Insights on Rural Health Insurance Market Challenges from the NACRHHS

Housekeeping

- Q & A to follow – Submit questions using Q&A area
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- Technical difficulties please call 866-229-3239
Insights on Rural Health Insurance Market Challenges

Policy Brief Webinar
December 12, 2018

Background on the Committee

• The Committee is a federally chartered independent citizens’ panel whose charge is to advise the Secretary of the U.S. Department of Health and Human Services (HHS) on health care challenges in rural America.

• The Committee is comprised of 21 members, including the chair, with knowledge and expertise in rural health and human services.
The Committee meets twice a year to:

- Examine important issues that affect the health and well-being of rural Americans
- Provide policy recommendations to advise the HHS Secretary on how the Department and its programs can better address these rural issues
- Recent Topics:
  - Suicide in Rural America
  - Adverse Childhood Experiences (ACES)
  - Social Determinants of Health

Link to Committee’s Policy Briefs:

Why this Topic?

- The current focus in health care is a transition from volume-based to value-based care (e.g. managed care)
- Health insurance markets do not necessarily take into consideration the economic, demographic, and population health challenges that are unique to rural areas
Webinar Speakers

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Executive Secretary | National Advisory Committee on Rural Health and Human Services
Senior Health Policy Advisor | Federal Office of Rural Health Policy

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Washington University in St. Louis, Brown School of Public Health
Senior Analyst | Rural Policy Research Institute

Normandy Brangan
Health Insurance Specialist | Federal Office of Rural Health Policy
Health Resources and Services Administration
U.S. Department of Health and Human Services

Mary Kate Rolf, MS, MBA
President, CEO | Nascentia Health
Committee Member | National Advisory Committee on Rural Health and Human Services

The Market Mechanism: Challenges and Solutions for Rural Health Access

Abigail R. Barker, PhD
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Motivation for Today

• The goal of this presentation is to provide an economics-based interpretation of the issues that arise when implementing market-based insurance models in rural places.

• The popular press, academics, and government agencies have all called attention to the lack of health insurance options in some rural counties at various points of time and across various programs.
Motivation for Today

The FEHB Program includes national and state-specific plans. The latter can choose at the county level where to offer coverage.

Background: Changing Cost Distribution

- As technological improvements over the last several decades led to increasingly expensive treatments this raised costs particularly in the upper tail of the cost distribution. Private companies had increased incentive to behave strategically.

<table>
<thead>
<tr>
<th>Number of state-specific plans</th>
<th>Number of counties</th>
<th>Percent of counties</th>
<th>Mean percent of enrollees in national plan</th>
<th>Distribution of counties by mean percent of enrollees in national plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>809</td>
<td>36</td>
<td>968</td>
<td>&lt;50</td>
</tr>
<tr>
<td>3</td>
<td>534</td>
<td>17</td>
<td>866</td>
<td>50-59.9</td>
</tr>
<tr>
<td>4</td>
<td>436</td>
<td>12</td>
<td>741</td>
<td>60-69.9</td>
</tr>
<tr>
<td>5</td>
<td>168</td>
<td>5</td>
<td>752</td>
<td>70-79.9</td>
</tr>
<tr>
<td>6</td>
<td>191</td>
<td>6</td>
<td>588</td>
<td>80-89.9</td>
</tr>
<tr>
<td>10</td>
<td>35</td>
<td></td>
<td>10</td>
<td>90-100</td>
</tr>
</tbody>
</table>

Source: Authors' analysis of Federal Employees Health Benefits Program enrollment files obtained from the Office of Personnel Management. Values are for Standard and High premium plans for the year 2014 by specific group. Percentages may not sum to 100 because of rounding. This table contains 801 counties whose only choice is Kaiser, high-deductible plan, which is more erosive for enrollees.

Mean Expenditures per Person as a Percentage of Per Capita Income

<table>
<thead>
<tr>
<th>Top 1 percent</th>
<th>2014</th>
</tr>
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<tbody>
<tr>
<td>Top 5 percent</td>
<td>157%</td>
</tr>
<tr>
<td>Top 10 percent</td>
<td>103%</td>
</tr>
</tbody>
</table>

Mean Expenditures per Person by Quartile

<table>
<thead>
<tr>
<th>Top quartile</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Third quartile</td>
<td>$1,986</td>
</tr>
<tr>
<td>Second quartile</td>
<td>$487</td>
</tr>
<tr>
<td>Bottom quartile</td>
<td>$41</td>
</tr>
</tbody>
</table>

The upper tail (top 1%) now spends 3.5 times per capita income.

