TRUMPCARE AND THE HEARTLAND

BIG PROMISES MAY BECOME BITTER PILL
BIG BILLS IN SMALL TOWNS

By ERIN MERSHON

In the southeast Georgia town of Statesboro, J. Wayne Collingsworth is fed up.
Collingsworth and his wife Kathy have watched their health insurance premiums jump from about $1,000 per month in 2015 to $1,550 per month this year. Last year the couple, who buy their insurance through HealthCare.gov, had to switch from a Humana plan they liked to a Blue Cross Blue Shield of Georgia plan after their original insurer stopped selling coverage in their area. Their new plan also doesn't pay for all the medications their previous insurer covered.

The Collingsworths, who run their own decorating and home repair company when they're not doting on their two grandchildren, say they're paying far too much for health insurance and have too few options. "By any measure of reason and intelligence, this entire act is insane," Collingsworth says of President Barack Obama's signature health care law. The Collingsworths and their neighbors had a lot to gain from the law. South Georgians in smaller towns and in the state's countryside were more likely than their big city counterparts to be uninsured before the health law's implementation. They are more likely to be lower income and suffer from expensive chronic conditions.

But rural and small-town Americans also had the most to lose when Obamacare's performance fell short.

Unlike urban areas, fewer insurers compete to offer health care in sparsely populated farm country or relatively small towns. In Statesboro, where just 4,000 individuals signed up for health coverage under the Affordable Care Act, the number of companies offering plans fell from three in 2016 to one this year.

If the Collingsworths lived about 200 miles north, in Atlanta, they could still get that Humana plan — and their monthly premiums would likely be under $1,000 this year, even before subsidies. In fact, they'd have a choice of four different insurers.

“We have to realize that there's just something different about rural,” says Tim McBride, a Washington University in St. Louis professor and a member of the Rural Policy Research Institute. “Going forward with the Affordable Care Act and any reform, people just need to think about looking at rural insurance differently.”

Across the country, small-town Americans are paying more than city dwellers for their insurance, with fewer options. Their prices are climbing faster, too: monthly premiums for insurance on the health care law's exchanges spiked by an average 30 percent in rural areas last year, compared to an average 20 percent premium rise in urban areas.

People in more than a third of U.S. counties, mostly rural, had just one insurance company from which they could buy Obamacare plans last year.

In Georgia — home to the newly installed Health and Human Services Secretary Tom Price — and around the country, these are the Americans who have both the most to gain and the most to lose from repeal. And
HEALTH INSURANCE COSTS HAVE RISEN IN RURAL AREAS MORE THAN MOST PLACES
they are the ones Price and congressional Republicans will answer to as they craft their replacements.

The Collingsworths and people like them also are the voters who helped elect a president determined to take down the health care law. They are dissatisfied with the status quo and looking for changes that will take their particular geographic, economic and health situations into account.

Republicans, at least in their rhetoric, say they understand those differences and that their plans to give states more flexibility will better account for the differences than the 2010 health care law did.

Senate Republican Policy Committee Chairman John Barrasso has seen the problem up close in his home state of Wyoming, where ranchers regularly complain about the high prices and fewer choices. "Patients in rural areas are facing higher premiums, fewer insurance choices and hospitals are being forced to close," he says. "We are committed to stabilizing the insurance market and giving states flexibility, so they can design reforms that meet their unique needs."

Supporters of the Affordable Care Act warn, however, that the policy details of the Republican replacement plans — like stripping funding for Medicaid or reducing the generosity of the law’s subsidies, especially those in high-cost rural areas — will only exacerbate the problems rural residents face. The health law’s subsidies, after all, were designed to be higher in areas where premiums are more expensive.

A Long-Simmering Problem

It’s not just the small business owners and farmers in south Georgia who watched their premiums skyrocket while Atlantans’ stayed relatively low.

A young family in Morton, Texas (population 2,000), would pay about $1,200 per month this year, compared to a $700 premium for a similar family in San Antonio. That same family would pay a whopping $1,500 per month in rural Selmer, Tenn., compared to about $1,000 per month 150 miles northeast in Nashville. And a family in Virginia’s Alleghany County might spend $900 per month on care, whereas the same plan 200 miles away in the suburbs of Washington, D.C., would cost about $750, according to estimates from the nonpartisan Kaiser Family Foundation.

In each of those tiny towns, just one insurer remains on the insurance exchanges. A San Antonio family, meanwhile, could choose among four companies. Two plans offer coverage in Nashville, and six offer options in Fairfax County, Va.

Out West, entire states like Wyoming and Oklahoma are experiencing the same dynamics, facing ballooning premiums and just a single participating insurance company.

About 41 percent of rural consumers nationwide have just one plan to choose from, according to the Kaiser Family Foundation. Just 18 percent of urban enrollees face the same situation. The vast majority of urban consumers could choose from at least three companies.

