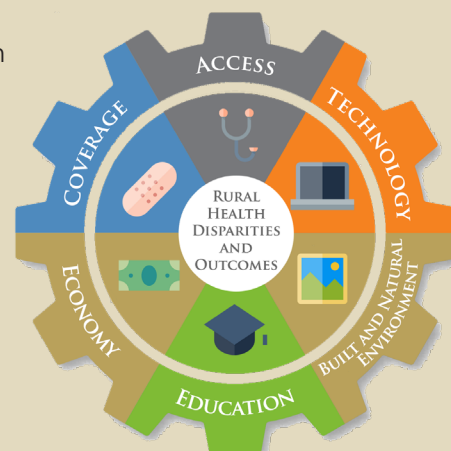


MAKING CONNECTIONS: RURAL HEALTH AND INSURANCE COVERAGE

There are a number of troubling population health trends that present challenges to rural health today. Persistent issues like higher rates of risky health behaviors, lower rates of health insurance coverage, and physician shortages are creating pressure on rural health systems to intervene in order to improve care, enhance quality of life, and decrease costs.

These trends weave together to tell a story based on the interplay of multiple factors and the resulting outcomes they produce. To better understand the big picture, it is important to recognize the relationships that exist between well-being and contributing factors both inside and outside of the traditional health care system.

The Georgia Health Policy Center (GHPC) has long-standing expertise in assisting rural communities to improve health and health care delivery in an effective and sustainable manner. GHPC created this series as a supplement to its *Understanding the Rural Landscape* learning module. This series explores the range of elements that influence rural health, with special emphasis on the unique challenges and innovative solutions emerging in rural communities. This installment of the series will specifically examine the relationship between rural health and health insurance coverage.

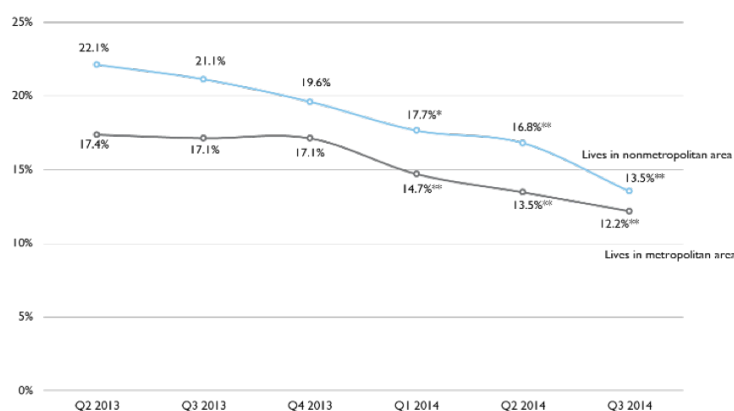


BACKGROUND

Health system costs have been steadily increasing over time, driven by limited use of preventive measures and primary care, overuse of emergency departments, and lack of health insurance. A primary purpose of the 2010 Affordable Care Act (ACA) was to increase affordable health insurance options, particularly for those who have traditionally struggled to obtain insurance. Since the ACA's passage, the overall uninsured rate has fallen 40%¹ with declines in both rural and urban communities, though the rural uninsured rates remain higher than those in urban areas — 13.5% versus 12.2% respectively.²

Another important factor contributing to the decrease in uninsured rates is the Medicaid expansion that occurred as a result of the ACA. In states that expanded Medicaid, rural

Trends in uninsurance for adults ages 18 to 64, by residence in a metropolitan area, from quarter 2 2013 to quarter 3 2014



Note: Estimates are regression adjusted.

*/** Estimate differs significantly from quarter 3 2013 at the 0.05/0.01 levels, using two-tailed tests.

Source: Health Reform Monitoring Survey. (2015). QuickTake: Thirty-six percent drop in uninsurance rate for adults in rural-urban coverage gap.

¹ Karpman, M., Long, S. K., & Zuckerman, S. (2016, May 25). *Taking stock: Health insurance coverage under the ACA as of March 2016*. (Health Reform Monitoring Survey.) Washington, DC: Urban Institute Health Policy Center.

