# Rural Implications of the Blueprints for State-Based Health Insurance Marketplaces

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## Key Findings

- State-based Marketplaces' choice of service and rating areas has particular relevance to rural areas. Some states have few rating areas, effectively requiring carriers to include rural individuals in large risk pools with urban residents, while others allow insurers to vary premiums across a large number of geographic areas. Designs matter, average monthly premiums are higher in less densely populated areas.

- Few states have explicitly made rural representation a priority in their Marketplace governance structure. In some states rural areas are represented by board members serving as consumer representatives. In addition, rural residents are more likely to work for small employers, so states where small businesses are well represented on the board may be more likely to design policies that facilitate access to health insurance for rural individuals. Ongoing appointments to the boards of state-based Marketplaces will provide opportunities for evolution in board composition.

- States take different approaches to network adequacy requirements in rural areas. Rural residents may gain insurance but still lack access to health care if the networks offered by insurance plans in their markets do not include local providers. However, strict network adequacy standards may also discourage insurers from offering plans in rural areas, or drive up premiums for the plans that are offered. States have so far ensured that existing network adequacy requirements will apply to the Marketplace regulations, but have not used the creation of the Marketplace as an opportunity to dramatically modify network adequacy requirements.

- In rural areas, enrolling individuals in the Marketplace will be especially challenging, due to dispersed populations, varying rates of uninsurance, and varying receptiveness to the idea of purchasing health insurance through the Marketplace. The tools and approaches developed to reach large numbers of people quickly for the purpose of establishing large rating pools may result in approaches that work well in urban areas but are not effective in rural areas. State marketing campaigns and navigator and in-person assister programs can include specific elements tailored to rural circumstances, including a possible role for agents and brokers. States that measure their success in terms of local enrollment numbers, rather than a single aggregated figure, will be more aware of the relative success or failure of rural outreach.

- Certification and oversight of qualified health plans (QHPs) are not conducted any differently for rural areas than for the state as a whole. Rural residents will benefit when states diligently review compliance with network adequacy requirements, since rural areas are most likely to experience circumstances that change availability of network providers, such as shortages, providers not agreeing to health plan contract terms, and plans leaving the market.

- The design of the Small Business Health Options Program (SHOP) Marketplace is particularly important to rural residents, who are more likely to work for a small employer. SHOP participants may have greater access to health insurance options under an employee choice model in which employer contributions may be applied to any policy offered in the Marketplace. Options may also be greater in states with low minimum participation rates. However, in both instances, individuals may face higher premiums. Given that rural individuals already have limited insurance choices and higher premiums, this trade-off is a challenge for state policymakers.

## Introduction

Section 1311 of the Patient Protection and Affordable Care Act of 2010 (ACA) created Health Insurance Marketplaces (Marketplaces), formerly known as Health Insurance Exchanges, as one of several strategies for expanding insurance coverage to more Americans. Marketplaces are intended to expand and organize the market for health insurance, providing a way for Americans purchasing insurance through the individual or small-group markets to choose among plan offerings that vary in cost and benefit design. Proactive states have significant flexibility in how to structure their Marketplace. Fifteen states and the District of Columbia currently operate their own individual and Small Business Health Options Program (SHOP) Marketplaces. In addition, three states have chosen to operate their own SHOP Marketplace, while operating an individual Marketplace in partnership with the federal government. Six states will operate a Marketplace in partnership with the federal government. Residents of the other 27 states will participate through a Federally-Facilitated Marketplace (FFM).[1] In later years, states operating partnerships or FFMs may choose to transition toward operating their own Marketplace. Each state's decision is summarized in Table 1 in the Appendix, along with measures of the size of each state's rural population. Key characteristics of state-based Marketplaces are summarized in Table 2 in the Appendix. Although states operating their own Marketplace are generally more metropolitan than states with an FFM or partnership Marketplace, millions of rural Americans live in states operating a state-based Marketplace.

In two previous papers,[2,3] the Rural Policy Research Institute (RUPRI) Center for Rural Health Policy Analysis identified several domains in which state choices could affect rural residents' access to care through the Marketplaces—market function, governance, access, enrollment, certification of qualified health plans (QHPs), and the SHOP. These papers traced the development of Marketplaces through the point at which enabling legislation authorized the creation of a state-based Marketplace in 17 states and the District of Columbia.

States that opted to create a state-based Marketplace were required to submit a Blueprint for Approval of Affordable State-Based and State Partnership Insurance Exchanges (hereafter, "Blueprint") prior to December 14, 2012, to the Center for Consumer Information and Insurance Oversight (CCIIO), part of the Centers for Medicare and Medicaid Services (CMS). In this paper, we assess the rural implications of the Blueprints by applying the framework developed in the two aforementioned RUPRI papers to the operational details available in the Blueprints of the states operating state-based Marketplaces for individuals. We also include New Mexico and Utah, both of which submitted Blueprints and are operating their own SHOP Marketplace.

## Methods

This paper is an analysis of state Blueprints as submitted to CMS. We obtained the Blueprint documents in June and July of 2013 from state government and individual Marketplace websites. As in previous papers, we focused particularly on narratives contained in sections 1, 2, 4, and 6, roughly corresponding to governance, marketing and outreach, QHPs, and the SHOP.[4] However, not all relevant sections of Blueprints were available through these sources or from CMS. In all, we obtained section 1 for 10 states, section 2 for 12 states, section 4 for 9 states, and section 6 for 6 states.[5] Further, although states submitted Blueprints in response to a standard form, the level of detail provided by states varied widely,

to the extent that information found in one state's Blueprint could not always be directly compared with that of another.

