

Assuring Health Coverage for Rural People through Health Reform

*Prepared by the
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Executive Summary

Rural residents of the United States have a higher uninsured rate than their urban counterparts, and therefore have the most to gain from efforts to reform the U.S. health care system.

Currently, the challenges that rural people face in obtaining health insurance are partly due to the structure of the rural economy: 64 percent of adults working in rural areas that are not adjacent to urban centers are employed in jobs where health insurance is provided, compared to 71 percent of their urban counterparts (adults working in urban areas). Self-employed workers in rural areas not adjacent to urban areas are more likely to be uninsured (40% vs. 32%). Rural workers also pay higher costs than do urban workers for similar health insurance plans. Seven in 10 firms in non-urban areas (69.2 percent) are more likely to offer plans that include deductibles, compared to 42.9 percent of firms in urban areas.

Effects of Reform:

Health reform proposals that include (i) a subsidy for individual purchase, (ii) availability of insurance plans to individuals and small groups through exchanges, and (iii) expansion of Medicaid would significantly improve coverage of rural populations.

- The total number of uninsured people in rural (nonmetropolitan) areas would decrease to 1.9 million from the current 8.1 million – leaving only 4.2 percent of rural Americans without insurance, less than the 5.9 percent projected in urban areas.
- Rural residents would be more likely than urban residents to take advantage of subsidies or tax credits (30.6 percent of those obtaining coverage, as compared to 25.4 percent in urban areas) and Medicaid expansions (28 percent as compared to 24.8 percent in urban areas). To a great extent this is because of the lower incomes of rural persons, and the greater likelihood that they are employed by small businesses.

Reforms Needed:

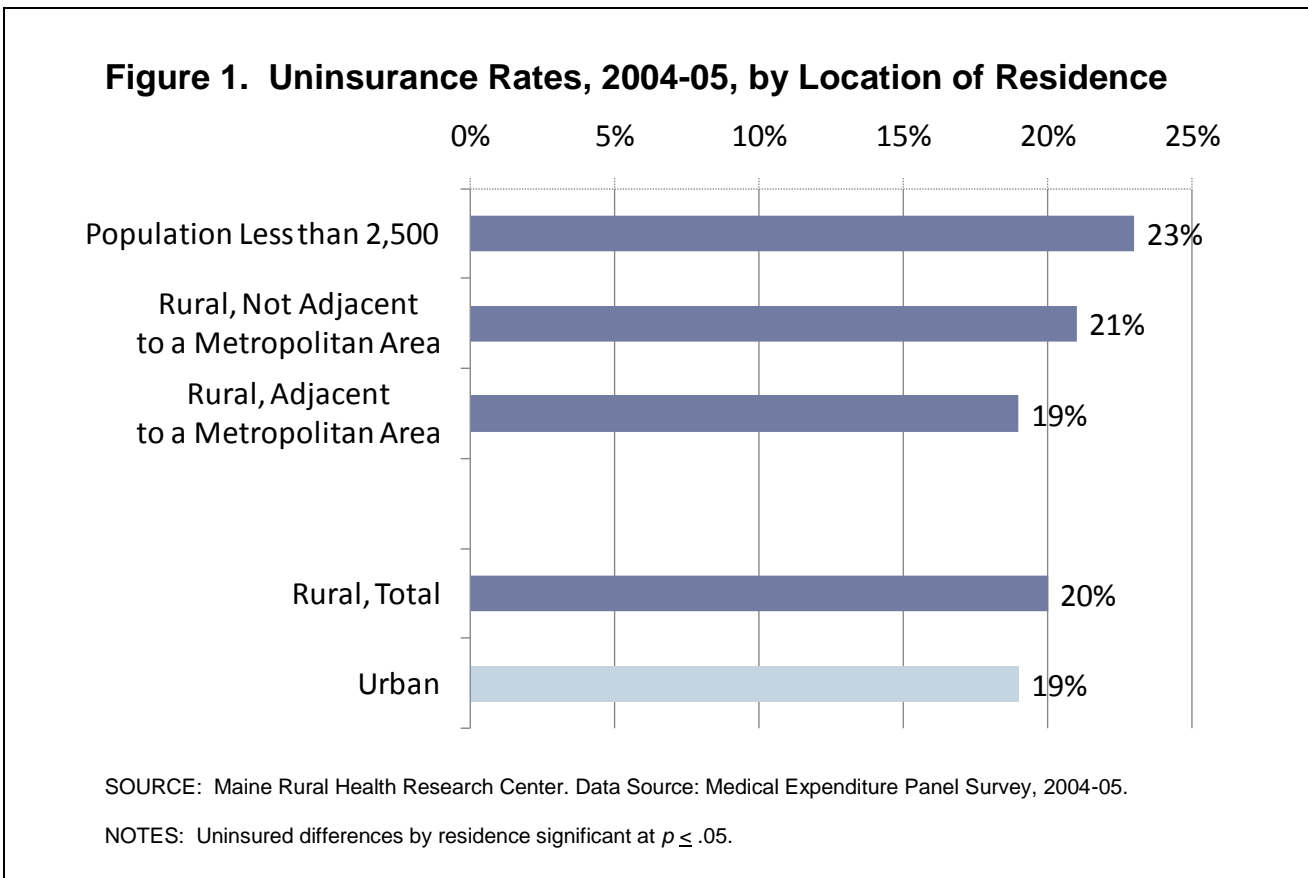
Given the characteristics of rural uninsured persons, certain features of reform legislation are especially important for solving the problem of uninsurance in rural areas, including:

- The creation of Health Insurance Exchanges (HIE) that effectively reach rural residents where they live, work, play, and pray with information about their insurance choices;
- Mandated insurance coverage, which would guarantee that the proposed insurance reforms can be implemented and financed;
- Choice among competing plans, each offering access to local providers in rural areas;
- Individual and small group insurance rating reforms that make insurance affordable to rural residents;
- Geographic rating, monitored for the impact on rural insurance premiums; and
- Medicaid expansion in order to make insurance affordable to rural households.

Assuring Health Coverage for Rural People through Health Reform

Why do rural residents need reform?

Rural residents in the United States are more likely to be uninsured or underinsured than their urban counterparts, and therefore have the most to gain from health reform (Figure 1)¹. In order to improve the health care of all Americans, regardless of geography, policy makers need to understand the differences in health insurance coverage between those living in rural and urban areas.



Differences in health insurance coverage between those living in rural and urban areas are important to consider in the debate over national health reform:

- The rural-urban difference in insurance coverage is driven by higher uninsured rates among rural adults who have lower incomes. Compared to urban adults, rural adult residents are less likely to be employed in jobs where health insurance coverage is offered (64 percent of working adults in rural areas not adjacent to urban areas compared to 71 percent in urban

¹ Lenardson, J., Ziller, E., Coburn, A., & Anderson, N. (2009, July). Health insurance profile indicates need for reform in rural areas. (Research & Policy Brief). Portland, ME: University of Southern Maine, Muskie School of Public Service, Maine Rural Health Research Center.

areas), and are more likely to be unemployed (30 percent of uninsured rural residents vs. 27 percent of uninsured urban residents) or self-employed (among self-employed are more likely to be uninsured, 40 percent of rural nonadjacent as compared to 32 percent in urban areas).²

- Comparable insurance is more difficult to obtain in rural areas; even after adjusting for business size, rural businesses pay more for the same health insurance plan than do their urban counterparts. Specifically, firms in rural areas are significantly more likely to have plans that include deductibles than those in metropolitan areas (69.2 percent vs. 42.9 percent), have lower actuarial value (79.9 percent actuarial value vs. 83.9 percent actuarial value), and have higher employee-only adjusted premiums (\$3,385 vs. \$3,178).³
- Rates of employer-sponsored health insurance coverage in rural places have declined over the past decade, reflecting rural small businesses' growing inability to afford health insurance.
- Compared with those living in urban areas, rural adults and children have higher rates of insurance coverage from public sources, including Medicaid and the state Childrens' Health Insurance Plan (CHIP) (Figure 2). Expansions of Medicaid coverage for children over the past decade have reversed previous urban-rural disparities in health insurance coverage; rural children currently have the lowest uninsured rates (Figure 2).

