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Senate Bill Would Devastate Health Care in Rural America

By Jesse Cross-Call, Tara Straw, Arloc Sherman, and Matt Broaddus

The Senate health bill — the Better Care Reconciliation Act (BCRA) — would, like the House-passed bill, effectively end the Affordable Care Act's (ACA) Medicaid expansion, radically restructure virtually the entire Medicaid program through a per capita cap, and replace the ACA's premium tax credit with a much smaller tax credit that would make coverage unaffordable for millions of people looking to purchase coverage in the individual market. Taken together, these and other provisions would raise the number of uninsured by 22 million by 2026, according to the Congressional Budget Office (CBO).[1]

The Senate and House bills would be particularly harmful to rural America. Medicaid has long played a larger role in providing health coverage and paying for care in rural areas than in urban areas. Medicaid's importance to rural America has only grown under the ACA. Nearly 1.7 million rural Americans have newly gained coverage through the Medicaid expansion. In at least eight expansion states, more than one-third of expansion enrollees live in rural areas: Alaska, Arkansas, Iowa, Kentucky, Montana, New Hampshire, New Mexico, and West Virginia. Moreover, in expansion states overall, rural residents make up a larger share of expansion enrollees than they do of these states' combined population. The Medicaid expansion has become a critical financial lifeline sustaining rural hospitals as well.

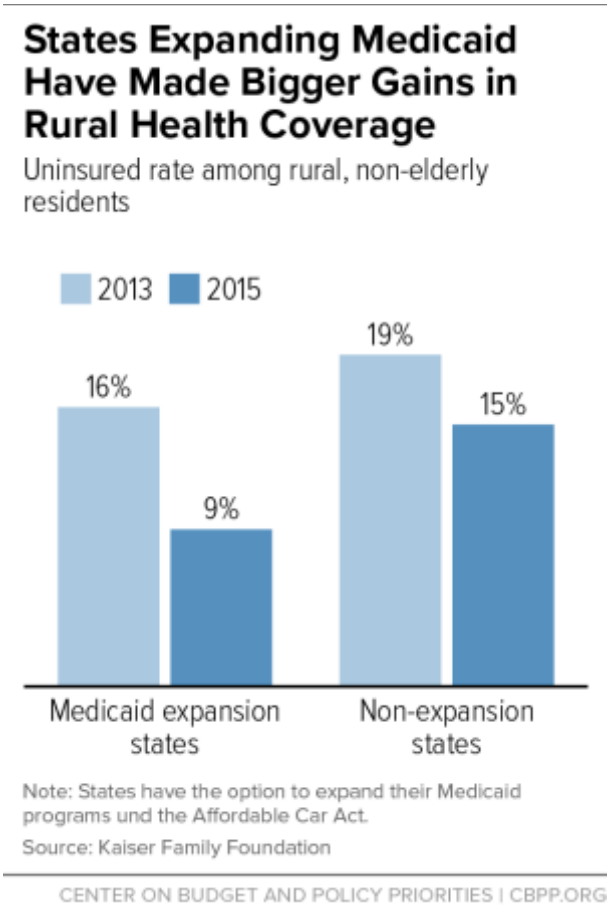
Rural areas have also greatly benefited from the ACA's premium tax credits and cost-sharing subsidies and would be disproportionately harmed by the Senate bill's smaller credits and elimination of help with deductibles and copayments. More than 1.6 million enrollees — or nearly 1 in 5 marketplace enrollees in the 39 states that use HealthCare.gov — live in rural areas. The Senate bill would increase out-of-pocket costs for most consumers around the country, but especially for older people and people in high-cost states and areas. That means the bill would disproportionately harm people in rural areas, where residents tend to be older on average and where health care costs and premiums tend to be higher. And many rural residents could face prohibitive premiums and out-of-pocket spending because the Senate plan would allow states to waive protections that enable people with pre-existing conditions to get the coverage and services they need.

[1] Congressional Budget Office, "H.R. 1628, Better Care Reconciliation Act of 2017," June 26, 2017, https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52849-hr1628senate.pdf.