To fill gaps in key themes we had identified through our review of the more detailed Blueprints, we consulted publications and websites of some of the other organizations tracking various aspects of the rollout of the Marketplaces, including the Kaiser Family Foundation, National Council on State Legislatures, the National Academy on State Health Policy, and the website State Refor(u)m. Where we could not obtain relevant Blueprint sections for a key theme (e.g., service and rating areas), we posed individual questions to officials with state-based Marketplaces by e-mail and phone in September 2013. For ten states (CO, CT, HI, KY, MA, MD, OR, RI, UT, VT), we relied on responses we received from Marketplace representatives. As the start date for open enrollment in the Marketplaces approached, states began to advance more rapidly beyond their decisions described in the Blueprints, while simultaneously becoming less available to answer our questions related to the Blueprints.

We recognize that many important decisions have been made since the Blueprints were submitted in late 2012 and that the Marketplaces are now operational. We explore some of the post-Blueprint developments in a later section of this paper in order to highlight ongoing implementation issues that affect rural consumers in state-based Marketplaces.

## Market Function

Early in the process of forming Marketplaces, states made important decisions about the extent of their involvement in organizing the health insurance market in their state. Most states opted to pursue a "clearinghouse" model, in which the state certifies all health plans meeting the federal requirements for QHPs and any applicable state requirements for insurers. Only a few states chose the "active purchaser" model to selectively contract with health insurance carriers [see Table 2a].

The Blueprints outlined some further decisions that states made related to the overall structure of the Marketplaces. Blueprints of states implementing an active purchaser model indicated how many plans would be offered, and a process for selecting those plans, but provided few details on the basis for deciding which plans to select. Instead, the selection of plans was a dynamic process that involved direct negotiation with issuers throughout 2013. For example, California developed standardized plan designs and required QHPs to submit initial bids by January 2013. In soliciting bids for its Marketplace, California noted that "The evaluation of QHP bids will not be based on a single, strict formula; instead, the evaluation will consider the mix of health plans for each region of California that best meet the Exchange's goals." In addition, California planned to use the active purchasing process to give preference to insurers "offering coverage options that provide reasonable access to the geographically underserved areas of the state as well as the more densely populated areas."[6]

Despite choosing a relatively less direct role in selecting plans, states that opted to pursue a clearinghouse model also faced important decisions about the structure of their Marketplace. For example, offering too many QHPs could create issues of adverse selection and consumer confusion, but offering too few QHPs could limit access to care (because of restrictive provider networks) or choices among health plans with variable benefit designs through the Marketplace, especially in rural areas. States have employed two primary policies that limit QHP offerings: plan standardization, in which a QHP's cost-sharing requirements must conform to one of a small number of plan designs endorsed by

the Marketplace; and limiting the number of QHPs offered by a single issuer. For example, in Nevada "each licensed carrier [is] allowed to offer no more than five (5) QHPs in each metal tier (includes catastrophic tier) in each market (Individual and SHOP)."[7] However, Nevada has not developed standard plan designs, only requiring "carriers to create QHPs that meet the requirements of the Affordable Care Act . . . not impos[ing] any additional cost sharing requirements on QHPs."[8] Utah structures its Marketplace to a greater degree. It requires that issuers "agree to offer any standardized plans developed by the DOI [Department of Insurance]," but allows insurers, "at [their] option, [to] offer non-standard plans in each metal level, but no more than a specified number of non-standardized plans (as determined by the DOI) in each level."[9]

States also had choices to make regarding service areas and rating areas. A service area is a minimum area within which a plan must offer coverage to any individual; in most instances, a carrier offering an insurance plan to individuals living in one part of a county must offer it to any resident of that county. A rating area is the area within which a single plan may not charge multiple premiums based on geography. Each state chose to establish a single statewide Marketplace, in spite of federal regulations permitting multi-state or sub-state Marketplaces.[10] Federal regulations require that service areas cover a minimum geographic area, and that these areas be established to avoid discriminatory effects.[11] CMS suggested (but did not require) that states align service and rating areas, and declined to specify criteria for states to use in establishing rating areas.[12] For the most part, states wrote their Blueprints to give themselves flexibility regarding service areas, and did not go beyond federal requirements. Minnesota's language is typical:

> "The Minnesota Department of Health will conduct the review of proposed service areas for each QHP to be offered on the Exchange. The purpose of this review is to assess whether each service area is being established without regard to racial, ethnic, language, health status, or other factors that exclude specific high utilizing, high cost or medically-underserved populations. In addition, the Department of Health will evaluate whether any proposed sub-county service areas are necessary, nondiscriminatory, and in the best interest of qualified individuals and employers."[13]

With respect to rating areas, states had to set clear boundaries or, by default, rating areas would be defined as one for each Metropolitan Statistical Area (MSA) in the state, plus a single rating area for the remaining areas not found within an MSA. Rating areas are the geographic regions across which plans may charge different premiums.[14] The number of rating areas in state-based Marketplaces varies substantially across states, with California having 19 and Rhode Island having 1.[15] These differences may be the result of differences between states in population, land mass, and natural markets. Nevertheless, rural residents of some states are likely to be in a rating area that also includes large urban areas, while rural residents of other states are included in completely rural rating areas. By combining urban and rural areas to create a larger risk pool, plans face more predictable expenses and bear less risk, potentially allowing for lower premiums.

