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# The Underinsured in Rural America: The Root of the Problem and Possible Solutions

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# The Underinsured in Rural America: The Root of the Problem and Possible Solutions

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Presentation to  
National Congress on the Un and Under Insured  
Washington DC

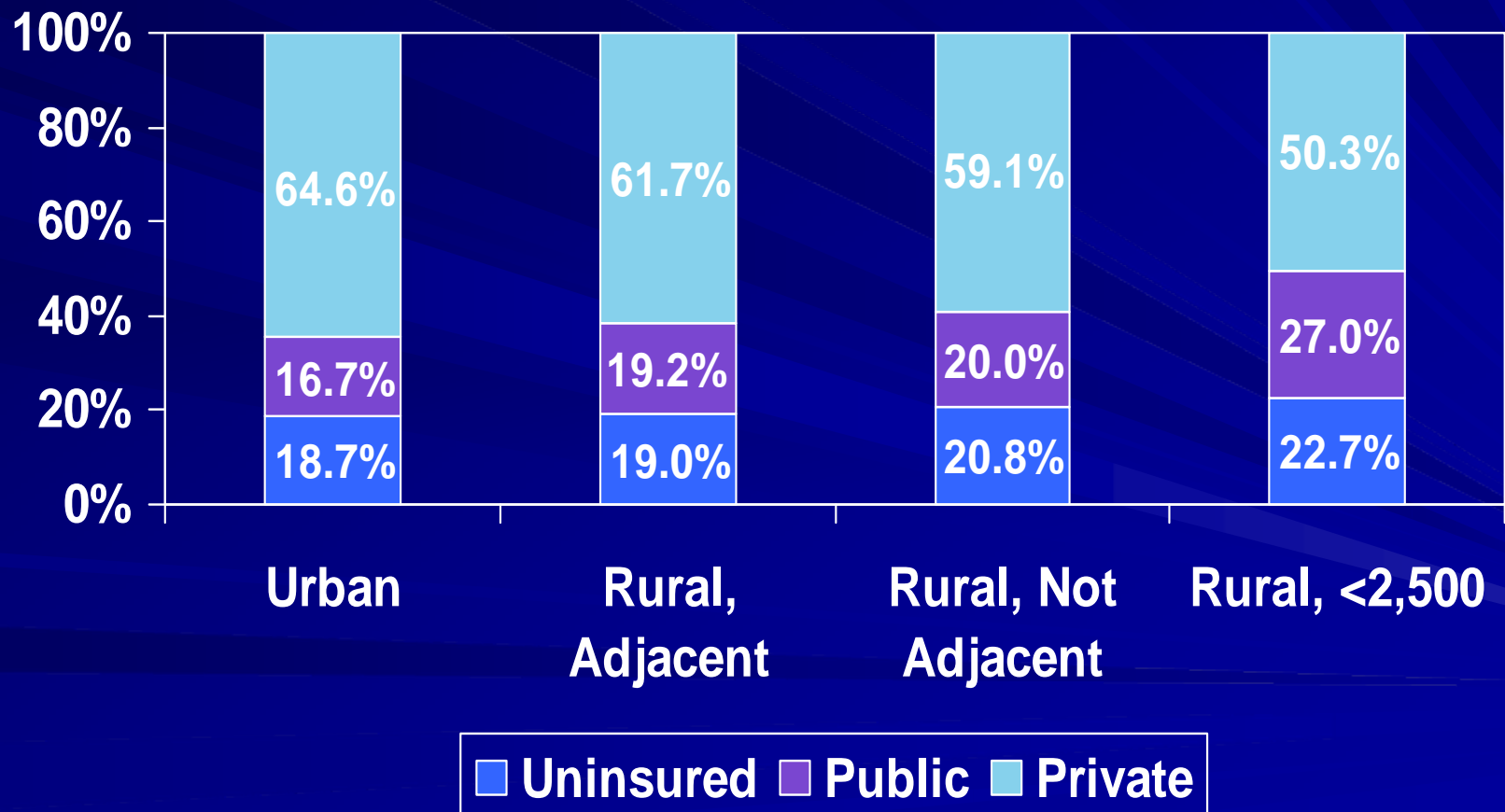
September 23, 2008

# Outline

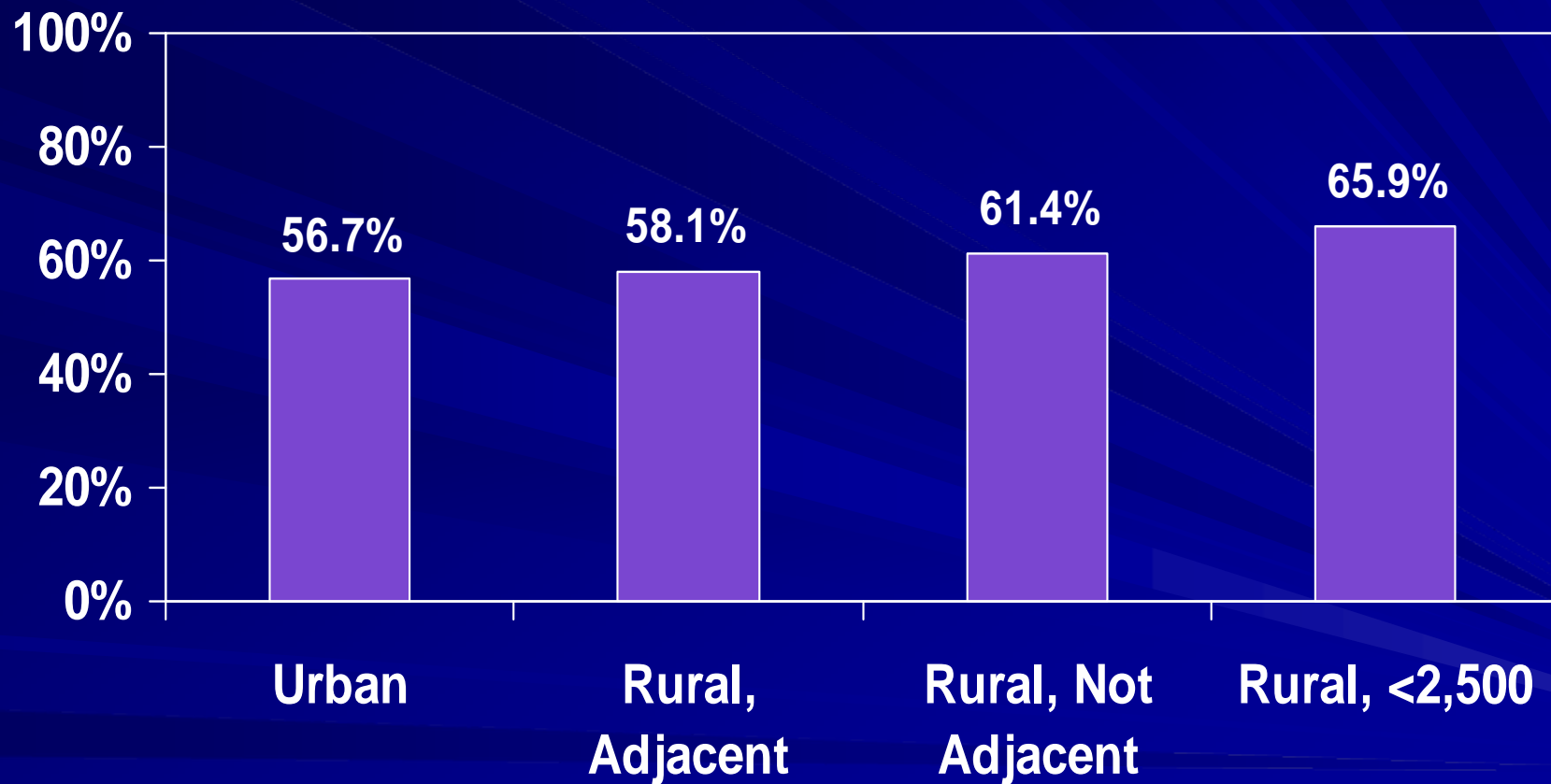
- Scope of the rural uninsurance and underinsurance problem
- Why are rural people and families more likely to be underinsured?
- Fitting solutions to the problem