The top quartile now spends about 400 times what the bottom quartile does. In 1970, it was about 140 times the bottom quartile.
Economic Theory

• The combination of markets and health insurance is inherently challenging.
• The most difficult theoretical issue is the problem of adverse selection.
  – Adverse selection describes a situation in which healthier individuals choose not to purchase insurance at a given price, because it is not worth it to them; also sicker individuals buy more comprehensive coverage.
  – This shifts the composition of the risk pool to being sicker and more expensive, driving the price up higher.
• Prior to the ACA, in order to mitigate the impact of adverse selection, firms adopted strategies such as screening and risk segmentation.
  – Screening means requiring a thorough health exam and history before agreeing to insure an individual.
  – Risk segmentation means creating smaller sub-markets that have different levels of risk in order to price each separately.
• Even within the market approach there is potential for the government to place limits on firms’ behavior.
  – Direct regulations as well as other structures – such as bans on pre-existing conditions, bidding mechanisms, subsidy design, and risk adjustment payments – are additions meant to incentivize firms to participate in the market under the theory that many participating firms will, due to competition, lead to better outcomes.
• Some evidence suggests that the market approach, with the additional structure, works reasonably well overall.
  – For example, MedPAC reports that in 2016, 81% of MA enrollees had access to a plan that charges zero additional premium (beyond Part B).
  – However, our analysis of CMS MA plan files shows that this is actually 83% of urban enrollees and 47% of rural enrollees.
Rural-Specific Issues: Smaller Populations

• Modern health insurance is intended to serve two functions. It is a mechanism for sharing risk, and it is a means of access to a range of providers who help manage the enrollee’s health. With respect to both functions, the current market-based insurance programs fall short in rural areas.
  – Sharing risk: because rural places by definition have smaller populations and lower population density, risk cannot be shared across many individuals.
  – Access to providers: because rural places by definition have smaller populations, there are fewer health care providers of all types, and ensuring access will be more challenging.

• About 10% of all Primary Care Service Areas (PCSAs) have one or fewer primary care providers
• about 13% have one or fewer primary care MDs
• about 32% have one or fewer specialists

Rural-Specific Issues: Risk Adjustment

• Why are small risk pools problematic?
  – Even though each program’s reimbursement formula has a risk adjustment component, risk adjustment is a very imperfect science. Even if we had access to a person’s full claims history, this only predicts about half of the variation in future claims.
  – One can always adjust for risk ex post, but this essentially means the government is the true insurer; furthermore it decreases firms’ incentives to actually manage care and control claims.
Rural-Specific Issues: Risk Pools

• So why are small risk pools especially problematic?
  – Firms must rely upon the law of large numbers to forecast the sum of claims they will face. In a large population, one can predict with some accuracy even the upper tail of the cost distribution.
    • Example: In 2014, the top 1% of health care spenders had mean spending of $107,208. The top 1% includes spenders ranging from about $75,000 to $5,000,000.
    • In a population of 100,000 people, there will be about 1000 who spend an average of $107,208, for a total cost of $107,208,000. It is very unlikely from a statistical view that the sum will deviate much from this value.
    • In a population of 1000 people, there will be about 10 who spend between $75,000 and $5,000,000. But with so few people in the upper tail, it is very uncertain whether the average will be close to $107,208. One or two outliers can move the average a lot.
    • Therefore, it is hard to "price in" the risk. In a large population, a firm can hedge by adding, say, $1,000,000 to its revenues by charging each person $10 extra. In a small population, this same hedging would cost $1000 per person, making insurance far less affordable.

• All of this takes place in an environment in which firms are pressured to show a positive return on investment every year, possibly in every quarter. The reality of managing risk is that there will be some negative as well as positive performance over time, but the focus is on consistent (positive) profitability.

Rural-Specific Issues: Network Adequacy

• The role of health insurance as a means of access also creates challenges that are more pronounced in rural areas.
• Many states have been proactive in defining what adequate access means, in the form of network adequacy standards.
• The standards mean that firms must do the work (and incur the administrative costs) of forming networks of providers who can serve a diffuse population.
  – Providers are more likely to be independent or part of small practices, rather than part of a system.
  – Administrative costs can be spread over only a small number of enrollees.
• Also, these standards, combined with sparse providers in some rural places, create opportunities for strategic behavior by firms (more on this below).
Rural-Specific Issues: Cost Structure

• Anecdotally, when justifying exiting from a rural place, firms sometimes state that rural providers are too expensive. Their reference point is the negotiated rate that urban providers are willing to accept.
• In economics, it is a fundamental part of any cost analysis to distinguish fixed costs from variable costs.
  – Fixed costs include facilities, equipment, and EMR systems, as well as minimal-level staffing costs.
  – Variable costs are those that vary with patient volume – mainly additional staffing.
• Fixed costs must be incurred as a lump sum and recouped by adding an amount equal to average fixed cost onto the price of services.
• Variable costs are flexible and may be recouped as part of the marginal cost of seeing a patient.

