

# Health Insurance Access in Rural America

March 2004

National Rural Health Association

## Executive Summary: Defining the Challenges

Living in rural America increases the risk of being uninsured. This is primarily because the rural economy tends to be dominated by smaller employers and the self-employed, and because rural residents are more likely to work for low-wage employers. Both small and low-wage employers are less likely to offer health insurance.

When rural residents enter the private insurance market, they are likely to pay higher administrative fees, find fewer health insurance choices, and be underinsured. Rural residents pay a higher proportion of their income for health insurance, because premium rates in rural America are comparable to or even higher than those in urban areas, but average income is lower.

Because rural populations tend to be older and poorer, they rely heavily on public sources of coverage. For this reason, rural residents and health care providers are more heavily impacted by coverage changes and inadequate provider payment rates in Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP).

Rural Americans are less likely to seek primary and preventive care and are more likely to be in poor health. This is the result of many factors, including lower coverage rates, lower incomes, less comprehensive coverage and less access to health care providers.

Strong and reliable sources of health care financing are critical not only for improving health outcomes, but also for maintaining a strong health sector in rural communities. Maintaining a strong health care industry has important ramifications for the economic vitality of rural communities.

## Principles and Recommendations: Overcoming the Challenges

The NRHA reaffirms its commitment to comprehensive health care for all people living and working in America. The NRHA supports the goal of affordable universal health coverage and access to care for all. In order to achieve this goal:

- The NRHA supports strategies targeted at expanding public coverage through expansion of programs such as Medicare, Medicaid and SCHIP.
- The NRHA supports alternatives to the current employer-sponsored system or modifications that make that system work better for small businesses and the self-employed.
- The NRHA supports strategies designed to pool risk and/or create purchasing pools with government subsidies as needed. The NRHA recognizes that failing to pool risk results in access barriers for those with pre-existing and chronic health conditions.
- The NRHA supports proposals designed to address the problem of underinsurance, defined both as being covered by a limited benefit package and spending a high percentage of one's income for health costs.
- The NRHA supports tax credit proposals that make high quality insurance affordable.

- The NRHA encourages policy-makers to examine current efforts in rural communities to provide coverage and expand the safety net. Additional demonstrations should be funded. Rural-based coverage strategies and/or insurance models should be encouraged. Furthermore, as proposals to address uninsurance and underinsurance are considered, policy-makers should assess the impact of these proposals on rural communities.

### **Data: Quantifying the Challenges**

#### ***Rural residents are more likely to be uninsured.***

23.7 percent of non-elderly rural residents are uninsured, compared to 17.9 percent of urban residents.<sup>i,ii</sup>

#### ***Rural Americans are less likely to be offered employer-sponsored coverage.***

60.5 percent of non-elderly rural residents have employer-sponsored coverage, compared to 71.5 percent of non-elderly urban residents.

#### ***Rural residents are more likely to be uninsured because they work for small business or are self-employed.***

32.7 percent of rural residents, compared to 23.8 percent of urban residents are self-employed; 20.7 percent of the rural uninsured are self-employed, compared to 16.5 percent of the urban uninsured.

Nearly half of rural employees work for firms with fewer than 20 employees, compared to 36.6 percent of urban workers. Those working in firms with fewer than 20 employees are twice as likely to be uninsured, regardless of location. Only 36.4 percent of small business employees living in rural areas have health benefits offered to them through their job, compared to 47 percent of urban small business employees. 68 percent of the uninsured in rural America work for small firms, compared to 56.1 percent of the urban uninsured.

#### ***Rural Americans are more likely to be uninsured because they earn lower wages (or are more likely to work for low-wage firms.)***

Low-wage workers (those earning less than \$7 per hour) are less than half as likely to be offered health insurance coverage through their employer; 32.0 percent of low-wage workers are offered health insurance, compared to 77.0 percent of those earning more than \$7. Because rural Americans are about twice as likely to earn low wages (33.4 percent of rural workers earn less than \$7, compared to 18.6 percent of urban workers), low-wage workers make up a higher percentage of the total uninsured population. 60.4 percent of the uninsured in rural areas are low-wage workers, compared to 39.8 percent in urban areas.