Medicaid — and Medicaid Expansion's — Critical Role in Rural America

Medicaid has long played an essential role in delivering health care in rural America. In 2010, prior to the ACA, 18 percent of rural residents nationwide were enrolled in Medicaid, compared to 15 percent of urban residents. This reflected various factors unique to rural America, including its lower access to job-based coverage, greater prevalence of self-employed jobs (such as farming and contracting), lower incomes, and greater share of people with a disability.[2] In a 2007 survey, for example, two-thirds of farmers cited the cost of health insurance as the biggest threat to their farms.[3]

FIGURE 1



Like the rest of the country, rural America has enjoyed large gains in health coverage since the ACA's major coverage expansions took effect in 2014. The uninsured rate among rural non-elderly individuals plummeted by nearly one-third between 2013 and 2015, from 17 percent to 12 percent, according to a Kaiser Family Foundation analysis. Over the same period, the Urban Institute's Health Reform Monitoring Survey found that rural individuals' insured rate rose by 7.2 percentage points, compared to 6.3 percentage points for individuals in urban areas.[4]

Coverage gains occurred in both Medicaid and private insurance, but states that expanded Medicaid have made larger gains in rural health coverage: the uninsured rate among rural, non-elderly individuals dropped much more in states that expanded Medicaid (from 16 percent in 2013 to 9 percent in 2015) than in non-expansion states (from 19 percent to 15 percent).[5] (See Figure 1.)

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[2] For more information about Medicaid's role in rural America prior to the ACA, see Center on Budget and Policy Priorities, "Rural America Will Benefit from Medicaid Expansion," June 7, 2013, http://www.cbpp.org/sites/default/files/atoms/files/Fact-Sheet-Rural-America.pdf.

[3] Kathleen Masterson, "Health Insurance Woes Add Another Challenge to the Risky Business of Farming," Vermont Public Radio, February 10, 2017, http://digital.vpr.net/post/health-insurance-woes-add-another-challenge-risky-business-farming#stream/0.

[4] Michael Karpman *et al.*, "Substantial Gains in Health Insurance Coverage Occurring for Adults in Both Rural and Urban Areas," Urban Institute, April 16, 2015, http://hrms.urban.org/quicktakes/Substantial-Gains-in-Health-Insurance-Coverage-Occurring-for-Adults-in-Both-Rural-and-Urban-Areas.html.

[5] Julia Foutz, Samantha Artiga, and Rachel Garfield, "The Role of Medicaid in Rural America," Kaiser Family Foundation (KFF), April 25, 2017, http://kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/. Definitions of "rural" differ. The CBPP analysis defines rural as not living in a metropolitan county, the definition used

Medicaid also plays a larger role in providing health coverage to children in rural areas than urban areas: 45 percent of children in small towns and rural areas have Medicaid coverage, as compared to 38 percent in urban areas. Medicaid is a big reason why the uninsured rate among children in rural areas fell from 9 percent in 2009 to 6 percent in 2015.[6]

Among non-elderly adults, 1.7 million of the more than 11 million people who have newly gained Medicaid coverage through the ACA expansion live in rural America, according to CBPP estimates (see Appendix Table 1). The expansion population is more rural than the population as a whole: rural residents make up 12 percent of the population of expansion states but 14 percent of expansion enrollees in these states. In at least eight expansion states, more than one-third of expansion enrollees live in rural areas: Alaska, Arkansas, Iowa, Kentucky, Montana, New Hampshire, New Mexico, and West Virginia.

People enrolled in coverage through the Medicaid expansion are receiving needed primary care and critical health services, research shows. For example, a survey of low-income, non-elderly adults in Arkansas and Kentucky — states in which half of expansion enrollees live in rural areas — found a 29 percent increase in the share of people with a personal physician, a 24 percent increase in the share of people who got a check-up in the past year, and a 42 percent increase in the share of people who say they are in "excellent" health.[7] In Kentucky, state data show tens of thousands of low-income individuals have received cholesterol, diabetes, and cancer screenings, and preventive dental services.[8] Medicaid expansion has also helped millions of people get treatment for opioid addiction and other substance use disorders.[9]

The Medicaid expansion has been a lifeline for rural areas in other ways. The ACA coverage expansions, especially the Medicaid expansion, have substantially reduced hospitals' uncompensated care costs, which fell by about *half* as a share of hospital operating budgets between 2013 and 2015

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by the Office of Management and Budget. KFF based its estimates on analysis of American Community Survey data from 2013-2015 and defined rural areas using the 2010 Index of Relative Rurality measure, where the population quintile with the highest degree of rurality is referred to as "rural." For a full description of KFF's methodology, see its report.