## *Discussion*

Service and rating areas have particular relevance to rural areas. Most states impose few requirements on insurers' choice of service areas, but approaches to rating areas vary. Some states have few rating areas, effectively requiring carriers to include rural individuals in large risk pools with urban residents, while others allow insurers to vary premiums across a large number of geographic areas. Other analysis

completed by the RUPRI Center shows that configuration of rating areas matters in resulting premiums: rating areas with the highest adjusted premiums are those with smaller populations, fewer persons per square mile, and with fewer health care providers.[16]

## Governance

Twelve of eighteen state-based health insurance marketplaces are independent state agencies or non-profit agencies. These Marketplaces must be governed by a Board of Directors. Federal regulations require that the board must:

- Include at least one voting member who is a consumer representative[17]
- Not be made up of a majority with a conflict of interest[18]
- Include individuals with specified expertise, which tends to relate to knowledge about insurance[19]
- Be governed based on an established set of governance principles[20]

Most states do not go beyond these requirements. While rural representatives may place a higher priority on addressing issues that are specifically relevant to health care in rural areas, no state specifically requires rural representation. In all state-based Marketplaces with independent boards of directors (i.e., Marketplaces that are separate from state agencies), the SHOP is governed by the same board, although federal regulations give states the option of creating separately governed individual and SHOP Marketplaces.

States have met the requirement for consumer representation in a variety of ways. For example, New Mexico's 14-member board includes five small employers, four employees of small employers, and the state insurance commissioner. Consequently, New Mexico's board may emphasize the interests of small businesses. On the other hand, Hawaii's board includes a number of representatives of Native Hawaiian community organizations, many of which are located in rural parts of the state.

The six states that have created a Marketplace inside a new or existing state agency are not subject to the federal requirements described above. Nevertheless, four of these six are governed by Boards of Directors.

### *Discussion*

Few states have explicitly made rural representation a priority in their Marketplace governance structure. In some states rural areas are represented by board members serving as consumer representatives. In addition, rural residents are more likely to work for small employers, so states where small businesses are well represented on the board may be more likely to design policies that facilitate access to health insurance for rural individuals. Ongoing appointments to the boards of state-based Marketplaces will provide opportunities for evolution in board composition. Interactions of rating and service area definitions with access to affordable health plans are best understood by board members with knowledge of rural health. Having board members with an understanding of the challenges of reaching rural residents, especially in sparsely populated areas with limited access to high-speed broadband connectivity that reaches residential settings, will help with consumer education to select

and use health plans. Knowledge of rural circumstances in maintaining access to essential services would help with

## Access: Availability and Affordability

The adequacy of plans' provider networks to serve rural residents where they live is a significant concern for insured individuals. In underserved places, plans have fewer providers with whom to contract. As a result, there is little or no competition among providers, which fundamentally alters market's dynamic. Insurers' strategy of guaranteeing patient volume in exchange for price discounts may not be an effective means of reducing premiums in these areas. However, other market characteristics, including historically low charges for inpatient services and lower aggregate utilization, may have already lowered costs, moderating the inability to negotiate discounts. In general, state policy makers face an implicit trade-off between affordability and availability. Consumers may find the inclusion of particular providers to be essential in preserving access to services. The ACA requires that QHPs incorporate essential community provides (ECPs) in their provider networks, which for QHPs operating in federally-facilitated exchanges CMS has operationalized to be 20% of ECPs under safe harbor standards and 10% minimum for all others.[21] States may set their own minimum standards and use their own provider lists, but will generally follow the same guidelines, and recognize the same list of providers as ECPs. In addition, the application of existing state-based network adequacy requirements to QHPs can help to ensure that plans offered in rural areas make care available to beneficiaries through local providers. However, strict network adequacy standards in rural areas may drive up premiums or discourage insurers from offering plans through the Marketplace, since local providers may refuse to consider discounts from their scheduled charges if they know they are essential to any adequate provider network.

States have balanced the issues of plan availability and affordability in different ways. At least 10 states have specific network adequacy requirements in their existing insurance regulations, which will be required of QHPs sold through the Marketplaces. To avoid adverse selection against QHPs offered through its Marketplace, Nevada's governing board has requested that the state legislature expand its network adequacy requirements to cover all insurance plans offered in the state, whether or not they are offered through the Marketplace (current requirements apply only to health maintenance organizations).[22] The governing board also asked the legislature to consider the availability of telemedicine and the inclusion of Essential Community Providers in designing statewide guidance on network adequacy, considerations with the potential to substantially impact the composition of networks.

We did not identify any state-based Marketplace that will conduct its own reviews of network adequacy. Instead, state departments of health or departments of insurance will conduct network adequacy reviews, as they already do for insurance plans sold in the state. For example, California noted that the Marketplace may become aware of network deficiencies and refer plans to the Department of Managed Care for action. Generally, network adequacy reviews will occur in conjunction with certification or recertification of QHPs. Minnesota also requires a network adequacy review when any provider is terminated, which will result in more frequent reviews than in states with no such requirement.

### *Discussion*

Rural residents, especially those living in places with few healthcare providers, may gain insurance but still lack access to health care if the networks offered by insurance plans in their markets are inadequate. However, strict network adequacy standards may also discourage insurers from offering plans in rural areas, or drive up premiums for the plans that are offered. States have so far ensured that existing network adequacy requirements will apply to the Marketplace regulations, but have not used the creation of the Marketplace as an opportunity to dramatically modify network adequacy requirements. States will want to monitor the balance between assuring local access for basic services (e.g., primary care, emergency care) and ability of QHPs to offer affordable plan options. In many rural places that balance may need to tip toward access, driving considerations for the design of service areas and rating areas.

