



# Looking at 2016 Open Enrollment: Learning from Rural Outreach and Enrollment Efforts 2013-2015



# Key Facts Regarding the Rural Uninsured



- Rural Americans, on average ....
  - Are nearly 16 percent of the total American population.
  - Are disproportionately older and therefore larger Medicare population.
  - Are more likely to have chronic disease.
  - Are less educated than their urban and suburban counterparts.
  - Are more likely to be on food stamps.
  - Are more likely to be uninsured than residents in urban areas.\*
  - Have lower income levels than urban and suburban counterparts.\*
  - Have access to fewer health resources.

\* Source: "The Uninsured: An Analysis by Income and Geography," Barker AR, Londeree JK, McBride TD, Kemper LM, Mueller K, RUPRI Center for Rural Health Policy Analysis, Rural Policy Brief, June 2013.  
<http://cph.uiowa.edu/rupri/publications/policybriefs/2013/Uninsured%20Analysis%202013.pdf>



# Effects of Medicaid Expansion on Rural Areas



- Fewer rural states have expanded Medicaid
- Majority of rural residents live in a state without plans to expand Medicaid
- Variation amongst states in Medicaid expansion has led to a wider rural-urban disparity in insurance coverage than had existed before the Affordable Care Act



Source: [“How Does Medicaid Affect Insurance Coverage of Rural Populations?”](#) K Thompson, B Kaufman, and M Holmes, North Carolina Rural Health Research Program, July 2014



# The Rural Uninsured: What We Know



- More likely to be eligible for coverage under the Marketplace
- More likely to be eligible for coverage under Medicaid Expansion

## RUPRI Center for Rural Health Policy Analysis *Rural Policy Brief*

Brief No. 2014-2

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[www.public-health.uiowa.edu/rupri](http://www.public-health.uiowa.edu/rupri)

### **The Uninsured: An Analysis by Age, Income, and Geography**

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#### **Key Findings**

- Assuming Medicaid expansion in each of the fifty states and the District of Columbia, a larger proportion of the rural (non-metropolitan) uninsured (43.5%) than the urban uninsured (38.5%) would be eligible for Medicaid.
- In both urban and rural places, across the adult non-elderly population, uninsured rates decline dramatically with age.
- Within each age group of the uninsured, rural people are less likely to have incomes above 400% of the federal poverty level (FPL), meaning that overall more rural uninsured would be eligible for some form of health insurance assistance under the Patient Protection and Affordable Care Act (ACA), either subsidized coverage in new marketplaces, or through Medicaid if all states were to implement expansion.
- While over half of the uninsured in both rural and urban areas are younger than 40 years, the uninsured in rural areas are disproportionately older across all income categories, which reflects the age distribution in the population.

#### **Introduction**

Recent analysis of 2010 health insurance data produced by the RUPRI Center for Rural Health Policy Analysis has shown that the proportion of the rural population that is uninsured and living at or below 138% of the federal poverty level (FPL) exceeds the urban proportion (9.9% as compared to 8.5%, respectively), and that a higher proportion of rural persons (10.7% as compared to 9.6%) are in households with incomes between 138% and 400% FPL.<sup>1</sup> We extend the previous work to differentiate the uninsured by income and age. Our analysis is based on data from the U.S. Census Bureau, Small Area Health Insurance Estimates (SAHIE),<sup>2</sup> estimates of the uninsured (for all of the previous calendar year) population by county, including age-level breakdowns.

#### **Rural and Urban Uninsured Rates by Age and Income**

Under the ACA, three significant income categories are used for eligibility purposes: (1) at or below 138% FPL (133% plus a 5% disregard of adjusted gross income), and therefore eligible for coverage under Medicaid expansion; (2) above 138% but below 400% FPL and eligible to receive subsidies in the form of premium tax credits on a sliding scale in the health insurance marketplaces (HIMs); and (3) at or above 400% FPL and ineligible for subsidies although still able to purchase health insurance through the HIMs. In states without Medicaid expansion, individuals earning above 100% FPL will be able to purchase subsidized HIM coverage,<sup>3</sup> but in the interest of presenting uniform results, we will use the 138% FPL cutoff. There are also reduced cost-sharing



