



Health Care in Rural America

Health care in rural communities has many aspects – access to physicians, dentists, nurses, and mental health services; the financial circumstances of rural hospitals; federal rules concerning Medicare reimbursement rates and the impact on rural hospitals and healthcare professionals; and the consequences of all of these on the health of rural people.

While each aspect is important, this brief will focus instead on issues related to health insurance coverage, health care costs of rural people, and solutions to reform the health care system.

HEALTH INSURANCE IN RURAL AMERICA

Rural residents – particularly those who reside in rural counties non-adjacent to urban counties (referred to here as “remote rural counties”) – are more likely to be uninsured than non-rural residents. Residents of remote rural areas are also more likely to be uninsured for longer periods of time – their chances of being uninsured for an entire year are a third greater than residents of urban counties.

The table below shows 2002 data on the insurance coverage and source of coverage of rural and urban America.

Table 1. Insurance Coverage and Source of Coverage for Rural and Urban America

County Type	Uninsured (%)	Public Insurance* (%)	Private Insurance** (%)
Rural Non-Adjacent	24	16	60
Rural Adjacent	18	10	71
Urban	18	11	72

* Public insurance includes Medicare, Medicaid, and state children's insurance programs (S-CHIP)

** Includes employer-provided insurance

From these figures we can deduce the following:

1. **Remote rural residents are poorer and older** – The reliance on public insurance programs demonstrate lower family income and a greater need in these communities, as well as an older population. Nationally, over one-quarter of children in remote rural counties are covered by Medicaid.
2. **Remote rural residents are less likely to be offered health benefits through their employment** – Only 59 percent of workers in rural non-adjacent counties are offered employer-sponsored health insurance, compared to 69 percent of urban workers. Less than half of workers in rural nonadjacent counties are covered by their employers (compared to nearly 60 percent of urban workers).

Two factors are primarily to blame for the lack of employer-sponsored insurance in rural areas – workers in remote rural counties are more likely to earn low wages and residents of remote rural counties are more likely to work in small businesses.

While low-wage workers (below \$7/hour) are about 3 times more likely to be uninsured as other hourly wage earners, working in a small business appears to be the highest predictor of being uninsured in a remote rural area – over two-thirds of uninsured workers in those counties work for a small business with less than 20 employees.

It's clear that the rural economy contributes – in fact, may be a cause – of the high levels of uninsured in remote rural areas. It follows that an economy built on low-wage labor and small businesses will have high levels of uninsured.

If a rural economy built on entrepreneurship and small businesses is a good to be pursued – as the Center for Rural Affairs has advocated –then resolving the issue of how to provide health insurance and health benefits to small business owners and their employees is essential.

WHO ARE THE RURAL UNINSURED?

Based on the most recent data available, the uninsured in remote rural counties are not a peculiar sub-population of their communities:

- **68 percent come from families with at least one full-time worker.**
- **30 percent are children.**
- **Almost two-thirds come from low-income families** (less than 200 percent of the federal poverty level – less than \$37,700 for a family of 4).
- **Families with two full-time workers, married couples, and the employed are also at greater risk of being uninsured if they live in a remote rural county.**
There is no difference in uninsured rates among the rural unemployed and the urban unemployed.

HEALTH INSURANCE ON THE FARM

Farm and ranch families are generally insured at higher rates than the rest of the rural population. A 2001 Iowa survey indicated that only 5 percent of the state's non-elderly farm population was uninsured. A 2002 survey of Wisconsin farmers found similar rates of uninsured.

However, those generally favorable rates may vary according to the type of farm and the economic situation. A recent survey of Wisconsin dairy farmers found 18 percent had no health insurance coverage, and 22 percent had insurance that did not cover all family members.

Farm and ranch families are more dependent on privately purchased insurance coverage than other rural residents or the nation as a whole. Half of the Iowa farmers surveyed and 56 percent of the surveyed Wisconsin farmers are covered by privately purchased health insurance. Only 6 percent of the nation as a whole has self-purchased health insurance.

Welcome to the rural world of “underinsurance.” While these coverage rates appear hopeful, they are often misleading.

UNDERINSURANCE IN RURAL AMERICA

Growing evidence reveals that rural residents have health insurance coverage that pays less of their health care expenses and that rural individuals and families devote more of their income to health care costs. According to the National Rural Health Association, these two phenomena are commonly accepted definitions of “underinsurance.”