# **Scope of the Problem: Insurance Coverage and Underinsurance**

# Insurance Status: Non-Elderly (0-64), by Rural-Urban Residence, 2004-05

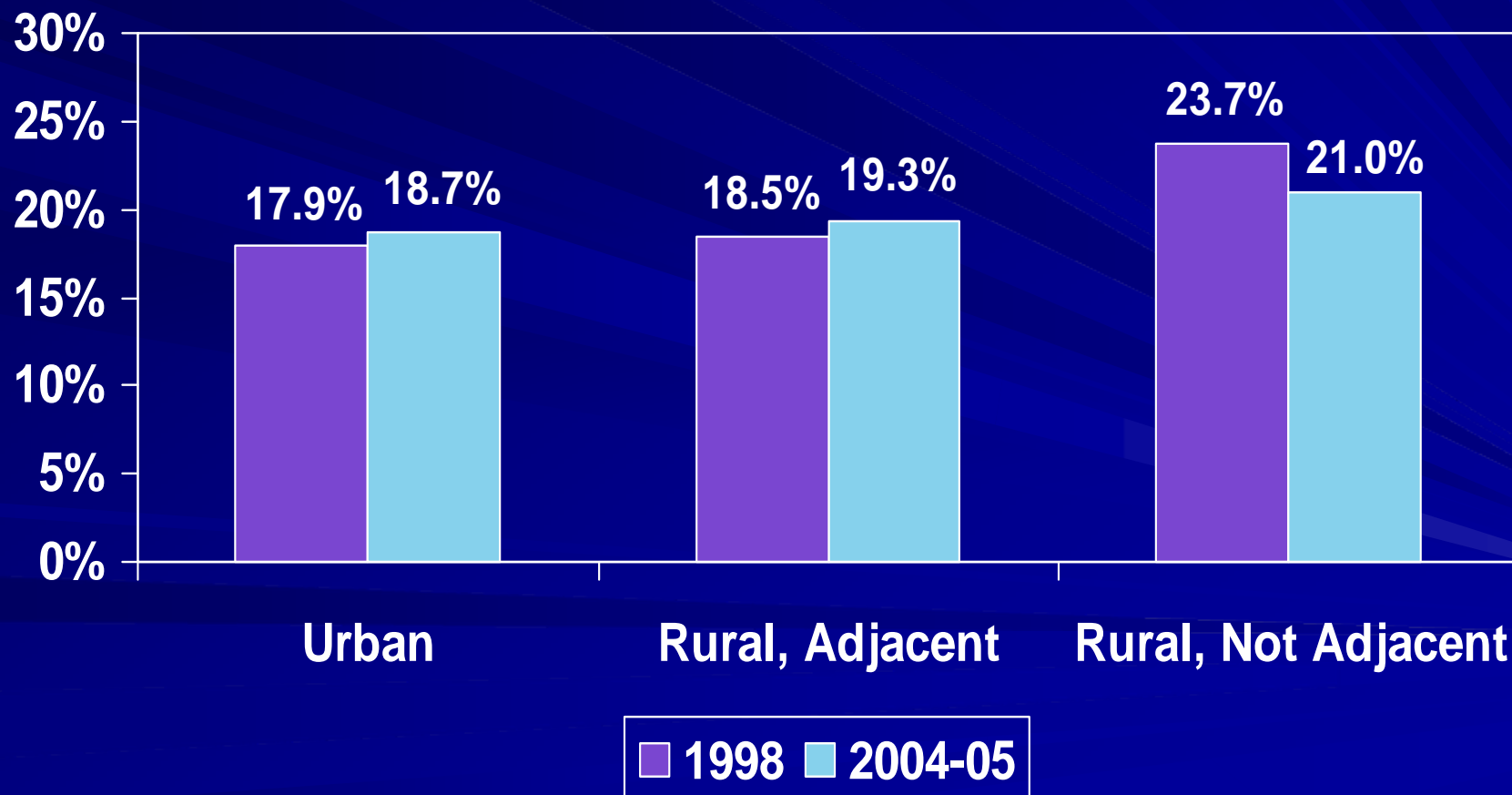


# Uninsured All Year\*: Non-Elderly Adults, 2004-05

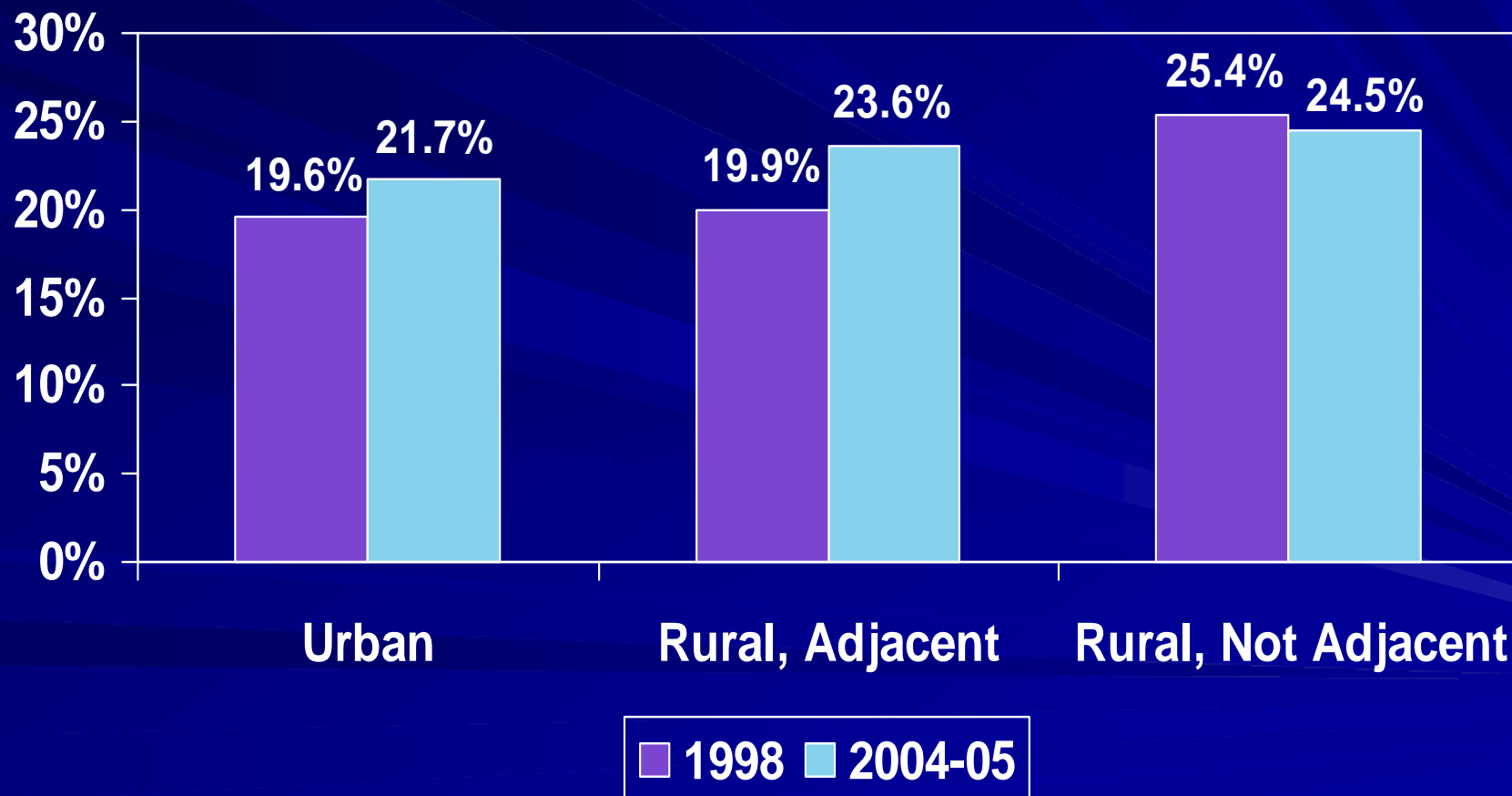


\*Among those ever uninsured during the year

# Uninsured Rates: Non-Elderly (0-64) Population, 1998 & 2004-05

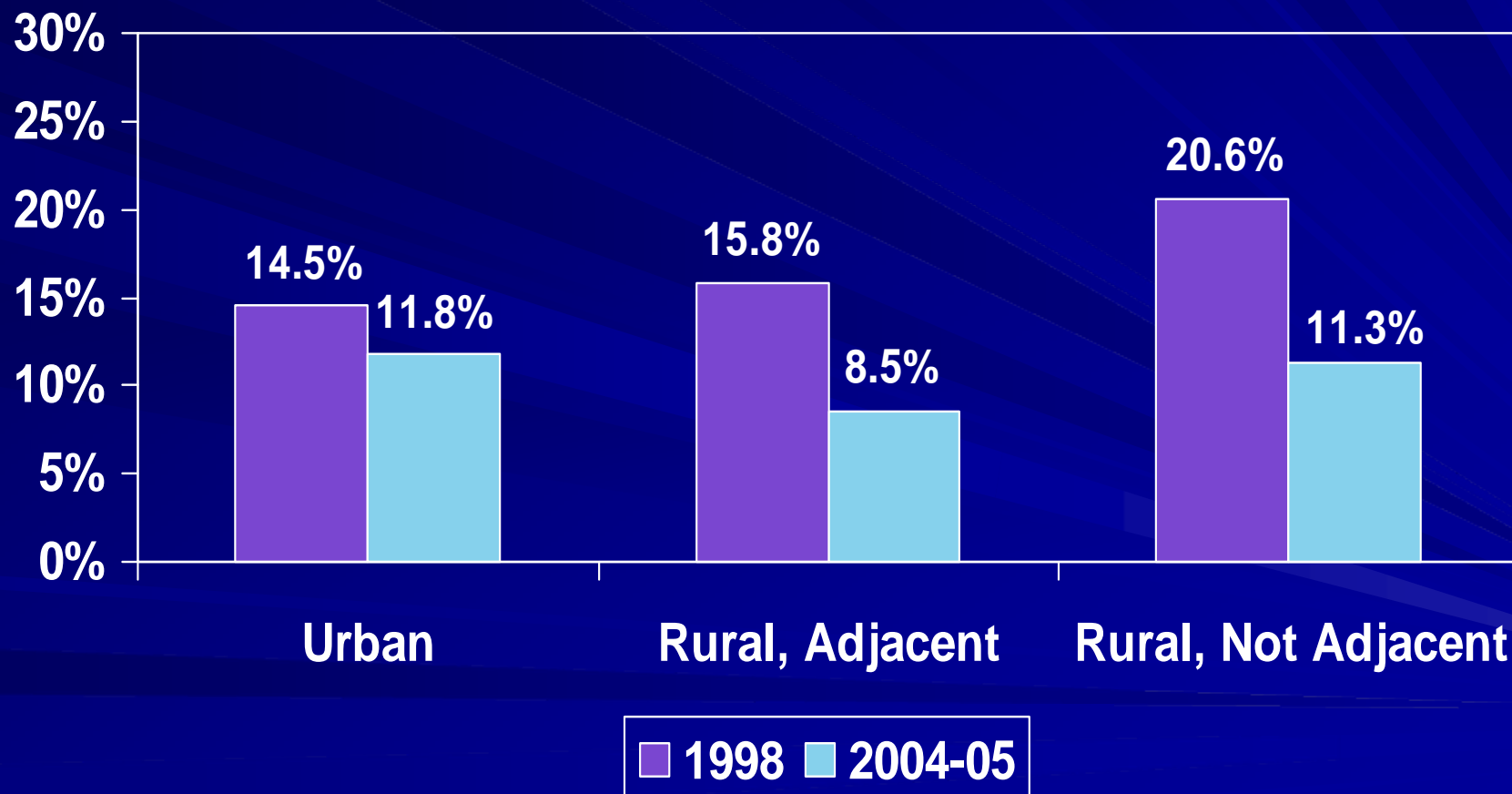