# The Health Insurance Marketplaces in Rural

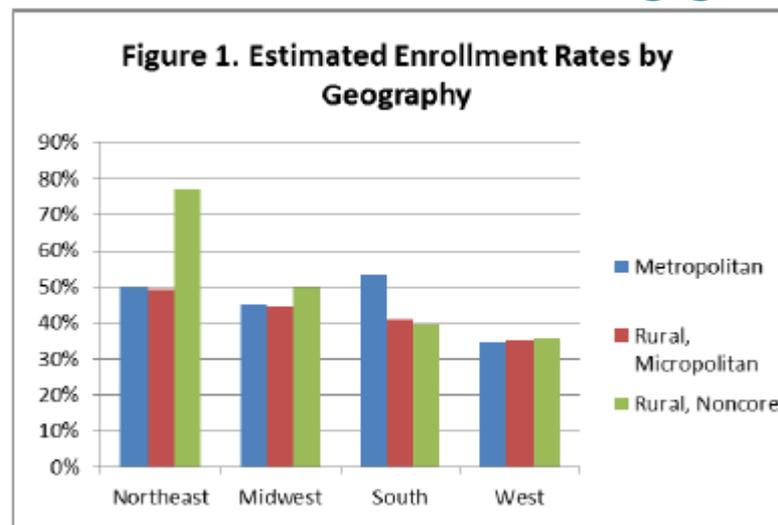


- Issuer Participation:
  - Increased participation of health insurance firms
- Premium rates:
  - There is a high amount of variability in Marketplace premiums. Similar to urban areas, some rural areas are seeing low and affordable premiums, while in other cases, premiums are higher.



# 2015 Rural Enrollment

- 1,542,970 (17%) of individuals selecting 2015 plans were rural residents
- Rural enrollment rates in the South lagged behind urban rates
- 85.6 % of rural residents insured in 2015



Source: <http://www.public-health.uiowa.edu/rupri/publications/policybriefs/2015/FFM%20Enrollment%20Brief.pdf>

Source: [http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/Mar2015/ib\\_2015mar\\_enrollment.pdf](http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/Mar2015/ib_2015mar_enrollment.pdf)



# HRSA Rural O&E Efforts



- HRSA funding to expand O&E assistance activities:
  - 2013:
    - The Federal Office of Rural Health Policy (FORHP) awards approximately \$1.3 million to 52 Rural Health Care Services Outreach Program grantees
    - Bureau of Primary Health Care supplemental funding awards for approximately \$208 million to 1,159 health center grantees
  - 2014:
    - FORHP awards \$1.3 million in supplemental funds to 57 grantees in the Outreach, Quality, and Delta programs.
- Ongoing efforts:
  - Holding regular Affordable Care Act webinars with rural grantees and stakeholders
  - Developing O&E materials specific to rural populations
  - Engaging in regular conversation with rural grantees around O&E efforts
  - HRSA has made a commitment to outreach and enrollment as an ongoing health center activity by incorporating O&E funding into health centers' base awards moving forward.



# Success Rural Outreach Strategies



- Building new and existing partnerships locally and regionally
- Targeting small business owners (e.g., barbershops, hair salons, and food trucks) as partners for information sharing and as venues for events
- Reaching out to agents and brokers
- Focusing on place-based outreach:
  - Enrolling the community where they “Work, Pray, Play”
  - Coordinating major outreach efforts with existing seasonal events and venues (e.g., parades, festivals, state fairs, and back-to-school campaigns)



# Successful grantee outreach strategies



- Mailing postcards or personalized letters to provide education and information about upcoming events
- Creating visuals when educating individuals about health insurance terms or concepts
- Leveraging existing community resources
  - Using local radio, TV ads, and other media to disseminate information about assistance events
  - Word-of-mouth: encouraging consumers to refer family and friends



# Grantee Story: Little Dixie Community Action Agency



- Navigator Grant recipient
- Community Action Agency serving 58 of 77 counties in OK
- Subcontracted to 13 other CAAs
- Successful O&E strategy: partnering with local schools, faith based communities, and local business to educate community