Examples of rural “underinsurance” include:

- Only one in four insured Wisconsin farm families had coverage for preventative care.
- 10 percent of rural residents rely on the individual insurance market for their health insurance, and, as we see above, the total is greater for farm and ranch families. On average, individual market plans cover 63 percent of medical costs, compared to 75 percent covered by group insurance plans. Half of individual market plans cover just 30 percent of health care expenses. More reliance on individual plans by rural people results in more uncovered medical and health care expenses.
- 35 percent of rural residents with health insurance lack dental coverage (compared to 29 percent of urban residents). As a result, rural residents are 50 percent more likely than urban residents to report never going to the dentist.
- The rural privately insured are over 50 percent more likely to have no drug coverage.
- Total annual health care expenses per person for non-metropolitan residents are 18 percent greater than annual health care costs for residents of metropolitan areas. When viewed as a percentage of household income spent on health care expenses, a two-person household in a non-metropolitan area would spend 20 percent of their income on health care expenses compared to 13 percent for a similar metropolitan household.
- Rural, privately covered residents have out-of-pocket costs about 10 percent higher than urban residents, suggesting the health benefits of rural residents are less comprehensive.
- A survey of Iowa farmers found that out-of-pocket medical expenses averaged 11 percent of their income each year. Lower income respondents had higher out-of-pocket expenses, with over 40 percent of the lowest income families spending more than 30 percent of their income on out-of-pocket medical costs.

THE RESULT: POORER HEALTH

The Center on an Aging Society at Georgetown University in Washington DC summarizes the health status of the nation as this: “The rural population is consistently less well off than the urban population with respect to health.” More rural people have arthritis, asthma, heart disease, diabetes, hypertension, and mental disorders than urban residents. The differences are not always large, but they are consistent – the proportions of rural residents with chronic conditions are larger.

The Kaiser Commission on Medicaid and the Uninsured found that despite an older population and higher rates of disability in rural areas – which should require higher health care needs –

rural residents actually receive comparable or less care in many measures, suggesting rural residents may not be receiving adequate care. For example, rural residents receive fewer regular medical check-ups, blood pressure checks, cholesterol checks, pap tests, and mammograms than they medically and statistically should.

The result of less than adequate care is worsening health status and increasing chronic conditions – exactly what has been found. The reasons are likely many – fewer doctors in rural areas and limited access to health care; rural people more likely to engage in risky behaviors like cigarette smoking and alcohol consumption; more rural people being overweight and exercising less; and more rural people being underinsured and uninsured for longer periods of time.

Despite an array of health care differentials between urban and rural people, the ultimate health status of rural people has much to do with health insurance coverage and the type of health insurance coverage. For example, rural people with employer-provided health insurance obtained more health care services than those with privately-purchased health insurance.

Insurance that provided better coverage at lower cost, therefore, resulted in more – and presumably more regular and better – health care services.

PRINCIPLES TO GUIDE SOLUTIONS AND REFORM

When discussing public policy solutions it is wise to begin with a set of guiding principles. We provide the following (in no order of priority, except for the first fundamental principle) as a beginning set of general principles. Similar principles were suggested by the *National Academy of Sciences' Institute of Medicine Committee on the Consequences of Uninsurance*.

- **Universal** – because of the long-term health and societal consequences of being uninsured and underinsured, health care coverage should be available to everyone.
- **Continuous** – gaps or interruptions in coverage lead to inadequate care and worse health outcomes. This is particularly important for rural people since rural residents lack health insurance for longer periods; any solution must have a long-term focus to assist rural people.
- **Affordable to individuals and families** – the primary reason given by businesses, employers, and people for lacking health insurance benefits is cost; the affordability challenge is even greater for low- and moderate-income individuals and families.
- **Affordable and sustainable for society** – any reform proposal must be cost-effective and efficient, both to the society as a whole and to individuals and families.
- **Enhance health and well-being** – coverage should include those services that provide for long-term health.

HEALTH INSURANCE SOLUTION MODELS

There is no lack of ideas or proposals for reforming health insurance coverage and cost. Based on our research of these proposals, we have grouped them in six models.

Note to Readers: The items that follow are only an overview of general provisions of detailed proposals; many different proposals have been lumped together for the sake of space and brevity. We apologize if your favorite solution is not included in sufficient detail.

INCREMENTAL REFORMS, PROGRAM EXPANSION, AND TAX CREDITS

- Expand Medicaid and State Child Insurance Programs (S-CHIP) to all people below a percentage of the federal poverty level (generally 125-150 percent) and above a certain age (generally 55).
- Expand Medicaid and S-CHIP by allowing people up to 300 percent of the federal poverty level to “buy into” those programs by paying an income-based premium.
- Provide tax credits for the purchase of private health insurance for people between 125 and 325 percent of the federal poverty level and for small businesses. Some ideas allow both a credit on federal income taxes and a credit when the insurance policy is purchased (similar to an instant refund upon purchase).