# Uninsured Rates: Adults (18-64), 1998 & 2004-05





# Uninsured Rates: Children (0-18), 1998 & 2004-05



# The Problem of Underinsurance Has Been Discovered in Rural, Farm States

“Health premiums distress families down on the farm”,  
Times-Herald, Vallejo, California, July 29, 2008

**“California's Farmers and Ranchers Hit Hard by  
Health Care Costs”, Reuters, July 2008**

“Farmers struggling with insurance costs”, Fox News  
Des Moines, Iowa, September 2007

“Healthcare costs imperil American farm and ranch families”,  
League of Rural Voters, November 2007

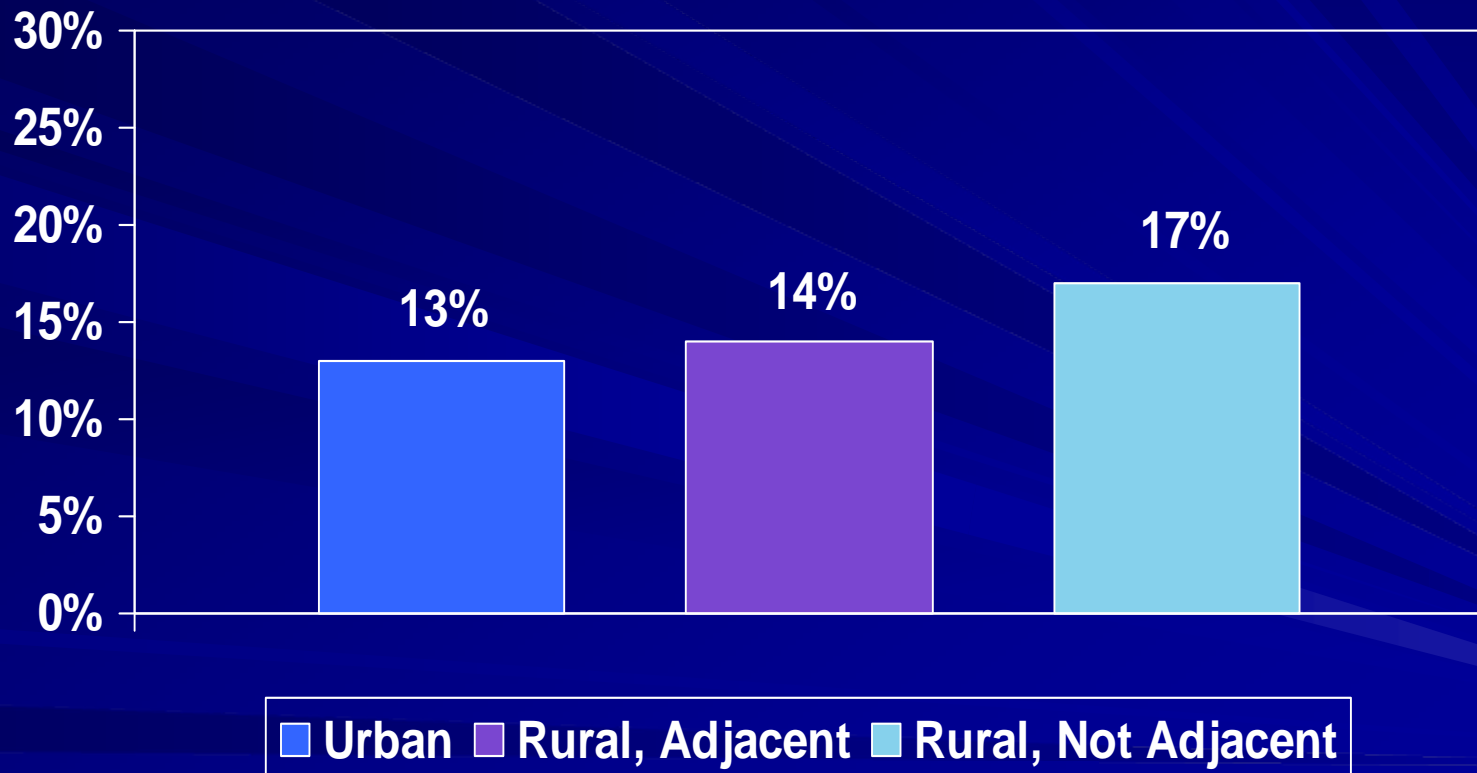
# Underinsurance in Rural America

- Overall estimates of the problem are highly dependent on how “underinsurance” is defined
- Based on multiple definitions, rural residents are at risk of being underinsured
  - Ziller, Coburn & Yousefian (2006)
  - Gabel, McDevitt, Gandolfo, Pickreign, Hawkins & Fahlman (2006)
  - The Access Project (2007)