[6] Karina Wagnerman *et al.*, "Medicaid in Small Towns and Rural America: A Lifeline for Children, Families, and Communities," Georgetown University Center for Children and Families and University of North Carolina NC Rural Health Research Program, June 6, 2017, https://ccf.georgetown.edu/wp-content/uploads/2017/06/Rural-health-final.pdf.

[7] Jesse Cross-Call, "Medicaid Expansion Has Improved People's Health, Access to Care, and Financial Security," Center on Budget and Policy Priorities, May 31, 2017, http://www.cbpp.org/blog/medicaid-expansion-has-improved-peoples-health-access-to-care-and-financial-security.

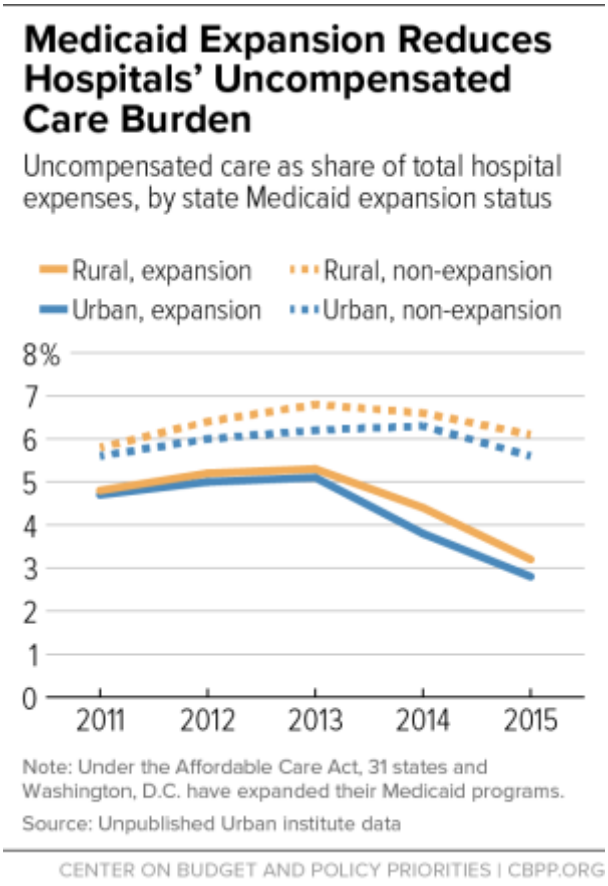
[8] Jesse Cross-Call, "Medicaid at 50: Kentucky's Experience Highlights Benefits of Medicaid Expansion," Center on Budget and Policy Priorities, July 23, 2015, http://www.cbpp.org/blog/medicaid-at-50-kentuckys-experience-highlights-benefits-of-medicaid-expansion.

[9] Peggy Bailey, "ACA Repeal Would Jeopardize Treatment for Millions with Substance Use Disorders, Including Opioid Addiction," Center on Budget and Policy Priorities, February 9, 2017, http://www.cbpp.org/research/health/aca-repeal-would-jeopardize-treatment-for-millions-with-substance-use-disorders.

in expansion states.[10] Reductions in uncompensated care and increases in the share of patients covered by Medicaid have been especially important for rural hospitals. For example:

- Both urban and rural hospitals in expansion states saw improvements in operating margins after the expansion. But these gains were larger for rural hospitals (a 4 percentage-point increase) than in urban areas (a 1 percentage-point increase).[11]
- Since 2013, hospitals' uncompensated care costs have fallen by 1.7 percentage points more, and their Medicaid revenue as a share of total revenue has risen by 2.9 percentage points more, in expansion states than in non-expansion states.[12] (See Figure 2.)
- Most of the 78 rural hospitals that have closed since 2010 are in southern states that haven't expanded Medicaid.[13]