The problems of rural insurance extend far beyond the health care law’s marketplaces, which provide coverage to about 4 percent of the U.S. population. The Medicare Advantage program, the program for older Americans that is administered by private insurers, has also struggled to attract insurance companies to rural areas, as have state Medicaid programs that rely on private plans to administer their services.

In the so-called individual market — which serves people who don’t get coverage

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**Paying For Obamacare in Trump Country**

In much of the rural U.S., where the president drew support, unsubsidized premiums under the 2010 health care law are higher.

**Source:** McKinsey & Co., Census Bureau

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<th>County</th>
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<td>Yukon–Koyukuk, Alaska</td>
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**2017 Premiums w/o subsidies**

- $924
- Median $196
- $199

**Source:** McKinsey & Co., Census Bureau
through their job or a government program — the problems existed long before Obama signed his signature law. Before then, rural Americans paid about 39 percent of their medical bills out of pocket, according to a 2006 study in the journal Health Affairs. They had higher uninsured rates and often, fewer options for coverage than their urban counterparts.

In many states, a single insurance company dominated the market for decades, before the law opened the field to more competition. In 2010, in 30 different states and D.C., a single insurance company covered more than half the people in the individual market. In states like Alabama and other rural states in the South and the mid-Atlantic region, the most dominant company was even more prevalent.

Cynthia Cox, an associate director for the Kaiser Family Foundation, adds that the market was made up of different people before the law passed — and was about half the size it is now because insurers could deny people with pre-existing conditions. Insurers were less willing to offer plans in rural areas then. That also makes comparisons before and after the law difficult, she says.

**Challenges in the Countryside**

Several factors explain the wide disparities in rural and urban health insurance markets.

Chief among them is the concentration of doctors and hospitals that offer services to rural residents. In areas where there is just one hospital or physician’s practice for miles in any direction, insurers struggle to negotiate lower prices, but the higher insurance costs get passed on to consumers in their premiums.

“Just like any other market, if hospitals or doctors or pharmaceutical companies or anybody faces less competition, they have higher prices. That’s very simple, and it’s that way if you buy gasoline at the pump, it’s that way with milk, with anything else,” says Martin S. Gaynor, a Carnegie Mellon University professor who focuses on health care competition. “The more expensive is health care, the more expensive and less affordable health insurance is going to be. It’s really that simple.”

A 2015 National Bureau of Economic Research study that looked at the costs private insurers pay for health services across the entire country found that even after controlling for factors like demand and local cost-of-living, hospitals that had monopoly power in their markets charged 15 percent more than those in more competitive markets.

That dynamic drives up prices and makes it less attractive for insurers to participate. Insurance companies must build a network of providers that can offer certain services, according to federal and state rules about how many specialists must be “in network” and how far from a given enrollee those providers can be located. It gets much more complicated and time-consuming to build networks in places with fewer providers.

Demographic trends also make rural ar-
eas less attractive to insurers. If insurance companies want to make money, they need to attract a balance of healthy customers to offset the costs of people who need a lot of health services. That mix is harder to achieve in rural areas, in part because there are fewer people overall and the low population density makes it tougher to spread out the costs of caring for the sick.

Though the 2010 health care law did expand coverage, it was less impactful outside big cities. Rural Americans were less likely to sign up for coverage than their urban counterparts — perhaps because costs were higher, because of politics or because rural residents saw less advertising about the law. That made the pool even smaller.

The escalating costs of health insurance can also exacerbate the problem in rural areas where residents are more likely to have incomes below the federal poverty level. That can make it difficult for anyone who isn’t very sick to afford coverage.

The subsidies in the law, of course, offset some of the costs that rural residents face. But with higher premiums and lower incomes, it may not be enough.

“There just needs to be an acceptance of the fact that our people are older, sicker and poorer and they need some help,” Michelle Mills, the CEO of the Colorado Rural Health Center, said last month at a National Rural Health Association meeting in Washington. “We’re never going to change that cycle unless somebody makes an investment.”

Looking For Solutions

The level of that investment is a chief consideration of Republicans in Washington, as they debate the policies that could replace parts of the 2010 law they believe need to be repealed. GOP leaders are still determining the parameters of their replacement plan, but nearly every option relies on a competitive individual market in which Americans can compare insurance company plans.

The Republican replacement plan so far, however, would almost certainly exacerbate the high prices rural consumers face. In their efforts to replace the health care law’s tax credits and subsidies, which are aimed at helping people like the Collingsworths afford their insurance, Republicans have largely coalesced around a plan to calculate a tax credit for consumers based on age and income — but not on the cost of the plans available to a person.

Because the subsidies wouldn’t take into account the local prices of plans, including the price differences between plans in rural or urban markets, they would be the same for a family paying $1,550 per month in Statesboro or $1,000 per month in Atlanta. Under current law, the Statesboro family would receive a higher subsidy. (See page 21.)

House Democratic Leader Nancy Pelosi of California emphasized in a March speech that it was the red-state voters who elected Trump who would lose the most benefits under the latest Republican tax credit proposal. “It’s a very sad transfer of wealth,” she said.