# Ziller, Coburn & Yousefian (2006)

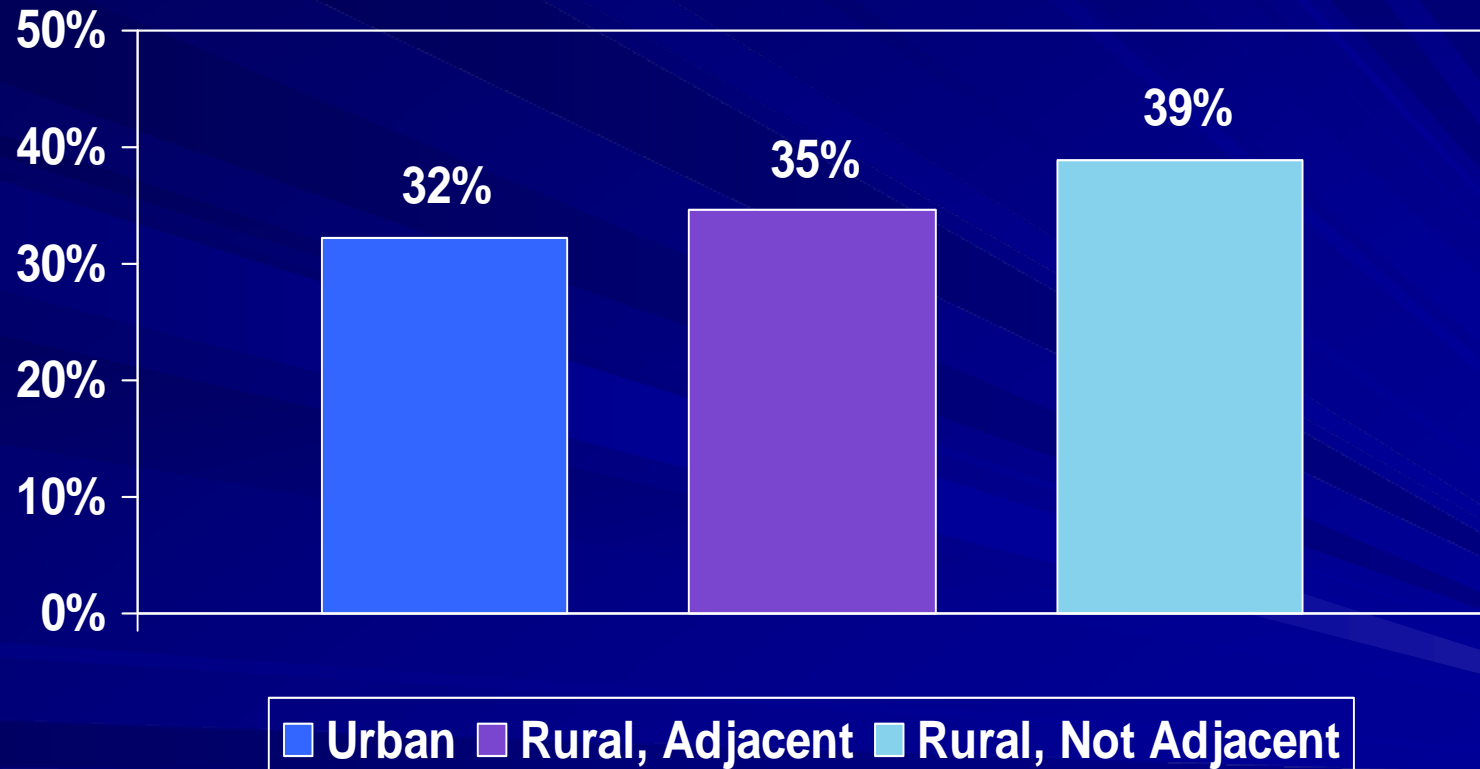
- Based on the 2001 & 2002 Medical Expenditure Panel Survey (MEPS)
- Compared rural-urban underinsured rates for privately insured based out-of-pocket (OOP) costs for medical care
- Considered OOP costs in raw dollars, as a proportion of expenditures, and of income (10%/5% as advanced by Schoen et al.)