VOLUNTARY INSURANCE POOLS

- Create voluntary (generally state-operated) insurance plan pools open to individuals, employer groups, and businesses. This is based on the theory that a large group can purchase coverage more cost-effectively than individuals.
- Most “pool” ideas also include subsidies to low- and middle-income people as incentives to purchase coverage through the pool.

PAY-OR-PLAY AND EMPLOYER MANDATES

- Employers would be required to provide a minimum standard of coverage for their employees. Maine and California are states that have recently enacted statewide programs based on this model.
- Employers who do not provide minimum coverage are required to pay a payroll tax that automatically covers their employees under a new public health insurance program. Non-workers can also obtain coverage under this public program.

It is estimated that these types of employer mandates would result in nearly all uninsured people being covered, but with a significant impact on employer costs.

Other proposals simply require employers to offer health insurance to employees and contribute to employee premiums. Generally these proposals combine an employer mandate with a federal premium subsidy to the employer.

These attempts to increase enrollment in private health insurance – whether through employer or individual plans – have significant impacts on rural people because of the “financial fragility of small rural employers” (*University of Southern Maine*) and the low wages and incomes of rural workers.

Many rural people and employers do not have the financial means to afford health insurance coverage for themselves, their families, or their employees. For these economic reasons,

attempts to enhance work-based health insurance or enrollment in private plans are unlikely to work as well for rural people without generous subsidies.

INDIVIDUAL MANDATE AND TAX CREDIT

- These proposals would mandate that all individuals provide health insurance for themselves and their families through the private market. To address cost issues, each person would be eligible for advance tax credits.
- These proposals also generally would eliminate all public insurance programs except Medicare.

MARKET-BASED PLANS

Significant state and federal legislation has opened the way for increased access of individuals, families, and businesses to “market-based health plans” such as Medical Savings Accounts and Health Savings Accounts. The theory behind such plans is to change consumer and societal behavior through public policy (primarily through tax policy).

- The current employer-based health insurance system encourages costly comprehensive benefit plans through tax exemptions that rise as the employer’s contribution rises. The “market-based” system theorizes that lower-cost plans that are dependent on consumer choice will decrease costs. These proposals are often accompanied with a tax credit for individuals and families to cover a significant amount or the entire premium.
- Medical Savings Accounts and Health Savings Accounts are low-cost, high-deductible health plans that allow a limited employer contribution and/or individual contributions. These plans have been offered as ways for the self-employed and small businesses to avoid the increasing cost of health insurance while still providing functional coverage.

SINGLE PAYER

- A single payer system would enroll everyone in a single, comprehensive benefit package. Supplemental private policies would be available for non-covered services. And it is important to note that under single payer systems, the current system of health care services – private doctors, clinics, hospitals, etc. – would remain.
- Single payer refers only to who pays for and who funds health care services. Under most single payer proposals the federal government or state governments (with federal funding and support) would administer the program; contractors and private health plans would be used to review and process claims and payments similar to Medicare. All industrial nations other than the United States have some form of a single payer system.
- Most single payer proposals are financed through a new payroll tax of both employers and employees that would take the place of current premium payments.

- Coverage in single payer systems would be comprehensive (generally with a menu of options comparable to current public employee plans), with no deductibles and low copay requirements.
- Virtually all Americans would be covered by a single payer system, with net new federal spending of approximately \$1,900 per person (payroll and income taxes).

A PROBLEM THAT CAN NO LONGER BE IGNORED

The United States already invests billions of dollars in health care coverage by directly providing insurance to some (Medicare, Medicaid, S-CHIP programs and public employee plans) and by offering subsidies to others (tax exemptions for business benefit plans and some individual plans). As *The Institute of Medicine* has stated, “The many consequences of uninsurance and the growing threat it poses to the very fabric of America’s health care system makes this a problem that can no longer be ignored.”

Is health insurance coverage a right or a privilege? Should employers or individuals be responsible for or mandated to provide health insurance coverage? And what role should the government play?

Please give us your views as we begin a discussion on an issue that impacts the well-being and development of rural people and rural communities.

We want to hear from you! Send your comments to Jon Bailey, jonb@cfra.org or 402.687.2103 x 1013.

Health Care in Rural America was first published as a two-part series in the Center for Rural Affairs Newsletter in August and September of 2004. The author is Jon Bailey, Rural Research & Analysis Program Director at the Center for Rural Affairs.



Established in 1973, the Center for Rural Affairs is a private nonprofit working to strengthen small businesses, rural communities, and family farming and ranching through action-oriented programs addressing social, economic, and environmental issues.

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