FIGURE 2



Senate Cuts Would Undermine Entire Medicaid Program in Rural America

The Senate bill would roll back this progress in coverage and harm rural providers by effectively ending the Medicaid expansion. Under the ACA, the federal government paid the entire cost of covering expansion enrollees from 2014 to 2016, and will pay no less than 90

[10] Council of Economic Advisers, "The Economic Record of the Obama Administration: Reforming the Health Care System," December 2016, https://obamawhitehouse.archives.gov/sites/default/files/page/files/20161213_cea_record_healh_care_reform.pdf.

[11] Analysis of unpublished data from the Urban Institute's April 2017 analysis on the Affordable Care Act's impact on hospitals. See published analysis at Frederic Blavin, "How Has the ACA Changed Finances for Different Types of Hospitals? Updated Insights from 2015 Cost Report Data," Urban Institute, April 2017, http://www.urban.org/sites/default/files/publication/89446/2001215-how-has-the-aca-changed-finances-for-different-types-of-hospitals.pdf.

[12] Matt Broaddus, "Affordable Care Act's Medicaid Expansion Benefits Hospitals, Particularly in Rural America," Center on Budget and Policy Priorities, June 23, 2017, http://www.cbpp.org/research/health/affordable-care-acts-medicaid-expansion-benefits-hospitals-particularly-in-rural.

[13] Sharita Thomas *et al.*, "A Comparison of Closed Rural Hospitals and Perceived Impact," North Carolina Rural Health Research Program, April 2015, http://www.shepscenter.unc.edu/wp-content/uploads/2015/04/AfterClosureApril2015.pdf. See also an updated list of rural hospital closures: http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.

percent of the costs in 2020 and thereafter. Under the Senate bill, the federal government would pay 85 percent of the cost of expansion enrollees in 2021, 80 percent in 2022, 75 percent in 2023, and then only the regular federal Medicaid matching rate — on average, 57 percent — in 2024 and each year thereafter. This means that in 2024, the Medicaid expansion would cost states between 2.8 and 5 times as much as under current law.[14]

In nine states (Arizona, Arkansas, Illinois, Indiana, Michigan, Montana, New Hampshire, New Mexico, and Washington), these higher costs would automatically trigger immediate or eventual termination of the expansion, with no action by state policymakers necessary. Nearly 3 million people have coverage through the expansion in these states, including more than 600,000 people in rural areas. Laws in these states either explicitly require the expansion to end if the federal matching rate falls or require the state to prevent an increase in state Medicaid costs. In practice, most or all of the other 23 states that have expanded Medicaid would also see their expansions end due to the size of the cost shift.

In addition, the Senate bill would radically restructure federal Medicaid financing by converting virtually the entire program for all states to a per capita cap. (States would have the option to cover non-disabled, non-expansion enrollees through a block grant beginning in 2020.) Under the cap, states would get less federal funding per beneficiary than under current law, with the cuts growing each year. States would be responsible for 100 percent of any costs above the per capita cap, whether due to unanticipated health care cost growth or to demographic changes that a per capita cap wouldn't account for.[15] To compensate for these cuts, states would have to raise taxes, cut other budget areas like education, or as is far likelier, cut Medicaid spending by cutting payments to providers or rolling back eligibility, with the cuts becoming increasingly severe over time.

Overall, these changes would cut federal Medicaid spending by $772 billion over ten years — a 25 percent cut by 2026 — and cut Medicaid enrollment by 15 million people by 2026, CBO estimates.[16] CBO also expects that after 2026, the reductions in Medicaid enrollment, relative to current law, would continue to grow.[17]

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[14] Matt Broaddus and Edwin Park, "Senate Bill Would Effectively Eliminate Medicaid Expansion by Shifting Hundreds of Billions in Expansion Costs to States," Center on Budget and Policy Priorities, June 23, 2017, http://www.cbpp.org/research/health/senate-bill-would-effectively-eliminate-medicaid-expansion-by-shifting-hundreds-of.