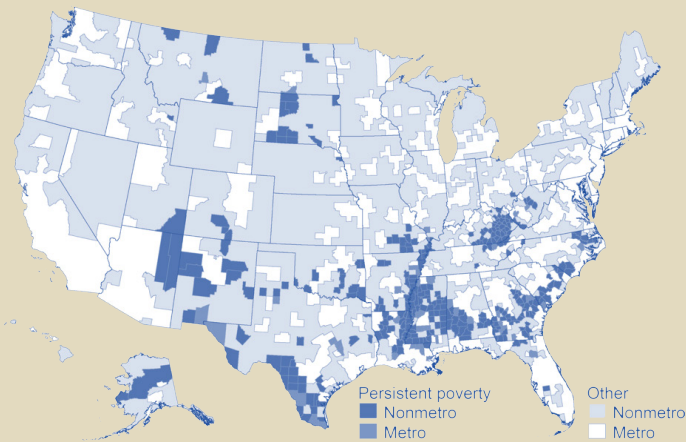
² Karpman, M. (2015, February 4). *QuickTake: Thirty-six percent drop in uninsurance rate for adults in rural areas narrows rural-urban coverage gap*. (Health Reform Monitoring Survey.) Washington, DC: Urban Institute Health Policy Center.

coverage increased from 21% to 25% compared to nonexpansion states, where coverage increased from 20% to only 21%.³ Overall, two-thirds of rural uninsured residents live in states that did not expand Medicaid, leading to a coverage gap for many rural residents.⁴

Other factors influencing insurance coverage post-ACA include premium costs (often driven by competition and number of insurance carriers participating in the Health Insurance Marketplaces), individuals' income level and eligibility for tax credits and subsidies, provider shortages and provider acceptance of available plans, and Medicaid expansion. Many individuals also experience competing financial priorities that may take precedent over paying for health insurance premiums. While health insurance options increased post-ACA for many, some people opted to pay the tax penalty because it was cheaper than purchasing coverage in their local market.

EXAMINING THE RURAL SYSTEM THAT IMPACTS HEALTH INSURANCE COVERAGE

Persistent poverty counties



Persistent poverty counties are those where 20% or more of county residents were poor, measured by the 1980, 1990, 2000 censuses, and the 2007-11 American Community Survey.

Source: USDA, Economic Research Service. (2015). *Geography of poverty*.

Systemic factors contribute to fluctuations in insurance coverage in rural communities, particularly from an economic perspective. Nearly two-thirds of rural counties experience persistent poverty with 20% or more of residents living in poverty over the last 30 years, compared with urban counties.^{5, 6}

Employment opportunities in rural economies are typically blue collar, part-time, or seasonal work and are often associated with lower wages and more limited benefits, including less access to employer-sponsored insurance. In addition, rural residents often experience greater financial burdens for out-of-pocket expenses, making it difficult to pay premiums and making private insurance less affordable.^{4, 7, 8, 9} Rural residents are more likely to utilize public insurance (e.g., Medicaid, Medicare, Veteran's Affairs health care)

rather than have employer-sponsored insurance, compared with their urban counterparts.⁴

Insurance coverage also affects access to and utilization of health care. The rural uninsured, in many cases, rely on emergency departments as their source of primary care, placing a burden on the health care system and driving up costs. Therefore, creating opportunities to obtain health insurance alone is not sufficient by itself to facilitate change in access to care. Building awareness, educating communities on the implications of important policy changes, and changing the culture of accessing care require new and innovative ways of approaching systemic change at the community level. The following highlights the impact of Medicaid expansion in rural areas and efforts rural communities made to increase insurance coverage after passage of the ACA.

³ Foutz, J., Artiga, S., & Garfield, R. (2017, April 25). *The role of Medicaid in rural America*. San Francisco: The Kaiser Family Foundation. Retrieved from <https://www.kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/>

⁴ Newkirk, V., & Damico, A. (2014, May 29). *The Affordable Care Act and insurance coverage in rural areas*. (Issue Brief). San Francisco: The Kaiser Commission on Medicaid and the Uninsured.

⁵ Beatty, K. E., Harris, J. K., Leider, J. P., Anderson, B., & Meit, M. (2016). The double disparity facing rural local health departments: A short report. *Frontiers in Public Health Services and Systems Research* 5(5), 1-8.

⁶ U.S. Department of Agriculture Economic Research Service. *Geography of poverty*. Washington, DC: Author. <https://www.ers.usda.gov/topics/ruraleconomy-population/rural-poverty-well-being/geography-of-poverty/>

⁷ Lu, N., Samuels, M. E., Kletke, P. R., & Whitler, E. T. (2010). Rural-urban differences in health insurance coverage and patterns among working-age adults in Kentucky. *The Journal of Rural Health* 26(2), 129-138.