## Enrollment

Federal regulations require states to make specific efforts to facilitate enrollment in the Marketplaces. In their Blueprints, states described their proposed efforts to ensure that all eligible individuals have the necessary information and assistance to enroll in insurance plans. States described their efforts in two areas: conducting outreach and marketing campaigns to make eligible individuals aware of the Marketplace, and paying navigators or in-person assisters (navigators/IPAs) to directly assist individuals with enrollment. Apart from these requirements, the Marketplace must "regularly consult on an ongoing basis" with stakeholders in 11 categories.[23] While this is not technically part of an enrollment strategy, engagement with particular stakeholders may be especially relevant to informing state efforts to enroll certain groups. For the purposes of this paper, the most relevant mandatory stakeholder categories are individuals and entities with experience in facilitating enrollment in health coverage, advocates for enrolling hard-to-reach populations, federally recognized Tribes, and public health experts. These categories could include rural stakeholders. Maryland, for example, requires that each of its advisory committees "reflect the gender, racial, ethnic, and geographic diversity of the state." Generally, navigators and others assisting consumers can reach out to rural residents, as CMS provides in its final rule for federal-facilitated and state partnership exchanges.[24]

### *Outreach Campaign*

Many states began their outreach campaign by identifying target markets, groups of uninsured individuals that may vary substantially across states. For example, Maryland conducted an "environmental scan . . . in November 2011 [to] provide the audience segmentation and prioritization necessary to develop plans for a communications and outreach campaign in advance of open enrollment."[25] Such a process may or may not result in the inclusion of rurality as an important factor. For example, California described the diversity of its target population in terms of geography, primary language, and many other factors, but ultimately identified its target populations on the basis of personal characteristics (gender, marital status, employment, risk aversion, use of the Internet, health status, health behaviors, and health care utilization), not rurality.

Hawaii's Blueprint is the most explicit about marketing directly to rural residents. In defining its target market segments and identifying effective outreach strategies, the Hawaiian Connector conducts phone and mail surveys "across urban and rural populations. Two surveys will be conducted for each of the

state's islands and include at least 300 participants."[26] Other states indicated, more generally, that "geography" will be a factor to consider in designing an outreach strategy.

In contrast, New York is pursuing a strategy that targets individuals who are most likely to enroll in large numbers, to build support for the Marketplace and encourage its ongoing viability. This strategy may lead the Marketplace to focus its initial outreach on urban parts of the state, where large numbers of new enrollees can be quickly reached through mass media. However, the state is also using enrollment by county as a metric of successful outreach. As a result, the Marketplace will be aware of any geographic differences in enrollment rates, and may choose to alter its outreach campaign to address any substantial differences.

The means of outreach chosen to carry out a communications strategy may also affect rural individuals' access to information, and trust in that information. Rural individuals may receive and process information differently than urban individuals, and it is therefore important for states to conduct outreach through a variety of methods. For example, rural residents may rely heavily on information received through local organizations to which they belong, including civic organizations (e.g., Eagles, Lions), farming/agricultural associations, and churches. Most states are using diverse methods of communication with the public, including advertising on television and other forms of mass media, attendance at in-person community events, and presentations to community organizations. Specific events and organizations may serve as outreach channels to uninsured rural populations. Minnesota, for example, has distributed information through the state Office of Rural Health and Primary Care, migrant health organizations, and the Minnesota homeschooler's alliance, organizations that may be able to reach members of the target population that mass media cannot. Similarly, Hawaii highlights the use of informal "talk-story" sessions for outreach, a culturally appropriate means of reaching the more traditional target population that prevails in rural parts of that state.

## *Navigators and In-Person Assisters*

Navigators and in-person assisters perform similar roles in most states. These individuals are paid to enroll individuals directly in insurance plans sold through the Marketplace.

All nine states for which we obtained the relevant Blueprint section recognize that the most important attribute of a navigator/in-person assister (IPA) is the capacity to reach and assist a population that does not traditionally purchase insurance. However, state decisions about who should be a navigator/IPA reflect different theories about the attributes that create such capacity. New York's navigator/IPA program is an extension of existing consumer assistance for its public insurance programs. A number of states (e.g., Minnesota, Hawaii) emphasize that navigators/IPAs should have an existing relationship with uninsured populations. Other states (e.g., Nevada, New York) emphasize the importance of physical accessibility of the site where navigators/IPAs deliver services to the uninsured population. Nevada's vision for navigators/IPAs is particularly concerned with the navigators'/IPAs' ability to help rural individuals overcome barriers to insurance: "[Targeted] groups include people who are eligible for publicly funded health care . . . and those individuals who do not have the means or ability to travel to a producer (Native Americans living on reservations, rural ranchers, farmers and persons with disabilities)."[27] Nevada emphasizes that navigators/IPAs should create "locations or mobile computing centers that will facilitate access to the Exchange's web portal, call center, or FAX line or provide the ability to print and mail hard copies of enrollment documents."[28] It should be noted that, regardless of the state, all individuals who carry out consumer assistance of this type must receive training on working

with "individuals with limited English proficiency, people with a full range of disabilities, and vulnerable, rural, and underserved populations."[29]

In some rural areas, insurance agents and brokers currently help many individuals and small employers navigate the insurance markets, and state decisions reflect these existing relationships. Section 1311 of the ACA permits insurance agents and brokers to act as navigators/IPAs in state-based Marketplaces, but agents and brokers must choose whether to take commissions from the Marketplace itself (by becoming a navigator/IPA) or to continue receiving payments from carriers; agents and brokers cannot do both. Blueprints varied in the extent to which they promoted the role of agents and brokers, and in their efforts to prevent conflicts of interest that could occur if agents and brokers steer consumers to certain plans. For example, Minnesota's Blueprint envisioned different roles for navigators/IPAs who were also agents or brokers than for those who were not (e.g. community-based organizations) The Blueprint assumed that all non-agent, non-broker navigators/IPAs would refer small businesses to agents and brokers, who would in turn act as the primary navigators/IPAs for the SHOP Marketplace. In contrast, Hawaii had not fully developed its compensation policy for agents when its Blueprint was submitted, but had determined that it would not work with web-based brokers to enroll individuals. California standardized commissions and directly pays agents and brokers for facilitating enrollment in the SHOP Marketplace. In the individual market, California allows agents and brokers to negotiate their own rates with carriers in the individual market, but also requires these entities to assist Medicaid-eligible individuals without compensation.