[15] For more information about the Senate bill's impact on Medicaid, see Edwin Park, "Senate Includes Even Deeper Medicaid Cuts Under Per Capita Cap," Center on Budget and Policy Priorities, updated June 26, 2017, http://www.cbpp.org/blog/senate-reportedly-considering-even-deeper-medicaid-cuts-under-per-capita-cap.

[16] CBO found the Medicaid cuts in the House-passed bill, the American Health Care Act (AHCA), would have similar effects, with $839 billion in federal Medicaid cuts over ten years, and Medicaid enrollment dropping by 14 million people in 2026. For the CBO score of the AHCA, see "Letter to Speaker Paul Ryan," March 23, 2017, https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628.pdf.

[17] Edwin Park, "CBO: Senate Bill Cuts Medicaid by More Than One-Third by 2036," Center on Budget and Policy Priorities, June 29, 2017, http://www.cbpp.org/blog/cbo-senate-bill-cuts-medicaid-by-more-than-one-third-by-2036.

Senate Bill's Tax Credits Would Not Meet Rural Residents' Needs

The Senate Republican bill's damage to rural America would extend beyond people who are or may become eligible for Medicaid. The bill's cuts to tax credits for the purchase of individual market coverage would raise premiums for many people in rural areas, especially for older people and people living in high-cost states. Many of the 1.6 million current rural marketplace enrollees could find themselves unable to afford their high insurance premiums.[18]

Today, premium tax credits are based on the value of "silver plan" coverage: a plan that covers, on average, 70 percent of health costs. Under the Senate bill, tax credits would instead be based on the cost of a plan that covers only 58 percent of costs — roughly equivalent to current "bronze plan" coverage. Since the tax credits would be smaller, most consumers who want to maintain their current level of coverage would pay more out-of-pocket in premiums. People who couldn't afford to pay more in premiums and enrolled in the bronze plan would pay much higher deductibles: in 2016, the median deductible for bronze plans was about *twice as high* as the median deductible for silver plans — $6,300 versus $3,000. The reduction in the share of medical expenses paid by insurance and the increase in deductibles would cause many low-income people to forgo insurance altogether.

The Senate bill would cut tax credits further for older consumers while increasing them for some younger consumers and, like the House bill, would allow insurance companies to charge older people up to five times more than younger people. It also would eliminate tax credits entirely for people with incomes between 350 and 400 percent of the poverty line — about $44,000 to $50,000 for a single person. These changes could have a substantial impact, separately and in combination. For example, according to CBO, a 64-year-old with income at 375 percent of the federal poverty line would have to pay $13,700 more in premiums in 2026 for a silver plan because he would no longer be eligible for financial assistance.

TABLE 1

Most States Where Low-Income Older People Would See Biggest Increases in Net Premiums Under Senate Bill Are Rural States

Premium accounting for tax credits of 60-year-old with income of 150% of poverty line, 2020

	Share of Marketplace Consumers Living in Rural Areas	Net Premium Under Senate Bill	Increase from Current Law	Percent Increase in Net Premium
Alaska	51%	$5,778	$4,789	485%
North Carolina	25%	3,601	2,811	355%
Oklahoma	37%	3,463	2,672	338%
Arizona	10%	3,450	2,659	336%
Wyoming	78%	3,394	2,603	329%

[18] This includes only the enrollees in the 39 HealthCare.gov states. Centers for Medicare & Medicaid Services, "Health Insurance Marketplaces 2017 Open Enrollment Period Final Enrollment Report: November 1, 2016 – January 31, 2017, March 15, 2017," https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-03-15.html.

