MedicalXpress

Study shows rural disadvantages under Obamacare

February 19 2015, by Clifton B. Parker

One year after the launch of Obamacare, some rural residents face significant disadvantages, a new Stanford study shows.

"Small and rural regions appear to attract fewer entrants. Insurers also charge higher premiums to rural residents," wrote Michael J. Dickstein, an assistant professor of economics, in a policy brief for the Stanford Institute for Economic Policy Research.

The brief originated from a research article by Dickstein; Mark Duggan, the Wayne and Jodi Cooperman Professor and a senior fellow at SIEPR; and Stanford economics doctoral students Joe Orsini and Pietro Tebaldi.

In 2014, nearly 8 million American residents signed up for private health insurance coverage through new state-run marketplaces created under the Affordable Care Act, also known as Obamacare. Under it, individual states have discretion in how they define coverage regions.

In the study, Dickstein examined how health insurance markets fared in the first year of the new health care operation, using data from 33 states. In particular, he studied the size and composition of coverage regions within a state and across states. He found significant effects for people living in small and rural markets.

"When states combine small counties with neighboring urban areas into a single region, the included rural markets see 0.6 to 0.8 more insurers, on average, and savings in annual premiums of between $200 and $300 for

the benchmark plan," he said in an interview.

For example, if there were two insurers in a rural coverage area as described above, the number would rise to 2.6 to 2.8 for the rural areas when combined with an urban neighbor.

As Dickstein pointed out, federal lawmakers left the definition of a community or "coverage region" to individual states. Each state was given the right to choose the geographic areas covered by each region.

"This decision has important implications for market outcomes," he wrote.

Drawing larger regions, he explained, might attract more insurers to compete for the larger pool of potential customers, leading to more plan choices and possibly lower prices. Larger regions, however, could prove costlier to serve, thereby discouraging insurers from entering that particular market.

Bundling rural, urban coverage

In his analysis, Dickstein found that states chose very different approaches to creating coverage regions. For example, Florida established its regions by county – there are 67 regions to cover the 67 counties in the state.

Near the other extreme, Texas drew its regions by using one region per major city and then a complementary region that covers all other counties of the state. As a result, Texas divided its 254 counties into only 26 regions.

Bundling rural counties with larger, urban areas appears to increase the supply of plans available to rural residents, the study concluded.

Such findings raise a question, he said. Should government regulators choose larger region sizes, to include entire states or maybe multiple states?

Or, at the extreme, Dickstein suggested, why not establish one nationwide market for insurance in which insurers can choose to participate?

He noted a clear trade-off in the designation of a region's boundaries. In other words, the research showed that regions with pockets of extremely high and low urbanity appear relatively unattractive markets for private insurers to enter.

Going forward

Dickstein suggested that states can encourage greater numbers of insurers to participate in the ACA's marketplaces and, in particular, to serve rural markets, by grouping these rural markets into coverage regions with larger urban markets.

For example, the study compares the plans offered in two very similar rural counties in Tennessee – one outside Memphis and one outside Nashville. Tennessee chose to group the first rural county in with the Memphis coverage region. For the rural market outside of Nashville, the state chose to include that market in a rural region rather than in the Nashville market.

"Residents of the county excluded from Nashville's region saw a benchmark premium that was 7 percent higher, and only one insurer chose to offer plans in that market," he said.

One challenge is the role of consumer-oriented and -operated co-op plans, a new type of nonprofit health insurer created under the ACA, he

said. Can co-op plans compete with larger insurance plans and improve access and affordability in traditionally under-served markets? The data now available from Obamacare's first year can help illuminate this issue, he said.

More information: The research article is available online: www.nber.org/papers/w20907.pdf

Provided by Stanford University