### *Discussion*

The outreach strategy for Marketplace enrollment is an essential component of providing rural individuals with affordable access to insurance. In rural areas, enrolling individuals in the Marketplace will be especially challenging, due to dispersed populations, varying rates of uninsurance, and varying receptiveness to the idea of purchasing health insurance through the Marketplace. The tools and approaches developed to reach large numbers of people quickly for the purpose of establishing large rating pools may result in approaches that work well in urban areas but are not effective in rural areas. State marketing campaigns and navigator/IPA programs can include specific elements tailored to rural circumstances, including a possible role for agents and brokers. States that measure their success in terms of local enrollment numbers, rather than a single aggregated figure, will be more aware of the relative success or failure of rural outreach.

## Qualified Health Plans: Certification and Oversight

Regardless of their choice of an active purchaser or clearinghouse model, states have the responsibility to certify QHPs for sale through the new Marketplaces and recertify QHPs as frequently as the state deems appropriate.[30] Certification and oversight of plans sold in the Marketplace is a key part of ensuring the quality of the plans (benefit design, cost, and access to providers) offered. States must balance the goals of encouraging carriers to offer a variety of plans with the responsibility to ensure that consumers are well-served by the plans offered through the Marketplace.

States have generally chosen to rely on existing government resources (e.g., departments of insurance, departments of health) to certify and recertify QHPs and to conduct complaint investigations that could potentially result in plan decertification. State agencies already perform similar functions for the non-Marketplace insurance plans sold in the state, but will now review compliance with additional

requirements specific to plans sold via the Marketplace (e.g., actuarial value for the metal level, cost-sharing limits, Essential Health Benefits applicable to all ACA-compliant plans). States are designing review processes using their own resources, sometimes complemented with outside resources. Utah, for example, notes that it may request federal assistance with some aspects of these new review responsibilities (e.g., rate reviews). As previously mentioned, Minnesota requires a review of network adequacy any time a provider is terminated from the network. Other states rely on the regular annual recertification process, making it more likely that a plan with a deficient network would nonetheless continue to be offered for some period of time. Such deficiencies are likely to occur for particular provider types, but are also likely to occur in rural areas, which often face more severe provider shortages.

Although the certification process would provide states an opportunity to impose new requirements on plans with relevance to rural areas, such as requiring outreach to rural residents, we have identified no state that has done so. Such requirements would add to the numerous federal standards specified in the ACA and the existing state insurance regulations, both of which will apply to QHPs and be added to the administrative responsibilities of state departments of health and departments of insurance.

### *Discussion*

Certification and oversight of QHPs are not conducted any differently for rural areas than for the state as a whole. Rural residents will benefit when states diligently review compliance with network adequacy requirements, since rural areas are most likely to experience circumstances that change availability of network providers, such as shortages, providers not agreeing to health plan contract terms, and plans leaving the market.

## Small Business Health Insurance Options Program

SHOP Marketplaces are particularly important in rural areas because small employers account for a greater share of total employment in rural areas.[31] Every state (except Hawaii) defines a small business as having between 2 and 50 employees, while Hawaii's SHOP Marketplace defines a small business as having between 2 and 100 employees.[32] Of the 17 state-run SHOP Marketplaces, 6 states are actively selecting the QHPs for their SHOPs, while the rest of the states have chosen to serve as clearinghouses for their state's QHPs (see Table 2b).

In seven states, employers must meet a minimum employee participation rate before their small business can enroll in the SHOP Marketplace. New Mexico requires that 50 percent of employees participate before an employer can enroll in the SHOP Marketplace,[33] while seven other states require a 70 or 75 percent participation rate (see Table 2b).[34] This requirement is based on a policy often imposed by private insurers who offer plans in the small group market. If an employer offers health insurance to his or her employees, the offer may be accepted only by the employees most likely to use health care services. As a result, SHOP premiums would increase to reflect the undesirable risk pool, making coverage less affordable for all small business employees within the state. Notwithstanding this rationale, setting a minimum employee participation rate may reduce access to health insurance for small business employees, since individuals will be unable to buy coverage through the SHOP Marketplace unless their co-workers also choose to do so. These individuals may then be able to buy subsidized coverage through the individual Marketplace.

In addition to setting minimum participation rates, states determined the range of plan choices an employer must offer its employees. Most states allow employers to restrict employees' choices to some extent, such as by offering only a single QHP or a choice of any plan offered by a single insurer. However, eight states chose an "employee choice" model.[35] In this model, the employer sets a defined contribution toward their employees' health insurance premiums and allows the employees to enroll in any health insurance plan in the SHOP Marketplace. The implications of state decisions regarding the SHOP Marketplaces for rural workers, who may have few options in their geographic area, are ambiguous. Insurers may offer lower rates to employers who can drive a larger number of beneficiaries to a single carrier. On the other hand, rural employees may maximize their choice of plans through employee choice.