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	Share of Marketplace Consumers Living in Rural Areas	Net Premium Under Senate Bill	Increase from Current Law	Percent Increase in Net Premium
Nebraska	51%	3,381	2,590	327%
West Virginia	41%	3,223	2,432	308%
Tennessee	27%	3,217	2,426	307%
Alabama	28%	3,211	2,420	306%
Montana	74%	3,192	2,401	304%
South Dakota	64%	3,148	2,357	298%

Shaded state = State where rural residents make up less than one-quarter of marketplace enrollees

Source: CBPP analysis. For methodology, see Aviva Aron-Dine and Tara Straw, "Senate Bill Still Cuts Tax Credits, Increases Premiums and Deductibles for Marketplace Consumers," Center on Budget and Policy Priorities, revised June 25, 2017, http://www.cbpp.org/research/health/senate-bill-still-cuts-tax-credits-increases-premiums-and-deductibles-for. The percentage of rural marketplace enrollees is from the Centers for Medicare & Medicaid Services 2017 marketplace open enrollment period public use files, May 11, 2017.

Because rural states and areas tend to have older populations and higher health care costs, the Senate bill's cuts would disproportionately affect them. The cuts to premium tax credits would be higher in high-cost areas for two reasons. First, the credits adjust for local premiums, so people losing eligibility for tax credits because they are between 350 and 400 percent of poverty would lose more in higher-cost areas. Second, in states where health costs — and hence premiums — are high, the difference in premiums between more and less generous coverage is high as well.

As Table 1 shows, ten of the 11 states where low-income older people would face the steepest percentage increases in net premiums have significant rural populations.[19] (Also see Appendix Table 2.) For example, in Wyoming, where rural residents constitute a higher share of marketplace enrollees than in any other state (78 percent), a 60-year-old enrollee at 150 percent of the poverty line ($18,890 for the 2020 enrollment year) would need to pay $2,600 more to keep his current coverage, quadrupling his premiums compared to ACA coverage. In Maine, a 60-year-old at 150 percent of the poverty line would pay premiums of $791 per year for a silver benchmark plan after the ACA's tax credit. Under the Senate bill, his premiums would more than triple.

[19] Our analysis uses the same methods as our earlier paper on the effect of the Republican plan in the states using the HealthCare.gov platform. See Aviva Aron-Dine and Tara Straw, "Senate Bill Still Cuts Tax Credits, Increases Premiums and Deductibles for Marketplace Consumers," Center on Budget and Policy Priorities, revised June 25, 2017, http://www.cbpp.org/research/health/senate-bill-still-cuts-tax-credits-increases-premiums-and-deductibles-for. The percentage of rural marketplace enrollees is from the Centers for Medicare & Medicaid Services 2017 Marketplace Open Enrollment Period Public Use Files, May 11, 2017, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Plan_Selection_ZIP.html.

Even within a given state, rural consumers would often fare worse than urban ones, county-level data from the Kaiser Family Foundation show. In urban Memphis (Shelby County), Tennessee, a 40-year-old earning $30,000 would get a $2,640 tax credit under the Senate plan, or $770 less than under current law. But in the rural counties to the north, like Gibson or Madison County, the Senate credit of $4,310 would be nearly $2,000 less than the ACA would provide.[20]

Finally, like the House bill, the Senate bill would eliminate the ACA's cost-sharing subsidies, which help lower deductibles and copayments for low-income marketplace enrollees, and would not replace them. This means the typical deductible would jump from about $500 to $6,300 for people with incomes between 150 percent and 200 percent of the poverty line.[21]

Senate Bill Would Fuel Market Instability and Lead to Higher Premiums and Benefit Reductions

CBO predicts that "a small fraction of the population resides in areas in which — because of this legislation [the BCRA], for at least for some of the years after 2019 — no insurers would participate in the nongroup market or insurance would be offered only with very high premiums." CBO posits that some areas may have no insurer participation in part because the large cuts to subsidies would shrink the demand for insurance so much that "it would probably not be profitable for insurers to bear the fixed costs of operating in some markets." While CBO doesn't predict which areas will be affected, rural areas would likely experience these consequences, since weak competition among insurers and providers and low population density already result in high fixed costs relative to profit opportunities and often make these areas unattractive to insurers.