#### ***Rural Americans rely more heavily on public coverage. This makes them more susceptible to changes in coverage levels in Medicare, Medicaid, and SCHIP.***

15.8 percent of non-elderly rural residents have publicly-financed health coverage, compared to 10.6 percent of non-elderly urban residents. 15 percent of rural residents are over 65 (which mean their likely source of coverage is Medicare), compared with 13 percent of urban residents.<sup>iii</sup>

#### ***The heavy reliance on public coverage in rural areas can mean more cost shifting to the privately insured and uninsured when Medicare and Medicaid payment levels are inadequate.***

The overall Medicare operating margin for rural hospitals was negative 2.9 percent in 2000,

compared to 8.4 percent for large urban hospitals and 2.9 percent of other urban hospitals.<sup>iv</sup> While Medicaid reimbursement rates vary by state, they typically fall below Medicare rates.

An April, 2002 MedPAC report indicated that cost shifting due to Medicare underpayments in rural areas is high and that the urban/rural differential is growing. In 1999, private insurers were charged 133 percent of cost in rural areas, compared to 113 percent in urban areas. In 1995, private insurers paid 137 percent of cost in rural and 132 percent in urban areas. This cost shifting drives up the cost of private coverage in rural areas.

***Because they rely more heavily on the individual and small group market, rural residents pay higher administrative and loading costs and they are more vulnerable to variations in price due to health risk.***

10.0 percent of rural residents rely on the individual insurance market for health coverage, compared to 7.9 percent of urban residents.<sup>v</sup> Nearly half of all rural workers are employed at firms with less than 20 employees, compared to 36.6 percent of urban workers.

Average administrative and loading costs range from 30 to 35 percent in the individual market and from 20 to 25 percent in the small group market, while large groups can typically keep costs around 10 percent.<sup>vi</sup> Administrative costs in the Medicare and Medicaid programs average below 5 percent.

Because the price of insurance policies in the small group and individual market vary according to the health status of those being covered (extent of variation depends on state regulation), those with the highest health care needs face the highest cost barriers to insurance.

***There is growing evidence showing rural residents have health coverage that pays less of their health care bills and that they spend more of their income on health care costs – two of the current definitions of underinsurance.***

According to a survey of Wisconsin dairy farmers, only one in every four *insured* families had coverage that paid for preventative care.<sup>vii</sup>

On average, individual market plans cover only 63 percent of medical costs, compared to 75 percent under group insurance. Half the people buying individual market policies are covered for just 30 percent of their health care bills.<sup>viii</sup>

35 percent of rural residents with health coverage (compared with 29 percent of urban residents) lack dental coverage. They are 50 percent more likely than urban residents to report that they never go to the dentist.

According to a State Health Access Data Assistance Center (SHADAC) report, one measure of underinsurance is when there is a 5 percent chance that out-of-pocket costs for health care will exceed 10 percent of income in a given year. The next several bullets show that this standard is regularly met and exceeded in rural America.

Total health care expenses per person per year average \$2,485 for those in metropolitan statistical areas (MSAs), while those living in non-MSAs spend \$2,934.<sup>ix</sup>

Average household income in non-MSAs is \$30,057, compared to \$39,381 in MSAs.<sup>x</sup>

This means that a two-person household in a non-MSA would spend would spend 20 percent of its income on health care costs, compared to 13 percent for an MSA household.

A 2001 study of Iowa farmers found that out-of-pocket costs averaged 11 percent per year, with over 40 percent of the lowest income families spending more than 30 percent of their income on health care costs.<sup>xi</sup>

***Uninsurance in rural America is more persistent, meaning that uninsurance spells last for longer periods of time and that rural people are more likely to move in and out of the individual market rather than to and from the group market.***<sup>xii</sup>

There is a large body of evidence in the health care community showing that being uninsured leads to reduced utilization of health care services and lower health outcomes. As expected, in conjunction with lower insurance rates, rural residents report both reduced utilization of health care services and poorer health outcomes.

Rural residents report their health as being less than very good or excellent at a rate of 42 percent compared to 38 percent for urban respondents.<sup>xiii</sup>

Only 38 percent of rural adults aged 18-64 had a physical exam in the last year, compared to 45 percent of urban residents.

Rural residents were 10 to 20 percent less likely to have received services such as mammograms, blood pressure and cholesterol checks and pap tests.<sup>xiv</sup>

***The fragile rural health care infrastructure could be further threatened by additional erosion of insurance coverage.***

Nearly three-quarters of rural counties have been at least partially designated as a Medically Underserved Area.<sup>xv</sup>

Despite the fact that around 20 percent of Americans live in rural America, only 11 percent of the nation's physicians reside there. Rural communities average 54.6 specialists per 100,000, compared to 190 in urban areas.<sup>xvi</sup>

***The economic success of health care providers is particularly important to the economic vitality of rural communities.***

According to Rural Health Works, around 15 to 20 percent of the economy of a small rural community depends on the health care sector.

