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NATIONAL RURAL HEALTH ASSOCIATION

July 28, 2021

Frank Pallone, Jr.
Chairman
House Committee on Energy and Commerce
United States House of Representatives
Washington, DC 20510

Patty Murray
Chairman
Senate Committee on Health, Education,
Labor, & Pensions
United States Senate
Washington, DC 20510

Dear Chairman Pallone and Chairman Murray:

The National Rural Health Association (NRHA) is pleased to offer comments on your request for information (RFI) regarding design considerations for legislation to develop a public health insurance option. We appreciate the work you are doing to ensure affordable health care access for all Americans, including the more than 60 million Americans that reside in rural areas. NRHA supports the goal to provide quality, affordable health coverage to all parts of the United States. We look forward to our continued collaboration to improve health and health care access throughout rural America.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including community hospitals, critical access hospitals, doctors, nurses, and patients. We provide leadership on rural health issues through advocacy, communications, education, and research.

As context for the conversation around a public health insurance option, NRHA believes it is important to understand coverage rates in rural areas of the country, as well the status of the rural healthcare infrastructure.

Rural Uninsured: The RFI discusses the goal of making health care simpler and more affordable, thereby reducing the number of uninsured individuals. Residents of rural counties still lack insurance at higher rates than those living in urban areas. In 2017, about 12.3 percent of people in completely rural counties lacked health insurance compared with 11.3 percent for mostly rural counties and 10.1 percent for mostly urban counties.¹ Further, rural employment fell considerably during the 2008-2010 recession and rural areas were unable to create the same job growth as their urban counterparts in the years following.² In recent months, the COVID-19 pandemic has curtailed rural employment, primarily due to the heavy reliance on industries that are highly susceptible to pandemic closures: outdoor recreation, tourism, and factory work.³ Lastly, rural workers are more likely to have lower wages,

¹ <https://www.census.gov/library/stories/2019/04/health-insurance-rural-america.html>

² <https://www.ers.usda.gov/topics/rural-economy-population/employment-education/rural-employment-and-unemployment>

³ <https://www.pnas.org/content/118/1/2019378118>

work for smaller employers, and be employed in sectors that do not typically offer employer sponsored health insurance, which is one of the central factors contributing to the higher uninsured rate.⁴

Rural Underinsurance: As the RFI states, even those with private health insurance coverage can be at risk of having high out-of-pocket health care costs. More than one-in-six privately insured rural nonadjacent residents (17 percent) spends \$1,000 or more on out-of-pocket health care costs.⁵ The average amount spent per year by someone living in a rural non-adjacent area is \$618, compared to \$512 for urban residents.⁶ Additionally, while the underinsurance rate in rural America has decreased in recent years, the rate remains consistently higher than in urban areas.⁷ Rural employers and employees typically have plans that offer less generous coverage with fewer benefits and higher out-of-pocket costs than plans in urban areas.⁸ As health care costs have continued to climb, more employers have offered their workers' health insurance with greater cost-sharing for care, thus increasing the number of underinsured individuals.

Rural Medicaid Rates: Medicaid plays an important role in helping address the unique challenges people in rural areas face in terms of health care coverage and access, including the low density of providers and longer travel times to care, limited access to employer-sponsored coverage, and greater health care needs due to older populations and lower incomes.⁹ Medicaid covers nearly one in four (24 percent) non-elderly individuals in rural areas, compared to 22 percent in urban areas and 21 percent in suburban areas.¹⁰ However, Medicaid has¹¹ expanded in 12 states, all of which are heavily rural. This leaves a significant portion of those states' rural population uninsured.

Rural Health Care Safety Net Providers: The elevated risk of being uninsured and/or underinsured among rural residents has implications for patients and providers. Given the higher proportion of uninsured and underinsured in rural areas, rural providers have yet another financial hurdle to overcome—even when their patients have private health insurance. High uninsured rates contribute to rural hospital closures, leaving individuals living in rural areas at an even greater disadvantage to accessing care. Rural America is experiencing an ongoing hospital closure crisis. Since 2010, rural America has seen 138 hospitals close, 19 of which closed in 2020 at the height of the COVID-19 pandemic.¹² Currently 453 rural hospitals are operating on margins similar to those that closed in 2020.¹³ A public option would need to create protections in reimbursement rates for rural hospitals and providers so they can stay financially solvent despite changing payer mixes.