Other potential changes, like those that increase state flexibility, could go further. “Our cost of health care in Alaska, being as rural as we are, it’s not a postage stamp
rate across the state,” noted Alaska’s Independent Gov. Bill Walker, who says he’s focused on making sure any modifications that are made take into consideration the rural nature of certain states.

“We do hope it’s not a one-size-fits-all, because one size certainly doesn’t fit all in Alaska,” he says.

Politicians are already discussing plans to reduce the regulatory burdens that participating insurance companies face, which could give plans new incentives to compete in both rural and urban markets. Less stringent requirements for adequate provider networks or even reduced requirements for health benefits that insurers must cover could give plans in rural areas more of an opportunity to diversify their offerings so they could differentiate themselves on more than just price.

“Less regulation could offer more ways for them to compete,” Kaiser’s Cox suggests. “But those ways for them to compete aren’t always in the best interest of the patient or the enrollee. ... It’s not necessarily benefiting patients in terms of good value of the plan, especially if they’re sick.”

Republicans, including Trump and leaders in Congress, have also supported plans to allow insurers to sell plans across state lines — a change they say would help mitigate some of the problems rural areas face by increasing competition.

Insurers, economists and other experts, however, say the difficulty of building an acceptable network of providers would reduce the impact of such a change. Some states already allow insurers to sell across state lines and few companies have taken advantage.

Instead, economists see the most potential in Republican plans to give states more control over their own marketplaces. The House Republican plan, for example, may offer as much as $100 billion in funds for so-called state innovation grants, which could be put toward several different policies aimed at improving the health insurance market, like so-called reinsurance programs that would provide funding for high-cost patients. It could even be spent on outreach and education aimed at bringing more rural consumers into the market, or on further subsidies to help certain populations better afford their insurance.

Several states have already begun to try to address the problems, even without the federal financing. Alaska, for example, last year faced average insurance premiums of $863 per month, more than double the national average of $396.

Officials in that largely rural state passed legislation to institute a reinsurance pool, funded in part by a tax on insurance companies that is aimed at helping to spread out the risks of the population and lower costs. The details are still being worked out, but actuaries have estimated it could dramatically lower premiums for individuals who rely on the marketplace in that state. The Obama administration held it up as a model for state-based innovations to improve the market.

Nebraska, meanwhile, made an inexpensive policy tweak that had a lasting impact: officials required that participants in the state’s Medicaid managed care plan also offer at least one plan on the state’s individual market exchange. Even as insurers pulled out of a number of other markets, none pulled out of Nebraska — including UnitedHealth, which dropped its coverage from more than 30 state markets.

Another favorite policy tweak among economists: reconfiguring the so-called ratings areas — the set of counties or other geographic areas in which insurers must offer the same price to all enrollees.

Each state has anywhere from one to 67 different ratings areas, and insurers set separate premiums for each. Redrawing those boundaries so that insurers who want to offer plans in competitive urban environments must also offer coverage to less attractive rural areas is a relatively simple fix that could have a sizeable impact on participation and prices.

In some ways, the ratings areas allow insurers to separate relatively healthy urban consumers from the somewhat sicker rural populations — much in the way they cherry-picked healthy customers and dropped sick ones before the health law was passed. Since they can choose to sell in some areas and not in others, they can geographically discriminate in the search for profits.

“States that have a lot of ratings areas — that’s frankly just kind of dumb,” Washington University’s McBride says. “That maybe helps insurers differentiate a lot but it doesn’t help people very much.”

Some caution, however, that redrawing the areas to encourage insurers to sell in rural areas would simply shift costs from high-cost areas to low-cost ones — a policy change that isn’t popular or lasting. “They found it just changes who’s calling in to complain about the high prices,” says Mills, of Colorado.

Even small tweaks, like redrawing the ratings areas, will create new winners and losers in the broader health care system, both for consumers and for industries like insurers and hospitals.

Tackling larger policy solutions that target the root causes of the urban-rural divides — like the worsening health conditions and low incomes prevalent among rural Americans or the overly consolidated provider markets — remain open questions.

There are signs, however, that even officials who have been reluctant to tackle the challenges of redesigning the health care system are newly ready to engage.

In Oklahoma, for example, voters were once so opposed to the 2010 health care law that they tried to ban the state from enforcing it. State leaders opposed both the Medicaid expansion and the creation of a state-based exchange.

But now, Oklahoma officials are examining major market changes. That’s in part because they have just a single insurer participating on their exchange and residents are facing especially high premiums even as health outcomes worsen, says Mike Rhoads, the state’s deputy commissioner of life and health insurance.

“See a much more progressive approach about this, about what does Oklahoma need. We have been actively looking at alternatives” to improve the system, he says. “There’s really some thought being given here in Oklahoma about how do you want to move the needle.”

Erin Mershon produced this special report as part of a yearlong Reporting Fellowship on Health Care Performance sponsored by the Association of Health Care Journalists and supported by The Commonwealth Fund.