### *Discussion*

The design of the SHOP Marketplace is particularly important to rural residents, who are more likely to work for a small employer. SHOP participants may have greater access to health insurance options under an employee choice model, or where minimum participation rates are low. However, in both instances subsequent small pools of insured persons may result in higher premiums. This trade-off will be particularly important to rural individuals, who already have limited insurance choices and higher premiums.

## Post-Blueprint Activity

State-based Marketplaces submitted Blueprints in late 2012, and began open enrollment activities on October 1, 2013. The RUPRI Center is monitoring implementation of the Marketplaces, and our early analysis of available data illustrates what is now available to rural residents. Further analysis of all publicly available data regarding variation across rating areas both within and across states will be forthcoming.

As expected, insured rural individuals face higher premiums in states with a greater number of rating areas because selective contracting is more difficult in rural areas, and because rural individuals' premiums will not be offset by risk-pooling with individuals in urban areas. For example, a 40-year-old purchasing a Silver-rated plan on the individual exchange in Orange County, California, (urbanized rating area) would pay an average monthly premium of $289.60, while the same 40-year-old purchasing a Silver-rated plan on the individual exchange in Inyo County, California, (rural rating area) would pay an average monthly premium of $372.00.[36]

In addition, rating areas that are completely rural appear to have fewer health insurer and QHP choices than rural areas included within primarily urban rating areas. For example, Nevada's Clark County (urban rating area) has 4 health insurers offering 90 different QHPs, while Nevada's Eureka County (rural rating area) has 2 health insurers offering 13 different QHPs. More options may create greater competition in rural areas, but may also create confusion for uninsured rural consumers. In addition, a large number of QHPs may enable insurers to create homogeneous risk pools through plan design. If QHPs serve dissimilar risk pools, the effect may be that premiums may vary more widely than intended under the ACA.

The number of health insurers participating in the SHOP Marketplaces similarly varies across states. For example, only 2 insurance carriers are participating in the Vermont and Hawaii SHOP Marketplaces,

while 11 and 16 carriers are participating in the New York and Colorado SHOP Marketplaces, respectively.[37]

## Conclusion

States have made many important policy decisions with respect to their rural populations and efforts to enroll that population in state-based Marketplaces. Lessons from the implementation of state-based Marketplaces will inform future policy decisions as states fine-tune their policies, and will influence state decisions about transitioning from a partnership or an FFM to a state-based Marketplace.

To evaluate the impact of the Marketplaces in rural areas in the future, it will be particularly important to monitor the availability of plans, their premiums, and rural individuals' rate of enrollment. These indicators will provide feedback to states on the relative merits of different outreach strategies, QHP requirements, or size of businesses eligible to participate in the SHOP. States may even choose to revisit the more fundamental decisions, such as the choice of an active purchaser or clearinghouse model (as Nevada's Blueprint suggests it may do once it has sufficient data).

In 2014, the RUPRI Center will continue to follow the impact of Marketplaces on rural areas. In particular, we will analyze the availability and variability of health insurance plans rural residents can purchase through the Marketplaces, and examine geographic and demographic factors, as well as policy decisions, that may impact the number, type, and cost of plans available in rural areas.

# Appendix

**Table 1. Health Insurance Marketplaces and Rurality**

| State | Marketplace Status[a] | Population in Non-Metropolitan Areas[b] | |
|---|---|---|---|
| | | People | Percent of State Population |
| Alabama | Federally-Facilitated Marketplace | 1,159,100 | 25% |
| Alaska | Federally-Facilitated Marketplace | 206,400 | 30% |
| Arizona | Federally-Facilitated Marketplace | 999,300 | 15% |
| Arkansas | Partnership | 1,076,000 | 37% |
| California | State Marketplace | 664,700 | 2% |
| Colorado | State Marketplace | 578,300 | 12% |
| Connecticut | State Marketplace | 157,300 | 4% |
| Delaware | Partnership | 184,200 | 21% |
| District of Columbia | State Marketplace | 0 | 0% |
| Florida | Federally-Facilitated Marketplace | 742,400 | 4% |
| Georgia | Federally-Facilitated Marketplace | 1,360,000 | 14% |
| Hawaii | State Marketplace | 372,000 | 28% |
| Idaho | State Marketplace | 577,500 | 37% |
| Illinois | Partnership | 1,413,700 | 11% |
| Indiana | Federally-Facilitated Marketplace | 1,724,700 | 27% |
| Iowa | Partnership | 1,279,700 | 43% |
| Kansas | Federally-Facilitated Marketplace | 958,800 | 35% |
| Kentucky | State Marketplace | 1,930,900 | 45% |
| Louisiana | Federally-Facilitated Marketplace | 802,000 | 18% |
| Maine | Federally-Facilitated Marketplace | 651,300 | 50% |
| Maryland | State Marketplace | 160,800 | 3% |
| Massachusetts | State Marketplace | 192,000 | 3% |
| Michigan | Federally-Facilitated Marketplace | 1,442,600 | 15% |
| Minnesota | State Marketplace | 1,378,300 | 26% |
| Mississippi | State SHOP, Federally-Facilitated Individual Market | 1,582,600 | 54% |
| Missouri | Federally-Facilitated Marketplace | 1,208,200 | 20% |
| Montana | Federally-Facilitated Marketplace | 627,700 | 64% |
| Nebraska | Federally-Facilitated Marketplace | 687,400 | 38% |
| Nevada | State Marketplace | 232,900 | 9% |
| New Hampshire | Partnership | 484,300 | 37% |
| New Jersey | Federally-Facilitated Marketplace | 0 | 0% |
| New Mexico | State SHOP, Federally-Facilitated Individual Market | 540,800 | 27% |