NRHA provides the following responses to the RFI related to rural residents and providers for consideration by the Committees. The primary issues at the core of a discussion around the public options from a rural consideration are: 1) the opportunity to offer risk smoothing (with

⁴ <https://www.ers.usda.gov/amber-waves/2007/june/rural-low-wage-workers-face-multiple-economic-disadvantages/>

⁵ <http://muskie.usm.maine.edu/Publications/rural/pb33.pdf>

⁶ <http://muskie.usm.maine.edu/Publications/rural/pb33.pdf>

⁷ <https://www.census.gov/library/visualizations/interactive/rural-urban-uninsured-2017.html>

⁸ <https://rupri.org/wp-content/uploads/20180802nsuring-Rural-America.pdf>

⁹ <https://www.kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/>

¹⁰ <https://www.kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/>

¹¹ <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>

¹² <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>

¹³ <https://www.chartis.com/the-rural-health-safety-net-under-pressure-understanding-the-potential-impact-of-covid-19>

premium impacts) to rural residents, and 2) establishing provider networks at payment rates that are sustainable for rural safety net providers.

1. *Who should be eligible for the public option? Should a federally administered plan be available to all individuals or be limited to certain categories of all individuals (e.g., ACA Marketplace eligible individuals, private employers and individuals offered employer coverage)?*

NRHA believes less segmentation of the health insurance risk pool will lead to better outcomes for rural areas, who already have challenges due to geography and poorer social determinants of health. Further divisions of the risk pool created by new public programs would create coverage options for rural areas that are less efficient (i.e., smaller) and more expensive. A public option should work in tandem with existing programs, like employer sponsored insurance, the ACA Health Insurance Marketplace (Marketplace), and the Federal Employee Health Benefit Program (FEHBP), to increase efficiency.

NRHA believes adding a public option for the rural population (uninsured, Marketplace, those currently receiving employer sponsored health insurance) could help address existing disparities in rural insurance and underinsurance. A public option could provide coverage to rural residents that are uninsured and increase reimbursement relative to current uncompensated care for rural providers. If included in the public option, rural residents currently covered by employer sponsored insurance may be able to retain coverage and face lower out-of-pocket costs. However, rural providers would likely lose reimbursement since private payers tend to pay at a higher rate than publicly funded health care (see question 2 response).

Due to the Affordable Care Act (ACA), employers that have 51 employees must offer employer-sponsored health insurance in the same manner as those that have 5,100 employees. Small businesses, a staple of rural communities, report they are less likely to offer employer-sponsored insurance to employees due to high premium costs and generally lower wages. Rural employers that offer health insurance options frequently experience a high burden due to the associated administrative costs, and therefore may welcome the opportunity to have another coverage source for their employees.¹⁴ NRHA believes inclusion of those with employer sponsored insurance in the public option may attract individuals that are underinsured (as discussed above). However, we anticipate the number of rural residents that would choose to be covered by a public health insurance option rather than their employer sponsored health insurance would be few and have a limited overall impact.

2. *How should Congress ensure adequate access to providers for enrollees in a public option?*

Ensuring adequate access to rural providers for public option enrollees depends significantly on which existing publicly funded option provider payments will be modeled on. Medicare and Medicaid rates are historically set below the costs of providing care, typically only 87 cents for every dollar spent by hospitals on average, resulting in underpayment for rural providers.¹⁵ Medicaid payment is 72 percent of Medicare for all services, and 66 percent for primary care.¹⁶ In the Medicare Payment Advisory Commission's (MedPAC) March 2018 report to Congress, the Commission found that rural hospitals' (excluding Critical Access Hospitals) Medicare margin was -7.4 percent.¹⁷

¹⁴ <https://rupri.org/wp-content/uploads/20180802nsuring-Rural-America.pdf>

¹⁵ <https://www.aha.org/system/files/2019-01/underpayment-by-medicare-medicaid-fact-sheet-jan-2019.pdf>

¹⁶ <https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

¹⁷ <https://www.aha.org/system/files/2019-02/rural-report-2019.pdf>

Private payers tend to pay higher reimbursement rates, but rural hospitals are more likely to serve populations that rely heavily on Medicare and Medicaid. In 2017, Medicare and Medicaid made up 56 percent of rural hospital's net revenue.¹⁸ As such, a public option modeled after Medicare or Medicaid reimbursement will lower already slim-to-nonexistent rural hospital operating margins (see above). A recent report released by FTI Consulting Inc., shows that providers faced with a sudden influx of patients on government plans with lower reimbursement rates could experience new financial challenges, further straining the rural safety net.¹⁹ The study estimates that a public option could decrease access to care in rural communities by putting one in four rural hospitals at increased risk of financial distress.²⁰ Given that many low-income rural areas have a limited number of health care providers, losing even one hospital could have a dire impact on local access to care.