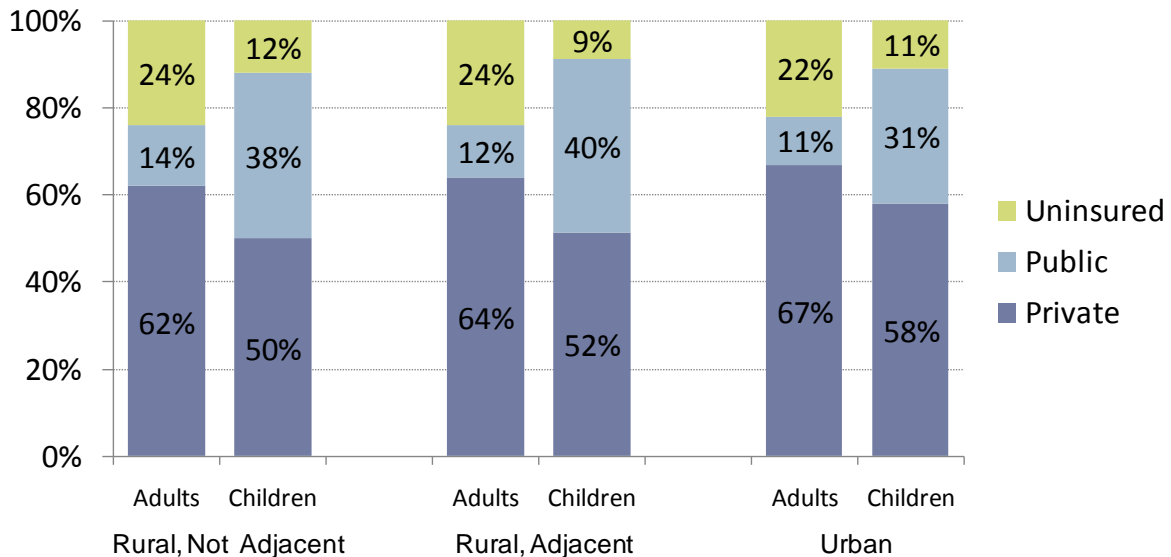
With no change in current trends, rates of employer-sponsored health insurance coverage in rural areas will continue to decline. These differences in the nature of the health insurance problem in rural America, and increasing numbers of uninsured residents, highlight the critical importance of reforming the insurance market to remove barriers for rural individuals and small groups to purchase affordable, meaningful health insurance. The specific design of insurance reform strategies will be important in determining whether rural needs and problems are addressed. For example, options for increasing private coverage will be less effective in rural areas if they exclude small employers or part-time workers. Because a greater percent of rural residents are self-employed, some form of subsidy (e.g., tax credits for individual insurance purchase) should be part of an effective solution. Finally, whether based on public or private plans, reform efforts to expand health insurance coverage through sliding-scale premiums, subsidies, or buy-in plans must consider the more limited means of the rural uninsured.

² *Ibid.*

³ Gabel J et al. Generosity and adjusted premiums in job-based insurance: Hawaii is up, Wyoming is down. *Health Aff(Millwood)*. 2006; 25:832-843.

Summary Data

Figure 2. Insurance Coverage of Adults and Children, 2004-05, by Location of Residence



SOURCE: Maine Rural Health Research Center. Data: Source: Medical Expenditure Panel Survey, 2004-05.

NOTES: Adults include all individuals between the ages of 18 and 64; Children include all individuals younger than 18; Public includes Medicaid, SCHIP, Medicare, and TRICARE; Uninsured differences by residence significant at $p \leq .05$. Due to rounding, some characteristics may not total 100 percent.

Covering the Uninsured in Rural America: Key Elements of Reform

A range of proposals are now being considered by the U.S. Congress to reform the health care system and to provide access to health insurance coverage for the uninsured. These approaches include a common set of elements that build on the current health insurance system:

- **Insurance reforms.** Reforms include provisions forbidding insurance companies from refusing coverage due to an individual's preexisting conditions, guaranteeing issue and renewability of insurance regardless of health status, restricting rating practices, and eliminating the practice of rescission (where insurance companies retroactively withdraw coverage).
- **Health insurance exchange (HIE).** Individuals and employers (initially only small employers, but will eventually be phased in to all employers) could purchase coverage plans from a range of private health insurance plans through an HIE. The plans should be more

accessible and affordable. The HIE would provide a single point of access to some number of private health insurance plans and perhaps a public option.