Contact: Chad Austin, Project Coordinator, Oklahoma's Community Action Agency Navigator Consortium Project, 580.326.6441



# Rural Hospitals: Key Partners



- Not-for-Profit Hospitals can consider doing Outreach and Enrollment to meet their Community Benefit requirements
- Getting patients into coverage can help improve population health
- Also helps improve the hospital's financial viability

“ ... helping, uninsured individuals and families learn about and enroll in sources of insurance such as Medicare, Medicaid, Children’s Health Insurance Program (CHIP), and the new Health Insurance Marketplaces (also known as the Exchanges) ... ”

Federal Register / Vol. 78, No. 66 / Friday, April 5, 2013 / Proposed Rules 20523

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<p><b>DEPARTMENT OF THE TREASURY</b> Internal Revenue Service</p> <p><b>26 CFR Parts 1 and 53</b> (REG-106499-12) RIN 1545-BL30</p> <p><b>Community Health Needs Assessments for Charitable Hospitals</b></p> <p><b>AGENCY:</b> Internal Revenue Service (IRS), Treasury.</p> <p><b>ACTION:</b> Notice of proposed rulemaking.</p> <p><b>SUMMARY:</b> This document contains proposed regulations that provide guidance to charitable hospital organizations on the community health needs assessment (CHNA) requirements, and related excise tax and reporting obligations, enacted as part of the Patient Protection and Affordable Care Act of 2010. These proposed regulations also clarify the consequences for failing to meet these and other requirements for charitable hospital organizations. These regulations will affect charitable hospital organizations.</p>	<p>Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies to the Internal Revenue Service, Attn: IRS Reports Clearance Officer, SE:W-CAR:MP:T:T:SP, Washington, DC 20224. Comments on the collection of information should be received by June 4, 2013. Comments are specifically requested concerning:</p> <p>Whether the proposed collection of information is necessary for the proper performance of the functions of the Internal Revenue Service, including whether the information will have practical utility;</p> <p>The accuracy of the estimated burden associated with the proposed collection of information;</p> <p>How the quality, utility, and clarity of the information to be collected may be enhanced;</p> <p>How the burden of complying with the proposed collection of information may be minimized, including through forms of information technology; and</p> <p>Estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information</p>	<p>amendments to § 1.6033-2 will be reflected in the burden on Form 990, "Return of Organization Exempt from Tax," after it is revised to require the additional information in the regulation. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number assigned by the Office of Management and Budget.</p> <p>Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and return information are confidential, as required by section 6103.</p> <p><b>Background</b></p> <p>The Patient Protection and Affordable Care Act, Public Law 111-148 (124 Stat. 119 [2010]) (the "Affordable Care Act"), enacted section 501(r) of the Code, which imposes additional requirements on charitable hospital organizations. Section 501(r)(1) states that a hospital organization described in section 501(r)(2) will not be treated as a tax-</p>
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# What are we doing for 2016?

- Focus on health literacy
- Continue ongoing efforts:
  - “ORHP, ACA, and You” case-tip videos
  - Regular newsletters with resources and information for rural stakeholders



# Resources



- HRSA Affordable Care Act Website
  - <http://www.hrsa.gov/affordablecareact>
- HRSA Office of Rural Health Policy Website
  - <http://www.hrsa.gov/ruralhealth/>
- Office of Rural Health Policy ACA Questions Listserv
  - [orhp-acaquestions@hrsa.gov](mailto:orhp-acaquestions@hrsa.gov)
- National Advisory Committee on Rural Health and Human Services Policy Brief
  - <http://www.hrsa.gov/advisorycommittees/rural/publications/ruralimplications.pdf>
- Partnering with Community Health Centers on Outreach and Enrollment Resource
  - <http://www.hrsa.gov/affordablecareact/healthcenterpartner.pdf>
- Marketplace Information and Enrollment
  - <https://www.healthcare.gov/>
- Provider and Partner Marketplace Resources
  - <http://marketplace.cms.gov>