On the other hand, increasing the numbers of rural residents with insurance could provide an increase in reimbursement relative to current uncompensated care for rural providers. On average, rural hospitals have Medicare bad debt percentages that are 60 percent higher than urban hospitals, due to higher rates of low-income patients.²¹ Further, in rural areas, where high-deductible plans are more prevalent and incomes tend to be lower than in urban areas, patients often struggle to pay their deductibles, resulting in uncollectible bad debt.²² According to the Healthcare Financial Management Association, hospital bad debt increased by \$617 million to nearly \$56.5 billion from 2015 to 2018.²³ Additionally, a greater number of hospitals, especially those in rural areas, are experiencing financial pressure due to the COVID-19 pandemic.

NRHA recognizes that if implemented correctly, a public option may lead to expanded coverage to rural residents. However, we remain concerned that this could further destabilize rural hospitals. **A public option would need to create protections in reimbursement rates for rural hospitals and providers so they can stay financially solvent despite changing payer mixes.** One example of such protections is included in legislation reintroduced by Senators Michael Bennet (D-CO) and Tim Kaine (D-VA), the [Medicare-X Choice Act \(S.386\)](#). The legislation addresses rural concerns by giving the authority to increase payments for rural providers by an additional 50 percent. *"To better support rural hospitals and providers and increase access to health care for Americans living in rural communities, the proposal would allow for payment adjustments of up to 150 percent of Medicare fee-for-service rates."*

3. How should prices for health care items and services be determined? What criteria should be considered for determining prices?

NRHA does not have comment on this question of the RFI.

4. How should the public health insurance option's benefit package be structured?

¹⁸ <https://www.aha.org/system/files/2019-02/rural-report-2019.pdf>

¹⁹ <https://americashealthcarefuture.org/wp-content/uploads/2021/07/FTI-National-Public-Option-Report.pdf>

²⁰ <https://americashealthcarefuture.org/wp-content/uploads/2021/07/FTI-National-Public-Option-Report.pdf>

²¹ <https://www.aha.org/system/files/content/11/factsheetbaddebt.pdf>

²² <https://www.usatoday.com/story/news/health/2020/01/10/rural-hospitals-high-deductibles-give-financial-hit-communities/4422129002/>

²³ <https://www.usatoday.com/story/news/health/2020/01/10/rural-hospitals-high-deductibles-give-financial-hit-communities/4422129002/>

NRHA believes it is logical for a public health insurance option to build on an existing foundation for providing coverage in the US, most likely the Marketplace.²⁴ We know from the Marketplace that rural premiums (before subsidies) tend to be higher than urban (see question 5 below) and that rural plans, when rated at the county or local level, are more likely to be higher because of diseconomies of scale.²⁵ As such, to be successful in rural markets, a Marketplace modeled public option should address two primary issues: 1) challenges associated with competition in the rural marketplace and 2) include a national plan option.

Rural experience in the Marketplace to date has seen an increase of high-deductible plans (bronze) plans purchased, leading to high rates of out-of-pocket costs for the consumer and bad debt for the provider.²⁶ Competition in the health insurance market within rural areas is a very different phenomenon than urban areas. In rural areas, competition may be relatively low in places where there is historical inertia in the market for insurance, where there is long-term domination by Blue Cross/Blue Shield plans, and where small plans cannot match the ability of national plans to put together provider networks.²⁷ Research conducted by the Rural Policy Research Institute (RUPRI) found a marked drop in premiums between rural areas with 2 to 3 plans when compared with rural areas with 1 to 2 plans.²⁸ A public option will have the challenge of creating regions for plan bids (assuming the Marketplace model) that are able to incorporate the worse risk pool (poorer, sicker, older populations) in rural areas in a way that makes it desirable to be included in plan offering and allows for some level of competition.

In rural areas with less competition the inclusion of a nation-wide plan is important. Nation-wide plans tend to be cheaper because of the nation-wide community rating and provide an important access point for rural residents. Given the collapse of the Marketplace Multi-State Plan (MSP) Program due to limits imposed in the authorizing statute and influence allowed by state insurance regulation, careful structuring needs to be done for a nation-wide plan to be successful. One idea is to model it off and/or included it as part of the FEHBP operated by the Office of Personal Management. The FEHBP is currently the largest health insurance program in the world, offering coverage to almost 8 million people.²⁹ Although, plans are widely available through FEHBP, approximately 90 percent of rural enrollment was concentrated in plans owned by a few organizations, typically Blue Cross not-for-profit plans, which have existing provider networks and structure which could be built from.³⁰ For further background on ideas to structure a nation-wide plan, please see [this Health Affairs article](#) from 2019.