- **Insurance premium subsidies.** Subsidies or tax credits would be available for low- and moderate-income persons to purchase insurance through the exchange; for example, premiums could be limited to a percent of family income, with the rest covered by a federal government subsidy.
- **Employer and individual responsibility.** Employers could be required to either cover their employees or pay a portion of the premium in the HIE. Alternately, they could pay the equivalent amount to the government. Some small employers could be exempted, while others would receive tax credits to assist them in the purchase of health insurance. Individuals would be required to obtain health insurance, if it is affordable.
- **Expanded public coverage.** Public insurance (most likely Medicaid) could be available to persons below some specific level of the federal poverty level (FPL) (e.g. below 133 percent of the FPL), and CHIP could be extended to include children in families with income up to a higher level of the FPL than is currently required (e.g., 400 percent of the FPL).

The Impact of Reform Proposals on Numbers of Rural Uninsured

Effects on Coverage and Health Spending. The approach to covering the uninsured described in this document (based on Senate and House proposals as of October 26, 2009) when fully implemented would reduce the number of uninsured by 6.2 million persons in non-metropolitan areas, leaving 1.9 million persons uninsured, leading to a coverage rate of 96 percent in rural areas (Table 1).⁴ The approach to covering the uninsured would leave a smaller percentage of rural Americans uninsured (only 4 percent) as compared to urban persons (6 percent would remain uninsured), largely because a lower proportion of rural persons are non-citizens who would not be covered under any of the proposed reform approaches.

These findings point out the greater importance of the subsidies, tax credits, and public program expansions to rural persons seeking insurance. Of the approaches used to covering the uninsured, a slightly lower proportion of the previously uninsured in rural areas (49.8 percent) would obtain insurance through the HIE as compared to 51.6 percent of urban persons. In contrast, a higher proportion of rural adults (28 percent as compared to 24.8 percent of urban adults) would obtain

⁴The results presented here are based on simulations produced by the RUPRI health simulation model, built on a range of data sources including the Census Bureau's Current Population Survey (CPS), based on the implementation of health reform provisions from the House Tri-Committee legislation (HR3200) and based on a series of assumptions about these policies with the responses of individuals to those policy settings. Further details about the RUPRI health insurance model are presented in McBride (2009). *A rural-urban comparison of a building blocks approach to covering the uninsured* (Brief No. 2009-5). Omaha, NE: RUPRI Center for Rural Health Policy Analysis.

coverage through Medicaid (because their income falls below 133 percent of the FPL), while a smaller proportion of rural children (22.1 percent as compared to 23.6 percent of urban children) would obtain coverage either through public programs (Medicaid or CHIP) or through private insurance obtained by their parents (through the exchange). Of those obtaining coverage through the HIE, a higher proportion of rural persons (30.6 percent as compared to 25.4 percent of urban persons) would obtain coverage with the assistance of a government subsidy (because their income falls between 133 percent and 399 percent of the FPL) with the remaining persons (19.2 percent in rural areas and 26.2 percent in urban areas) paying the full cost of the premium through their employer or individually.

Table 1. Coverage under reform proposals in rural and urban areas

	Rural	Urban	Total
Number of uninsured persons (in millions)			
Before reform	8.1	41.8	49.9
After reform	1.9	12.1	14.0
Uninsured rate after reform	4.2%	5.9%	5.4%
Proportion of newly insured persons obtaining coverage through:			
Health Insurance Exchange (adults)	49.8%	51.6%	51.3%
With subsidies or tax credits	30.6%	25.4%	26.3%
Employer or individual responsibility	19.2%	26.2%	25.0%
Medicaid expansion (adults)	28.0%	24.8%	25.3%
Children	22.1%	23.6%	23.3%

SOURCE: RUPRI Health Reform Simulation Model. (The RUPRI health simulation model, built on Current Population Survey data and a range of other data sources, is based on a series of assumptions about the policies described here, and the responses of individuals to those policy settings, such as the likelihood of taking up coverage (based on a probability model and the characteristics of individuals). Further details about the results and the RUPRI health insurance model are available from the RUPRI Center for Rural Health Policy Analysis (www.unmc.edu/ruprihealth).

The remainder of this paper considers the rural implications of health insurance reform, and the important issues to be considered when implementing insurance reform in rural areas.