# Percent of Privately Insured with \$1000 or more in Out-of-Pocket Costs, 2001-02



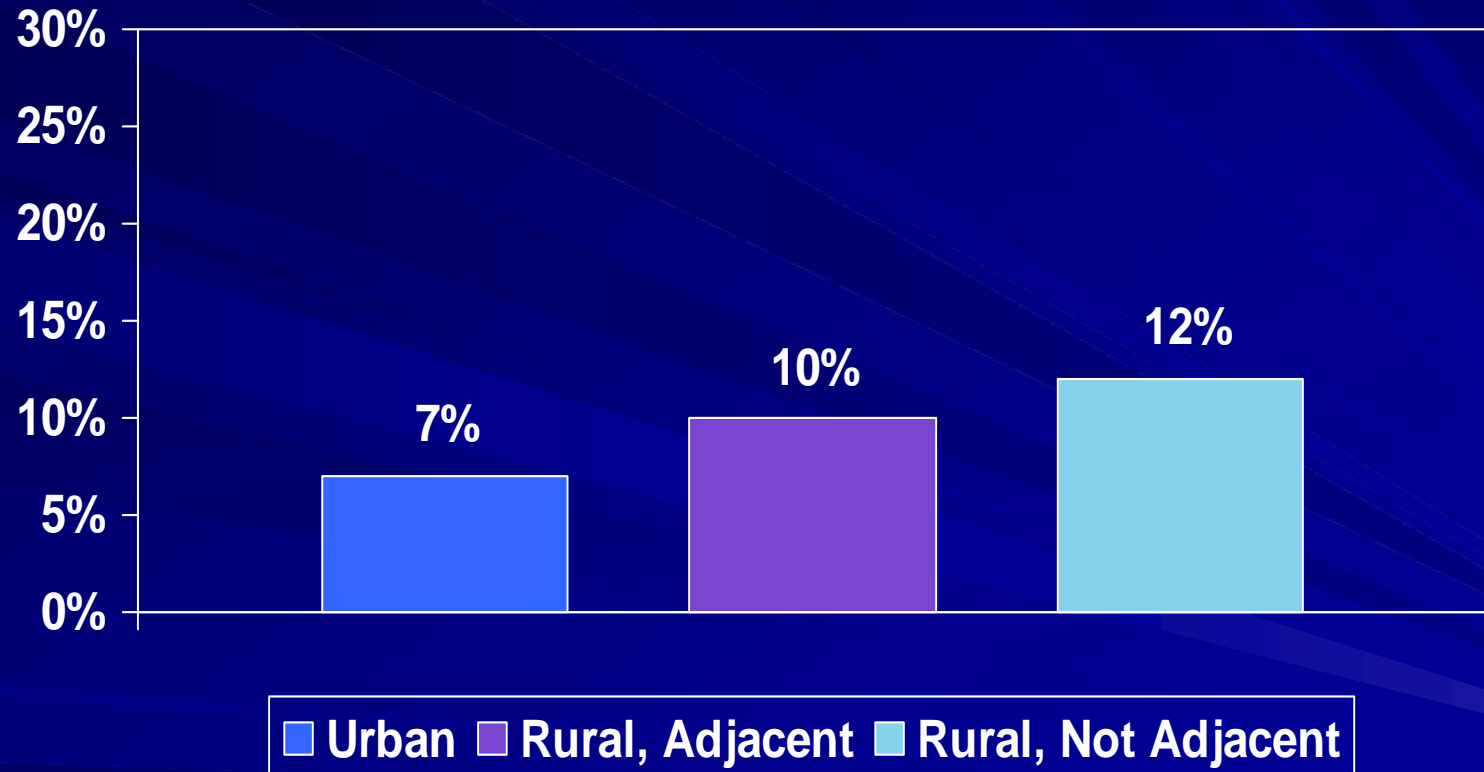
Source: Ziller, Coburn & Yousefian (2006). Out-of-Pocket Health Spending and the Rural Underinsured. *Health Affairs*, 25 (6), 1688-1699.

# Percent of Total Medical Costs Paid Out of Pocket by Privately Insured, 2001-02



Source: Ziller, Coburn & Yousefian (2006). Out-of-Pocket Health Spending and the Rural Underinsured. *Health Affairs*, 25 (6), 1688-1699.

# Underinsurance Among Privately Insured (10%/5% Definition), 2001-02



Source: Ziller, Coburn & Yousefian (2006). Out-of-Pocket Health Spending and the Rural Underinsured. *Health Affairs*, 25 (6), 1688-1699.

## Gabel et al. (2006)

- Used MEPS and KFF/HRET Employer Benefits Survey (2000-04) to assess the relative “generosity” of private employer-based health plans
- Developed measures of “actuarial value” and “adjusted price” that standardize benefits and cost-sharing to allow for uniform comparisons



# Deductibles in Private Employer Plans

	<b>% with Deductible</b>	<b>Mean Deductible (\$)</b>
<b>Rural</b>	<b>69%</b>	<b>\$463</b>
<b>Urban</b>	<b>43%</b>	<b>\$437</b>
<b>Small Business (1-49)</b>	<b>52%</b>	<b>\$599</b>
<b>Large Business (50+)</b>	<b>44%</b>	<b>\$386</b>

Source: Gabel et al. (2006). Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii is Up, Wyoming is Down. *Health Affairs*, 25 (3), 832-843.