Rural-Specific Issues: Marginal Geography

• The current market-based models encourage “marginal” thinking. Firms assess the cost of one more person against the benefit (i.e. the premium) they will receive for enrolling that person.
• Even when premiums can vary by geography (e.g. the Medicare Advantage benchmark is different in every county), firms will still want to keep their premium/bid as low as possible.
  – This creates an incentive to pressure rural providers to accept lower rates (if that provider is needed for network adequacy purposes) or omit providers who cannot accept lower rates (if the provider is not needed for network adequacy).
Real World Rural Impact

- As mentioned above, the geographical unit for MA is the county.
  - Firms bid against a benchmark that is tied to prior data on fee-for-service Medicare costs in that county.
  - This encourages the firm to treat each county as a marginal decision — enter, stay, or exit?
- The geographical unit for Health Insurance Marketplaces is different in different states, but most commonly is a group of 5-10 counties including a metro or micro area.
  - State regulations vary on whether the firm must offer coverage throughout the rating area.
- The benefit of a larger rating area is a larger risk pool.
- The possible problem with a larger rating area is the formation of a network that can cover the larger area.

Real World Rural Impact

- The process of negotiating reimbursement rates ultimately depends upon a number of factors, including the market position of the insurance firm and the provider.
  - If the firm is accustomed to reimbursing marginal costs only, it may refuse to contract with a rural provider who needs fixed costs covered.
- Bargaining power of the provider is weakened when they are heavily dependent on public-dollar programs.
- Bargaining power of the firm is strengthened by policies that limit their exposure if they fail to contract with the provider.
Real World Rural Impact

• In the real world, prices are negotiated for a continuum of different health care services of varying degrees of complexity. Similar to other industries, this gives larger providers (larger hospital systems) the incentive to behave strategically in order to undercut smaller local providers.
  – Specifically, they can offer marginal cost (or below marginal cost) pricing on those services that smaller providers (CAHs, rural clinics, etc.) are providing, while making up their own fixed costs on the complex services for which they do not face local competition.
  – This undercuts the local provider’s ability to stay in the market.
  – It also conveys to the insurer the sense that the local provider is “too expensive” to include in their network.

Federal and State Programs Impacting Rural Health Insurance Markets

Normandy Brangan

Health Insurance Specialist | Federal Office of Rural Health Policy
Health Resources and Services Administration
U.S. Department of Health and Human Services
Insurance Programs Under the Authority of HHS

HHS has varying degrees of authority over the programs that utilize managed care:
• Medicare Advantage and Part D
• Medicaid Managed Care
• The Health Insurance Marketplace

Policy Recommendations

Kate Rolf
President, CEO | Nascentia Health
Committee Member | National Advisory Committee on Rural Health and Human Services
Site Visit: Glens Falls, New York

- Attendees:
  - Adirondack Health Institute (AHI)
  - Adirondack Health
  - Nascentia Health
  - Chautauqua County Health Network
  - Citizen Advocates
  - Franklin County Office for the Aging
  - Glens Falls Hospital (GFH)
  - United Helpers

Stakeholder Input from the Site Visit

- “Access to insurance providers is one of the highest issues, but quality coverage by insurance is also a challenge”
- “While well-intentioned, network adequacy standards make it hard to get providers to sign a Medicaid contract”
- “[There are difficulties] accessing resources on insurance and services, connecting people to those resources, and educating consumers on what resources are available to them.”
Availability of Insurance

1. The Committee recommends the Secretary require the alignment of insurance plan service areas with rating areas for insurance programs under HHS authority, utilizing models that integrate urban and rural areas in a region to increase risk pool size. Under this model, the Committee recommends requiring full participation across the rating/service area rather than allowing insurers to offer products to only a portion of the rating area.

2. The Committee recommends the Secretary require states have processes in place to streamline the transition from Medicaid to the individual market (or vice versa), reducing the churn between the two and minimizing lapses in insurance coverage.

Network Development & Adequacy

1. In order to encourage insurer participation in rural areas, the Committee recommends the Secretary allow more flexibility in network adequacy standards in rural areas when there are provider and/or plan shortages.

2. The Committee recommends simplifying the process for requesting and justifying network adequacy exemptions.

3. The Committee recommends that HHS provide technical assistance for under-resourced rural providers to enhance their ability to effectively negotiate with insurers.
Consumer & Provider Engagement

1. The Committee recommends the Secretary supports efforts to educate providers and consumers on the availability of insurance products for individuals and small employers to promote consumer engagement.
2. The Committee also recommends educating providers on insurance options to help inform their network participation decisions.

Conclusion

• The Committee is concerned that rural areas continue to be at a disadvantage in the current public and private insurance markets
• There are steps HHS can take to mitigate these challenges
• Policymakers need to think more proactively about the unique challenges faced by rural markets (and account for them when setting regulations and policies)
For More Information

To find out more about the Committee, please visit our website at http://www.hrsa.gov/advisorycommittees/rural/ or contact:

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Q&A Session
Questions?

Thank you!

- Contact us at ruralhealthinfo.org with any questions
- Please complete webinar survey
- Recording and transcript will be sent to you
  - Slides are available at https://www.ruralhealthinfo.org/webinars/nacrhhs-insurance-market-challenges