*Table 1 continues on page 14*

**Table 1. Health Insurance Marketplaces and Rurality (continued)**

| State | Marketplace Status | Population in Non-Metropolitan Areas | |
|---|---|---|---|
| | | People | Percent of State Population |
| New York | State Marketplace | 1,567,300 | 8% |
| North Carolina | Federally-Facilitated Marketplace | 3,024,800 | 32% |
| North Dakota | Federally-Facilitated Marketplace | 334,400 | 51% |
| Ohio | Federally-Facilitated Marketplace | 2,696,900 | 24% |
| Oklahoma | Federally-Facilitated Marketplace | 1,209,500 | 33% |
| Oregon | State Marketplace | 850,800 | 22% |
| Pennsylvania | Federally-Facilitated Marketplace | 2,263,800 | 18% |
| Rhode Island | State Marketplace | 0 | 0% |
| South Carolina | Federally-Facilitated Marketplace | 1,466,100 | 32% |
| South Dakota | Federally-Facilitated Marketplace | 401,200 | 50% |
| Tennessee | Federally-Facilitated Marketplace | 1,522,300 | 24% |
| Texas | Federally-Facilitated Marketplace | 2,809,500 | 11% |
| Utah | State SHOP, Federally-Facilitated Individual Market | 573,100 | 21% |
| Vermont | State Marketplace | 421,300 | 68% |
| Virginia | Federally-Facilitated Marketplace | 1,026,400 | 13% |
| Washington | State Marketplace | 524,300 | 8% |
| West Virginia | Partnership | 784,600 | 43% |
| Wisconsin | Federally-Facilitated Marketplace | 1,361,300 | 24% |
| Wyoming | Federally-Facilitated Marketplace | 389,700 | 70% |

[a] State Refor(u)m, https://www.statereforum.org/where-states-stand-on-exchanges. Accessed December 2, 2013.

[b] Kaiser Family Foundation, http://kff.org/other/state-indicator/metropolitan-distribution/#table. Accessed December 2, 2013.

**Table 2a. Key Characteristics of State-Based Marketplaces: Governance and Market Function**

| | Governance | | Market Function | | | |
|---|---|---|---|---|---|---|
| State | Type of Entity | Number of Board Members | Type of Exchange | QHP Standardization[a] | Maximum Plans per Insurer[b] | Rating Areas in State[c] |
| California | Quasi-governmental[d] | 5 | Active Purchaser | Yes | No | 19 |
| Colorado | Quasi-governmental | 12 | Clearinghouse | Yes | No | 11 |
| Connecticut | Quasi-governmental | 14 | Clearinghouse | Yes | Yes | 8 |
| Hawaii | Private Non-Profit | 15 | Clearinghouse | No | No | 1 |
| Idaho | Quasi-governmental | 18 | Clearinghouse | No | No | 7 |
| Kentucky | Existing State Agency | 11 | Clearinghouse | No | Yes | 8 |
| Maryland | Quasi-governmental | 9 | Clearinghouse | No | Yes | 4 |
| Massachusetts | Quasi-governmental | 11 | Active Purchaser | Yes | Yes | 7 |
| Minnesota | Quasi-governmental | 7 | Clearinghouse | No | No | 9 |
| Nevada | New State Agency | 10 | Clearinghouse | No | Yes | 4 |
| New Mexico | Quasi-governmental | 13 | Clearinghouse | No | No | 5 |
| New York | Existing State Agency | NA[e] | Active Purchaser | Yes | Yes | 8 |
| Oregon | Quasi-governmental | 9 | Active Purchaser | Yes | Yes | 7 |
| Rhode Island | Existing State Agency | 13 | Active Purchaser | No | No | 1 |
| Utah | Existing State Agency | NA[f] | Clearinghouse | No | No | 6 |
| Vermont | Existing State Agency | 5 | Active Purchaser | Yes | Yes | 1 |
| Washington | Quasi-governmental | 11 | Clearinghouse | No | No | 5 |

[a] Our review of Blueprints shows that Colorado has developed standard plans, in contrast to other studies of the Marketplaces.

[b] Dash, S., Lucia, K.W., Keith, K., & Monahan, C. (July 2013). *Implementing the Affordable Care Act: Key Design Decisions for State-Based Exchanges*. Washington, DC: The Commonwealth Fund.

[c] Authors' email communication with State Health Insurance Marketplaces.

[d] Quasi-governmental entities are independent public agencies that do not directly report to an executive agency or legislative body.

[e] New York has no governing Board, but five regional steering committees.

[f] Utah has no governing Board, but an executive steering committee.

**Table 2b. Key Characteristics of State-Based Marketplaces: QHP Certification, SHOP, and Offerings as of October 2013**

| State | QHP Certification | SHOP | Offerings as of October 2013[a] | |
|---|---|---|---|---|
| | Network Adequacy Requirements[b] | Minimum Employee Participation % in SHOP[c] | # of Carriers – Individual Marketplace | # of Carriers – SHOP |
| California | Essential Community Provider and 340B | No | 13 | 6 |
| Colorado | | No | 10 | 16 |
| Connecticut | Essential Community Provider and FQHC | No | 3 | 3 |
| Hawaii | | NA | 2 | 2 |
| Idaho | | 70% | 4 | 3 |
| Kentucky | Hospital, primary care, and specialist requirements; driving distance; and wait times | 75% | 3 | 4 |
| Maryland | No | 75% | 6 | 5 |
| Massachusetts | | NA | 9 | 9 |
| Minnesota | Driving time/distance requirements | No | 5 | 3 |
| Nevada | Driving time/distance and provider ratios | 75% | 4 | 4 |
| New Mexico | Driving time/distance and provider ratios (specialist and primary care) | 50% | 5 | 3 |
| New York | Network composition and driving time | No | 16 | 11 |
| Oregon | No | 75% | 11 | 8 |
| Rhode Island | Primary care geographic distribution and office hours | No | 2 | 3 |
| Utah | | 75% | 6 | 3 |
| Vermont | Driving time and waiting time requirements | No | 2 | 2 |
| Washington | Provider sufficiency and choice requirements | 100% if ≤ 3 employees and 75% if 4-50 employees | 8 | 10 |

[a] Authors' communication with staff of state-based Marketplaces and searches of state-based Marketplace websites.