In studying several rural states, researchers have found that for every person employed in a hospital another person in the state owes his/her job to the economic activity generated by those hospitals.<sup>xvi</sup>

Reliable health care financing is critical for the continued success of rural health care providers. More rural communities are looking for ways to keep their health care dollars in their communities. Primarily, rural communities are seeking to configure health care services to ensure they are offering the services that can be provided locally in an efficient and effective way. In rare cases, rural communities have worked together to develop alternative financing mechanisms that offer choice outside of traditional insurance markets.

## NRHA Policy Brief

- <sup>i</sup> All statistics in the report are taken from the Muskie School and The Kaiser Commission on Medicaid and the Uninsured report entitled "Health Insurance Coverage in Rural America" by Erika C. Ziller, Andrew F. Coburn, Stephanie L. Loux, Catherine Hoffman, and Timothy D. McBride unless otherwise noted.
- <sup>ii</sup> All rural numbers from the Ziller, et al, report rely on county-based Medical Expenditure Panel Survey data (these data can be found at [www.meps.ahrq.gov](http://www.meps.ahrq.gov)). The study makes a distinction between rural counties that are adjacent to urban counties and those that are non-adjacent. When the Ziller report is the source, "rural residents" refers to rural non-adjacent counties unless otherwise noted.
- <sup>iii</sup> Rogers, C.C. (2000) Changes in the Older Population and Implications for Rural Areas. (Economic Research Service, Rural Development Research Report No. 90).
- <sup>iv</sup> Medicare Payment Advisory Committee March 2003 Report.
- <sup>v</sup> Timothy D. McBride, Courtney Andrews, Andrew Coburn, Alexei Makarkin, Erika Ziller. 2003. "The Dynamics of Individual Insurance Coverage in the U.S." April 2003.
- <sup>vi</sup> Pauly, Mark, Percy, Allison, and Herring, Bradley. (1999.) "Individual Vs. Job-Based Health Insurance: Weighing the Pros and Cons." *Health Affairs*: Volume 18, Number 6.
- <sup>vii</sup> Whitaker, Julie A. and Doris P. Slesinger. (2002). "Health Status: Use of Medical Services and Health Insurance Coverage: A Comparison Between Farmers, Other Self-Employed and Wage/Salary Workers in Wisconsin," Program on Agriculture Technology Studies Report No. 12.
- <sup>viii</sup> Jon Gabel, Kelly Dhont, Heidi Whitmore and Jeremy Pickreign. *Individual Insurance: How Much Financial Protection Does It Provide*, Health Affairs (Web Exclusive), April 17, 2002.
- <sup>ix</sup> Agency for Health Care Quality and Research. (2001) 2000 Medical Expenditure Panel Survey.
- <sup>x</sup> 2000 United States Census, U.S. Census Bureau.
- <sup>xi</sup> Lange J, Roy NC, Fisher K, & Sheridan C. (2003). "Health Services Survey of Northwest Iowa Farmers 2001." Spencer (IA): AgriSafe Clinic of Spencer Hospital.
- <sup>xii</sup> Andrew Coburn, Timothy McBride, and Erika Ziller. 2002. "Patterns of Health Insurance Coverage Among Rural and Urban Children," Medical Care Research and Review 59 (3): 272-292, September 2002
- <sup>xiii</sup> The Kaiser Commission on Medicaid and the Uninsured. (2003). "The Uninsured in Rural America." Fact Sheet.
- <sup>xiv</sup> The Kaiser Commission on Medicaid and the Uninsured. (2003). "The Uninsured in Rural America." Fact Sheet.
- <sup>xv</sup> Schur, CL and SJ Franco. "Access to Health Care" in *Rural Health in the United States* (ed. Ricketts, T). Oxford University Press, 1999.
- <sup>xvi</sup> Taken from "Eye on Health" by the Rural Wisconsin Health Cooperative, form and article entitled, "Rural Health Can Lead the Way," by former NRHA President, Tim Size; Executive Director of the Rural Wisconsin Health Cooperative.
- <sup>xvii</sup> Taken from a study in progress by Gerald Doekson for the Mississippi Hospital Association called, "The Economic Impact of Mississippi Hospitals on the State's Economy."

Questions in regard to this policy brief should be directed  
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