In response to this dilemma — and the premium increases that CBO projects under the Senate bill in 2018 and 2019 — some states would seek waivers of the ACA's market regulations. CBO estimates that states with about half of the nation's population would take up "section 1332" waivers that the Senate bill would dramatically expand, primarily to eliminate or weaken the ACA requirement that insurers cover essential health benefits. As CBO's analysis of the House-passed bill explained, people living in such states could experience "substantial increases in out-of-pocket spending on health care or would choose to forgo the services" entirely.[22]

Excluded services could include maternity care, mental health and substance use disorder treatment, rehabilitative and habilitative services, or pediatric dental care. CBO notes that out-of-pocket costs associated with maternity care and mental health and substance abuse services could increase "by thousands of dollars" and that annual and lifetime limits on benefits would also no longer apply. Those with the greatest health care needs would see their out-of-pocket payments rise the most in states that eliminated or substantially altered the essential health benefits requirement.

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[20] Kaiser Family Foundation, "Premiums and Tax Credits Under the Affordable Care Act vs. the Senate Better Care Reconciliation Act: Interactive Maps," June 23, 2017, http://www.kff.org/interactive/premiums-and-tax-credits-under-the-affordable-care-act-vs-the-senate-better-care-reconciliation-act-interactive-maps/.

[21] CBPP analysis of Centers for Medicare & Medicaid Services data for 2016.

[22] Congressional Budget Office, "Letter to Speaker Paul Ryan."

Because rural populations tend to be older and sicker than urban populations and have significant needs for mental health and substance use disorder treatment, waivers of certain essential benefits could have an especially large impact on them. For example, rural suicide rates are nearly double urban rates and families in rural areas experience considerable stress due to high poverty and unemployment.[23] In addition, the opioid epidemic has hit rural areas hard and reducing treatment options would be particularly consequential in those parts of the country.[24] For these reasons, rural residents likely benefit disproportionately from the ACA's health benefit protections — and could be disproportionately harmed by the loss of those protections, as well as by the other major provisions of the Senate bill.

APPENDIX TABLE 1

Nearly 1.7 Million Rural Residents Have Health Coverage Through the Medicaid Expansion

State	Estimated percent of expansion enrollees who live in rural areas	Estimated number of expansion enrollees living in rural areas
United States	15%	1.7 million
Alaska	38%	5,500
Arizona	10%	11,600
Arkansas	47%	130,900
California	3%	97,500
Colorado	21%	87,500
Connecticut	3%	6,700
Hawaii	27%	8,600
Illinois	14%	94,100
Indiana	20%	49,000
Iowa	44%	61,600
Kentucky	50%	223,700
Louisiana	17%	72,400
Maryland	4%	10,100
Michigan	19%	113,800
Minnesota	24%	53,900
Montana	63%	29,300
Nevada	13%	27,200
New Hampshire	48%	25,200
New Jersey	0%	
New Mexico	35%	85,900

[23] American Psychological Association, "The Mental and Behavioral Health Needs of Rural Communities," https://www.apa.org/about/gr/issues/gpe/rural-communities.pdf.

[24] Luke Runyon, "Why is the Opioid Epidemic Hitting Rural America Especially Hard?" National Public Radio Illinois, January 4, 2017, http://nprillinois.org/post/why-opioid-epidemic-hitting-rural-america-especially-hard#stream/0.

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State	Estimated percent of expansion enrollees who live in rural areas	Estimated number of expansion enrollees living in rural areas
New York	7%	18,200
Ohio	21%	135,800
Oregon	19%	92,700
Pennsylvania	13%	85,700
Rhode Island	0%	
Washington	13%	75,300
West Virginia	43%	76,900

Notes: Because it expanded Medicaid in July 2016, Louisiana's figures are based on the state administrative enrollment data as of April 2017. The expansion states of Massachusetts and Vermont are not included because they offered coverage to the expansion group prior to the ACA. No data were available for North Dakota.

Source: CBPP estimates based on March 2016 data of the number of non-elderly adult Medicaid enrollees who gained eligibility through the ACA's expansion (from Kaiser Family Foundation) multiplied by the percentage of that population that lives in a rural (non-metropolitan) area. CBPP estimated the rural share of each state's Medicaid expansion population using the Census Bureau's American Community Survey.