# Actuarial Value of Plans (Gabel et al. 2006)

- Adjusted, actuarial value of rural plans lower than urban, with rural residents paying more for the same policy
- The three states with the lowest actuarial value were Iowa, Mississippi and Montana
- Controlling for firm size and plan type (PPO, POS, indemnity), urban plans still of higher actuarial value

# 2007 Health Insurance Survey of Farm and Ranch Operators

- Collaboration between the Access Project, Brandeis University and University of North Dakota Center for Rural Health
- Telephone survey of 2,000 non-corporate farm/ranch operators

Source: The Access Project. "How Farmers And Ranchers Get Health Insurance and What They Spend For Health Care". Brandeis University, December 2007.

# 2007 Survey of Farm Families

- Families on average spent \$7,247 annually on insurance premiums and out-of-pocket costs, while individuals spent \$3,619.
- Heavy reliance on individual policies with high out-of-pocket spending on premiums and cost sharing.

Source: The Access Project. "How Farmers And Ranchers Get Health Insurance and What They Spend For Health Care". Brandeis University, December 2007.

# In Their Own Words

- “We just make the deductible and then the year is over, so we never really feel the benefit from having the insurance. We are paying everything at 100%. If the deductibles were lower and the cost not so high, it would benefit the farmers and ranchers.”

Source: The Access Project. “How Farmers And Ranchers Get Health Insurance and What They Spend For Health Care”. Brandeis University, December 2007.

# Impact of Underinsurance

- Underinsured have access problems similar to uninsured: forgo/delay care, face medical debt, lack confidence in ability to access care (Schoen et al., 2005)
- 75% of medical-related bankruptcies filed by persons with insurance coverage (Himmelstein et al., 2005)
- Underinsurance exacerbates some rural health care providers' financial stress

# Factors Contributing to Rural Underinsurance

# Population, Employment, and Insurance Market Differences

- Population/Health Status
  - Lower wages and lower incomes
  - Poorer health, more chronic conditions
  
- Employment
  - More self-employed
  - Smaller employers
  - More part-time, seasonal workers



# There are Also Significant Insurance Market Differences

- “Actuarial value” of health plans tends to be much lower in rural states (Gabel et al., 2006)
- Individual insurance market is more important for rural residents (Coburn, Ziller et al., 2005)
  - “Value” of those individual policies (cost/benefits) is much lower (Gabel et al., 2006)
- Likewise, rural ESI depends on small group market where value of insurance is lower

# Fewer Safety Net Resources May Increase Rural Underinsurance

- Availability of free or reduced-cost care in rural areas is not known
  - Rural areas tend to have fewer formal safety net providers (e.g., public hospitals)
  - Rural providers less able to cross-subsidize free or reduced-cost care?

# Policy Options

# Reform Strategies: Rural Considerations

- Individual and/or employer mandates
- Expand higher value private coverage: ESI and individual plans
- Expand public coverage
- Strengthen the rural safety net

# Individual and/or Employer Mandates

- Individual mandate without adequate subsidies likely to lead to coverage that promotes underinsurance and access problems
- Employer mandate impact depends on exemption levels
- Potential disproportionate effect on rural employers and employment with potentially serious impact on rural economies

# Private Coverage: Expanding and Improving Individual Plans

- Individual market fixes: equalize tax deductibility, tax credits, reduce administrative expenses (e.g., Connector), insurance regulation, high risk pools, re-insurance
- Affordability and risk rating: Rural residents face higher costs due to age and chronic illness. Danger in expanding access to low-value plans that perpetuate underinsurance.

# Expand ESI

## ■ Premium subsidies:

- Tax credits: Higher subsidies likely to be needed to purchase adequate coverage for low- and middle-income consumers
- Premium subsidies: High premiums make subsidies expensive; high administrative costs; high-deductible and consumer-driven plans can exacerbate underinsurance

# Expand Public Coverage

- High rural take-up rates for previous expansions suggests that expanding public coverage would be a feasible and effective strategy.
- Premium assistance plans would likely be necessary—need standards for such plans to avoid low-value coverage.



# Expand Rural Safety Net

- Expand direct subsidies to rural health care providers to subsidize un- and underinsured:
  - subsidize Rural Health Clinics (RHCs) for uncompensated/charity care
  - Expand Community Health Center program

# Final Thoughts

- Not all rural is the same: problem more acute in non-adjacent rural areas
- Important to take income and employment differences into account in reform
- Public coverage especially important in rural America
- Expanding individual coverage and ESI more challenging without mandates
- Mandates will require significant subsidies to compensate for income differences.