5. What type of premium assistance should the Federal government provide for individuals enrolled in the public health insurance option?

Subsidies have proven to be a critical aspect of affordability for rural individuals enrolled in the Marketplace. Marketplace premium rates in rural regions have increased more substantially than in urban areas.³¹ Additionally, health insurer participation is lower in rural regions compared to urban areas. In counties where 20 percent or less of the population lives in an urban area, 68.4 percent of

²⁴ Which was modeled off of the Federal Employee Health Benefits Program.

<https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2011.1265>

²⁵ <https://www.rwjf.org/en/library/research/2018/11/are-marketplace-premiums-higher-in-rural-than-in-urban-areas.html>

²⁶ <https://www.healthdeals.com/blog/learn/rural-healthcare/>

²⁷ <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2011.1265>

²⁸ <https://rupri.public-health.uiowa.edu/publications/policybriefs/2016/HIMs%20rural%20premium%20trends.pdf>

²⁹ <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2011.1265>

³⁰ <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2011.1265>

³¹ <https://theactuarymagazine.org/the-acas-impact-on-rural-areas/>

counties had two or more health insurers offering coverage in the federally facilitated marketplace (FFM) in 2020, compared to 92.7 in 2015.³² If Marketplace premiums are higher in areas with less competition among issuers, and less competition is occurring in rural areas, the result is a differential in premiums that is affecting people based upon where they live.³³

Current premium rates are not affordable for many uninsured individuals living in rural areas who are not eligible for premium tax credits.³⁴ Therefore, it will be critical to offer premium assistance similar to the Marketplace for any public option. The ACA model of premium support for those under 400 percent of the federal poverty level (FPL), with sliding scale of premium assistance is a good framework. The 2021 American Rescue Plan includes a 2- year provision that extends the possibility of premium assistance to all people above 400 percent FPL, with premiums limited as a percent of income. A public option could use this model as a permanent part of its foundation, especially given that uninsured over 400 percent FPL will be disproportionately from rural areas.³⁵

6. *What should be the role of states in a federally-administered public health insurance option?*

NRHA believes that for a public health insurance option to be effective it would likely have to be administered by the federal government. State-specific plans in rural areas have heavy startup costs associated with establishing a new provider network and must be able to charge premiums that allow them to cover these expenses, therefore increasing costs.³⁶ Having a single platform under a federally based public option would increase efficiency in terms of design, implementation, and operation, rather than 50 different systems. From a rural standpoint, a federal system could more effectively operate national plan offerings (as discussed in question 4 above) and promote equity among rural areas and between rural and urban areas (see question 8 below).

7. *How should the public health insurance option interact with public programs, including Medicare and Medicaid?*

Ideally, the four national programs (Medicare, Medicaid, Marketplace, and public option) should align and complement each other. It is critical that reimbursement rates for rural providers under the public option be higher than rates offered by both Medicare and Medicaid in order to maintain the long-term sustainability of the rural safety net (as noted in the response above to question 2).

8. *What role can the public option play in addressing broader health system reform objectives, such as delivery system reform and addressing health inequities?*

A federal public option could address health disparities between rural and urban areas by establishing nation-wide transformation and health system reform objectives. Through establishing a federal program, trends in health outcomes for rural communities can be tracked more easily and used to direct policy solutions. This could be modeled after the equity principle in Medicare, providing equal treatment and equal payment for beneficiaries and providers in the program regardless of geographic

³² <https://theactuarmagazine.org/the-acas-impact-on-rural-areas/>

³³ <https://rupri.public-health.uiowa.edu/publications/policybriefs/2016/HIMs%20rural%20premium%20trends.pdf>

³⁴ <https://theactuarmagazine.org/the-acas-impact-on-rural-areas/>

³⁵ <https://www.kff.org/health-reform/issue-brief/impact-of-key-provisions-of-the-american-rescue-plan-act-of-2021-covid-19-relief-on-marketplace-premiums/>

³⁶ <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2011.1265>

location. Further, using an FEHP-like nation-wide framework, has the potential to build in targets and reasonable times for health system reform objectives, including incentives to address social determinants of health, especially targeted for rural. Known regional differences in network adequacy and challenges with enforcement could be lessened by a federal-level standard. For example, efforts could focus on equity improvement in specific regions, such as rural parts of the South and Southwest, which experience dramatic health disparities compared to other parts of the country