (CO-OP) authorized \$6 billion in grants and loans to help nonprofit organizations develop and market health insurance

³ Coburn AF, Ziller E, Croll Z, Kilbreth E. The Rural Implications of Geographic Rating of Health Insurance Premiums. Minneapolis, MN: State Health Access Reform Evaluation Program, RWJF, 2012. Available [online](#).

plans in individual and small group markets. Such plans could expand competition and lower costs in rural insurance markets, expand access to integrated health care delivery systems, and give rural areas more control of their health care infrastructure.

Findings

However, in an [issue brief](#)⁴, the researchers identified the following barriers to implementing CO-OP plans in rural areas:

- **Rural CO-OP plans must have enough enrollees to allow them to become stable, sustainable enterprises.** Such plans will need at least 25,000 members, according to some estimates—a high figure for regions with low population density.
- **Developing CO-OP plans will require significant administrative and financial capacity—\$100 million to \$150 million in capital and surplus, for example—and a lack of resources in rural areas may constrain their development.**
- **Nonprofits in some rural areas might find meeting state standards on enrollee access to providers challenging, because providers are scarce, or because the plans do not have enough enrollees to persuade providers to participate.**

Recommendations

The research team offered these recommendations for lowering such barriers:

- **States could allow nonprofit organizations to market their CO-OP plans to large employers outside health insurance exchanges, to enable the plans to attract more enrollees.** States could also give CO-OPs preferred provider status for state employees and enrollees in Medicaid managed care.
- **Integrated nonprofit health care delivery systems that already serve rural areas may be best positioned to overcome the challenges entailed in creating and administering CO-OPs.** Existing health care systems may already have:
 - Access to the necessary capital
 - The ability to build CO-OP membership by offering CO-OP plans to their employees and patients
 - The administrative infrastructure needed to handle CO-OP plans

⁴ Coburn AF, Talbot JA, Ziller E, Croll, Z. CO-OP Health Plans: Can They Help Fix Rural America's Health Insurance Markets? Minneapolis, MN: State Health Access Reform Evaluation Program, RWJF, 2011. Available [online](#).

Communications

The team gave presentations on the project at two annual meetings of the National Rural Health Association, and promoted the policy briefs through the Maine Rural Health Researcher Center at the University of Southern Maine.

The research team conducted a webinar on CO-OP plans as an option for rural areas, hosted by RWJF's *State Health Access Reform Evaluation* and the Rural Assistance Center of the Department of Health and Human Services, in October 2011. (The webinar is available online as [audio with slides](#) or as a [transcript](#).)

LESSONS LEARNED

1. **Gather input from stakeholders when selecting topics for research.** The team had preconceived ideas about which rural health care challenges to investigate. However, feedback from the advisory board, which included a rural physician, steered the team to other topics that proved fruitful. (Project Director/Coburn)
2. **Build extra time into projects that involve public policies that are changing.** The Department of Health and Human Services issued guidance on the ACA while the research team was pursuing the project. In response, the team enlisted an information specialist to track new federal ACA-related publications. (Project Director/Coburn)

AFTERWARD

The researchers continue to investigate the implications of the ACA for rural communities. For example, they received another grant through RWJF's *State Health Access Reform Evaluation* to analyze the number and characteristics of rural residents newly eligible for Medicaid through the ACA⁵.

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⁵ ID# 70116

APPENDIX

National Advisory Committee

(Current as of the end date of the program; provided by the program's management; not verified by RWJF.)

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Coburn A, Ziller E, Croll Z and Kilbreth E. The Rural Implications of Geographic Rating of Health Insurance Premiums. Issue Brief. Minneapolis, MN: State Health Access Reform Evaluation Program, Robert Wood Johnson Foundation, 2012. Available [online](#).

Communication or Promotion

Andrew F. Coburn. "CO-OP Health Plans: Can They Help Fix Rural America's Health Insurance Markets?" Webinar, October 19, 2011. Available online as [audio with slides](#) or [transcript](#).