Insurance Reforms

All bills currently under consideration include similar provisions to reform insurance underwriting practices. Since rural persons are more likely to work for small employers or to need to access the individual insurance market, these insurance reforms are of critical importance for removing barriers for rural individuals and small groups to purchase affordable, meaningful health insurance. Of particular importance to assuring access to comprehensive health insurance plans in rural places are the provisions for guaranteed issue, forbidding denial of coverage of pre-existing

health conditions, forbidding use of health status as a component of premium rating, and requiring assurance of continuous coverage. These provisions should maintain or increase access to insurance for individuals with medical conditions or other reasons that might increase insurance risk. These provisions would be particularly helpful for rural people who, on average, have poorer health status and more chronic disease than their urban counterparts.

Under health care reform, insurance premium rate setting would vary by enrollee age, family size, tobacco use, and geography. In rural places, determining the service area of health plans will be critical when determining access to competing plans. Geographic rating based on areas where expenditures are higher or lower than other places in the same state may become a means of setting higher premiums in rural areas based on payers' limited negotiating power with providers. Conversely, geographic rating may benefit rural areas with historically lower expenditures than urban areas. Reform legislation will likely include a maximum rating band, so the combined effects of four factors will be limited. Limiting rating to four factors and the total range allowed would help rural residents who otherwise may have paid higher premiums because of health status.

Access to Health Insurance Options

New HIE and insurance plan structures resulting from health reform efforts would decrease the number of rural uninsured, improve the quality of rural health insurance coverage, and expand health insurance options for rural Americans. The HIE, or Gateway, could make side-by-side comparisons of different insurance plan benefit structures and premium prices possible through a new web-based portal for individuals and small businesses. This would foster competition among insurance plans, improving consumer choice and insurance value. The HIE would be a particularly important addition for rural residents due to the increased prevalence of individual and small business health insurance markets in rural America.

The reform legislation would standardize the actuarial value of competing health plans, mandating that at least four insurance plan options, or tiers, are available everywhere. This would be a significant improvement in many rural areas, where access to competing plans has been limited and the actuarial value of available plans has been substantially lower than those offered in urban markets. Since rural people have relatively lower incomes, rural individuals and businesses may more often select the basic insurance plan option (termed the "Bronze" plan). Thus, the basic plan's premium cost and benefit structure and associated actuarial value could be a significant rural concern. Setting the actuarial value at a minimum value would assure rural residents of adequate coverage. Rural residents would also benefit from new limits on out-of-pocket expenses and elimination of the life-time benefit maximum. In addition to lower incomes, rural people suffer more from chronic disease and disability. Early detection of disease states is important to

rural residents; making full coverage of preventive services by all health insurance plan options is a key provision.

Dental health is an important rural health concern with ramifications of poor health and economic poverty beyond dental conditions, particularly for children, so including a pediatric dental benefit is an improvement for rural residents.

Rural people have less access to the Internet and less experience enrolling in insurance plans. Thus, implementation will need to incorporate rural-relevant enrollment options and outlets. For example, reform might allow presumptive eligibility when an uninsured individual presents for hospital care (including to a critical access hospital), allowing hospital staff to enroll them. Funded community outreach by trained assistants, accessed through organizations present in rural areas (e.g., Area Agencies on Aging, civic organizations, others that have been partners with the Centers for Medicare and Medicaid Services in Medicare Part D enrollment) might be another strategy to ensure broad rural health insurance participation.

Market-based approaches to health insurance coverage in low-volume rural areas have often resulted in few choices and higher costs. Experience in the Medicare Advantage program suggests that as insurers offer less choice in sparsely populated areas, access to affordable plans diminishes in comparison to other areas. Health care reform would markedly improve this situation by changing the nature of the market (higher percentage of rural residents in the market due to subsidies), but health care reform should specify insurance plan access standards to optimize rural choice. Furthermore, since market-based health insurance approaches have not consistently served rural people well, rural areas must be assured that an affordable plan will be available everywhere, regardless of market conditions. Market-based approaches to health insurance coverage in low-volume rural areas have not always resulted in affordable insurance options, or plans that assure affordable access to providers in close proximity to rural persons when they need medical care. To assure affordable access to medical care, reform proposals should include access standards to optimize rural choice. Potential options include a “public option” that would be available in all places, or a “trigger” that would become active if certain insurance company and plan choice requirements are not met.