APPENDIX TABLE 2

Premiums Net of Tax Credits for Marketplace Consumers Under Current Law and Senate Bill

Premiums Accounting for Tax Credits for Consumers with Incomes of 150% of the Poverty Line*

Assumes Consumers Face Their State Average Benchmark Premiums

	Share of Marketplace Consumers Living in Rural Areas	30-year-old		45-year-old		60-year-old	
		Senate Bill	Change From Current Law	Senate Bill	Change From Current Law	Senate Bill	Change From Current Law
Alabama	28%	$1,485	$694	$1,823	$1,032	$3,211	$2,420
Alaska	51	2,361	1,374	3,030	2,042	5,777	4,789
Arizona	10	1,554	763	1,925	1,134	3,450	2,659
Arkansas	40	1,239	448	1,457	666	2,354	1,563
Delaware	22	1,418	627	1,723	932	2,977	2,187
Florida	3	1,279	488	1,516	725	2,492	1,701
Georgia	14	1,284	493	1,524	734	2,511	1,720
Hawaii	37	1,431	521	1,684	774	2,725	1,815
Illinois	13	1,329	539	1,592	801	2,669	1,878
Indiana	25	1,205	414	1,406	615	2,234	1,443
Iowa	46	1,347	557	1,618	828	2,732	1,941
Kansas	34	1,347	557	1,618	828	2,732	1,941
Kentucky	45	1,259	468	1,487	696	2,423	1,632
Louisiana	15	1,405	614	1,704	914	2,933	2,143
Maine	57	1,364	573	1,643	852	2,788	1,998
Michigan	23	1,203	412	1,403	613	2,228	1,437
Mississippi	53	1,284	493	1,524	734	2,511	1,720
Missouri	28	1,342	551	1,610	819	2,713	1,922
Montana	74	1,479	689	1,815	1,024	3,192	2,401
Nebraska	51	1,534	743	1,895	1,104	3,381	2,590
Nevada	10	1,241	450	1,460	669	2,360	1,569
New Hampshire	43	1,187	396	1,379	588	2,171	1,380

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	Share of Marketplace Consumers Living in Rural Areas	30-year-old		45-year-old		60-year-old	
		Senate Bill	Change From Current Law	Senate Bill	Change From Current Law	Senate Bill	Change From Current Law
New Jersey	1	1,308	517	1,559	768	2,593	1,802
New Mexico	31	1,196	405	1,393	602	2,202	1,412
North Carolina	25	1,597	806	1,989	1,198	3,601	2,810
North Dakota	61	1,311	521	1,565	774	2,606	1,815
Ohio	22	1,199	408	1,398	607	2,215	1,424
Oklahoma	37	1,557	766	1,930	1,139	3,463	2,672
Oregon	22	1,310	519	1,562	771	2,599	1,809
Pennsylvania	13	1,382	591	1,669	879	2,851	2,061
South Carolina	19	1,367	577	1,648	857	2,801	2,010
South Dakota	64	1,467	676	1,796	1,005	3,148	2,357
Tennessee	27	1,487	696	1,825	1,034	3,217	2,426
Texas	12	1,263	472	1,492	701	2,436	1,645
Utah	15	1,322	531	1,581	790	2,643	1,853
Virginia	13	1,268	477	1,500	709	2,454	1,664
West Virginia	41	1,488	698	1,828	1,037	3,223	2,432
Wisconsin	37	1,340	549	1,608	817	2,706	1,916
Wyoming	78	1,537	746	1,900	1,110	3,393	2,603

Source: CBPP analysis. States listed are those that use the HealthCare.gov enrollment platform. For methodology, see Aviva Aron-Dine and Tara Straw, "Senate Bill Still Cuts Tax Credits, Increases Premiums and Deductibles for Marketplace Consumers," Center on Budget and Policy Priorities, revised June 25, 2017, http://www.cbpp.org/research/health/senate-bill-still-cuts-tax-credits-increases-premiums-and-deductibles-for. The percentage of rural marketplace enrollees is from the Centers for Medicare & Medicaid Services 2017 marketplace open enrollment period public use files, May 11, 2017.