[b] State Refor(u)m. *States' Approaches to Qualified Health Plan Certification*. Retrieved from http://www.statereforum.org/state-QHP-certification on October 4, 2013.

[c] Authors' communication with staff of state-based Marketplaces.

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[2] Garter, B., & Mueller, K. J. (January 2012). *Affordable Insurance Exchanges and Enrollment: Meeting Rural Needs.* Iowa City, IA: RUPRI Center for Rural Health Policy Analysis.

[3] Eves, A. R., & Mueller, K. J. (February 2013). *State Health Insurance Exchanges: Assessing Rural Implications of Statutes.* Iowa City, IA: RUPRI Center for Rural Health Policy Analysis.

[4] The full list of Blueprint sections is as follows: Section 1 (Legal Authority and Governance); Section 2 (Consumer and Stakeholder Engagement and Support); Section 3 (Eligibility and Enrollment); Section 4 (Plan Management); Section 5 (Risk Adjustment and Reinsurance); Section 6 (SHOP); Section 7 (Organization and Human Resources); Section 8 (Finance and Accounting); Section 9 (Information Technology); Section 10 (Privacy and Security); Section 11 (Oversight and Monitoring); Section 12 (Contracting, Outsourcing and Agreements).

[5] Section 1 obtained for CA, HI, ID, MD, MN, NV, NM, NY, OR, and UT. Section 2 obtained for CA, CO, HI, ID, MD, MN, NV, NM, NY, OR, UT, and WA. Section 4 obtained for CA, ID, MD, MN, NV, NY, OR, UT, and WA. Section 6 obtained for ID, MN, NM, NY, OR, and UT.

[6] California Health Benefit Exchange (December 2012). *2012-2013 Initial Qualified Health Plan Solicitation to Issuers and Invitation to Respond.* Sacramento, CA: California Health Benefit Exchange.

[7] Silver State Health Insurance Exchange (November 2012). *Blueprint to Operate a State-based Health Insurance Exchange*: Section 4.4.

[8] Ibid.

[9] State of Utah (December 2012). *Request to Run Utah's Version of a State-Based Health Exchange*: Section

[10] 45 CFR Section 155.140.

[11] 45 CFR Section 155.1055.

[12] 45 CFR Section 156.255.

[13] State of Minnesota (December 2012). *Minnesota Health Insurance Exchange Blueprint Documentation*: Section 4.2.

[14] http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-gra.html. Accessed July 23, 2014.

[15] Authors' e-mail communication with State Health Insurance Marketplaces.

[16] Barker AB, McBride TD, Kemper LM and Mueller K (2014) *Geographic Variation in Premiums in Health Insurance Marketplaces: Impacts on Rural People and Places*. Rural Policy Brief 2014- . Iowa City: RUPRI Center for Rural Health Policy Analysis. http://www.pubic-health.uiowa.edu.

[17] 45 CFR Section 155.110(a)(1)(c)(3)(i).

[18] 45 CFR Section 155.110(a)(1)(c)(3)(ii).

[19] 45 CFR Section 155.110(a)(1)(c)(4).

[20] 45 CFR Section 155.110(a)(1)(d)(1).

[21] Center for consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services (2013) "Affordable Exchanges Guidance." Letter to Issuers on Federally-facilitated and State Partnership Exchanges. April 5.

[22] Silver State Health Insurance Exchange (November 2012). *Blueprint to Operate a State-based Health Insurance Exchange*: Section 4.7.

[23] 45 CFR Section 155.130.

[24] 45 CFR Part 155, Section 155.215.

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[28] Silver State Health Insurance Exchange (September 2012), p. 5.

[29] 45 CFR Section 155.215(b)(2)(xii).

[30] 42 CFR Section 155.1075.

[31] U.S. Small Business Administration Office of Advocacy (2012). *Frequently Asked Questions*. Retrieved from http://www.sba.gov/sites/default/files/sbfaq.pdf.

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[33] New Mexico Human Services Department (2012). *State Health Insurance Exchanges: Key questions*. Retrieved from http://www.hsd.state.nm.us/pdf/hcr/Key SHOP Questions and Answers prepared for Planning Review.pdf.

[34] Access Health Connecticut (2012). *Connecticut Health Insurance Exchange: Shop Briefing*. Retrieved from http://www.ct.gov/hix/lib/hix/SHOP_Issue_Brief_61212.pdf.

[35] Dash, S., Lucia, K.W., Keith, K., & Monahan, C. (July 2013). *Implementing the Affordable Care Act: Key Design Decisions for State-Based Exchanges*. Washington, DC: The Commonwealth Fund. The eight states offering an employee choice model are HI, MN, NV, NY, OR, RI, UT, and VT.

[36] https://www.statereforum.org/sites/default/files/ca_health_plans_booklet.pdf.

[37] Authors' communication with staff of State Health Insurance Marketplaces and searches of State Health Insurance Marketplace websites.