Affordability

Rural persons are more likely to experience lower incomes and higher poverty rates. In addition, even under reform, geographic rating may lead to higher premiums in rural areas than in urban areas of the same state, based on insurance company inability to negotiate lower rates. Therefore, subsidies for individuals and individual households to purchase even the basic benefit plan are critical in rural areas. A reformed health system would not only offer lower premiums through the

HIE, but government subsidies would also make health insurance affordable to low income households. Eligibility up to 400 percent of the FPL as a cutoff would help make comprehensive plans with low to moderate out-of-pocket costs affordable. A well-designed subsidy policy would improve affordability for the uninsured and create opportunity to improve the value of insurance for others (e.g., lowering high deductibles and copayments).

Small businesses in rural America would have access to an array of plans through state, regional, or national exchanges, including plans that are less expensive than current offerings because the pool of plans would be larger than is currently true. Nonetheless, the cost of premiums would still be beyond the means of small employers with a low to moderately employed workforce, a characteristic of many rural firms. Therefore, tax credits are critical as a means to making insurance coverage affordable.

Purchase of higher value health insurance in rural areas would benefit providers who currently operate on very thin margins because they would be collecting more fees from insurance carriers, improving timeliness (no need for payment plans extending over long periods of time), and collecting accounts receivable (rather than allowing for the inability of low income households to pay).

Individual and Employer Responsibility

All bills mandate that individuals must obtain health insurance, with exceptions based on hardship and religion. Given the strong positive relationship between health insurance coverage and health, the individual mandate should have a positive impact on the health of rural Americans. It is important, though, that an individual mandate to obtain health insurance is combined with reasonable protections/subsidies for those with low incomes. In addition, increasing the number of patients who transition from being charity, self-pay, or uncompensated care to insured will also benefit rural providers, and through cost-shifting should reduce prices for insured persons. The individual mandate is also important to the success of insurance reforms, especially guaranteed issue and prohibition of pre-existing condition clauses, because insurers who can no longer exclude individuals on the basis of health status could face adverse financial problems unless all persons (including healthy ones) are mandated to remain insured.

Employer participation is also a cornerstone of health insurance reform. All current bills recognize that mandatory employer participation may be too onerous for small businesses, but there is substantial variation across bills in the penalties for non-participation and the definition of small businesses that are exempt from these penalties. Several provisions should increase the affordability of health insurance to small employers. The HIE should offer a range of plans that are affordable, even to small employers. The insurance reforms should keep premium rates affordable

even to small firms which currently face prohibitive premium rates. Finally, the bills do provide subsidies (or tax credits) to small businesses that want to offer insurance to their employees. Small businesses are more prevalent in rural areas and many of these businesses are currently priced out of the insurance market, so the crafting of provisions related to employer participation will have a substantial effect on the extent to which insurance in rural areas expands through employer-based policies or through the individual market. Regardless, the ability of individuals and small businesses to buy insurance through an exchange should greatly improve rural residents' access to affordable health insurance coverage.

Public Program Eligibility Expansions

Medicaid expansions proposed in all three of the reform bills are an especially important and effective means for expanding health insurance coverage for rural people. Because the rural uninsured are more likely than those in urban areas to have incomes in the ranges targeted by these reform bills, Medicaid expansions would have a greater relative impact in expanding rural insurance coverage.

As noted above, rural citizens are more likely than those in urban areas to rely on Medicare and Medicaid as their primary sources of coverage. Over the past decade, expansions of Medicaid coverage for children have offset declines in employer-sponsored health insurance rates with the effect of bringing coverage rates for children above those in urban areas.

Each of the major health reform proposals expands Medicaid eligibility and coverage for populations that have not typically been covered, primarily adults without dependent children, and families with incomes exceeding current eligibility thresholds. Several bills would require states to provide premium assistance for Medicaid beneficiaries with access to employer sponsored coverage. Several bills would expand children's coverage through the Children's Health Insurance Program (CHIP) with increases in the income eligibility level (typically up to 400 percent of the FPL). Although income eligibility levels vary across the bills, they would all have a significant impact in expanding coverage to rural populations.

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The Rural Policy Research Institute (RUPRI) provides unbiased analysis and information on the challenges, needs, and opportunities facing rural America. RUPRI's aim is to spur public dialogue and help policymakers understand the rural impacts of public policies and programs. RUPRI is housed within the Harry S. Truman School of Public Affairs at the University of Missouri-Columbia and is a joint program of Iowa State University, the University of Missouri, and the University of Nebraska. RUPRI's reach is national and international and is one of the world's preeminent sources of expertise and perspective on policies impacting rural places and people. Read more at www.rupri.org.

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