After passage of the ACA, rural communities across the country received federal funding from the Federal Office of Rural Health Policy to conduct outreach, education, and enrollment activities to increase health insurance coverage in rural areas. Initial funding was heavily focused on training of certified application counselors, education of residents, clarifying misinformation, and building partnerships to maximize resources and reach. Through this work, communities began realizing other barriers to enrollment and, as a result, began to evolve their partnerships to reach vulnerable populations, create wraparound networks to address barriers to coverage, build capacity to assist consumers in enrollment, and establish new processes and systems to embed enrollment support in clinics and hospitals. From an examination of the experiences of 78 funded communities, a typology of partnerships emerged:

INNOVATION:

FACILITATING ACCESS TO COVERAGE IN RURAL COMMUNITIES THROUGH THE AFFORDABLE CARE ACT



Plug-In Partnerships: These are organizations focused on partnering to build trust and leverage resources to reach new populations. As an example, a network of clinical and community partners in Oregon partnered with the parole and probation departments to assist the incarcerated, soon-to-be-released population with enrollment in health insurance coverage.



Wraparound Partnerships: Communities expanded their work to ensure consumers better understood their benefits, maintained coverage, and were able to access care. To do this, they partnered with nontraditional entities such as transportation, financial education and planning organizations, and local food banks. A Federally Qualified Health Center in Maryland partnered with its Community Action Agency to help consumers access food and energy assistance.



Capacity-Building Partnerships: In addition to training navigators and staff to assist with education and enrollment, learning communities were created to share lessons learned and further build capacity around “real-life” scenarios related to challenges individuals experience in obtaining coverage. In Arizona, a joint educator training program was developed with local social service agencies, such as the housing authority, food bank, community development corporation, and the hospital. They met regularly to host “grand rounds” on enrollment cases and troubleshoot and share information about their enrollment efforts.



Closed-Loop Partnerships: Health care systems, hospitals, and clinics in rural and frontier communities working on insurance coverage and access to care efforts engaged in a reorganization of internal relationships across departments within their entities. Internal process changes were driven by an interest in connecting the uninsured to a source of coverage and addressing consumer health-seeking behavior by encouraging utilization of preventive and wellness benefits in a primary care setting, rather than an emergency department. A clinic in rural Indiana embedded its navigator into the clinic setting and operations so she was part of the patient visit whenever possible. As a result, an uninsured patient would have the opportunity for back-to-back visits with the provider and the navigator at a single site.

⁸ Caldwell, J. T., Ford, C. L., Wallace, S. P., Wang, M. C., & Takahashi, L. M. (2016, August). Intersection of living in a rural versus urban area and race/ethnicity in explaining access to health care in the United States. *American Journal of Public Health*, 106(8), 1463-1469.

⁹ Blankenau, J., Bailey, J. M., & Hudson, J. (2009, April). *The causes and consequences of the rural uninsured and underinsured*. No. 3. Lyons, NE: Center for Rural Affairs.

¹⁰ Snell-Rood, C., & Willging, C. E. (2017, January 11). *How Obamacare repeal would harm rural America*. Scholars Strategy Network. Retrieved from <http://www.scholarsstrategynetwork.org/brief/how-obamacare-repeal-would-harm-rural-america>

IMPACT OF MEDICAID EXPANSION ON RURAL AMERICA



After passage of the ACA, there was growth in Medicaid and private coverage in rural areas, with states that expanded Medicaid seeing significant gains in rural coverage rates. While the largest share of coverage in rural areas prior to the ACA was private insurance, nonelderly rural adult residents were less likely to have private coverage compared to their urban counterparts. Medicaid fills a needed gap in coverage for many who would otherwise not be able to afford insurance. In many states, Medicaid coverage rates are higher in rural areas than in urban areas (e.g., California, Hawaii, Arkansas).³

In the Appalachia region of Kentucky, a county that has been struggling with poverty, poor health, and the decline of the local coal industry saw a one-third increase in those covered by Medicaid after Kentucky expanded coverage. Now, approximately 90% of those receiving services at a community mental health center are covered by Medicaid.¹⁰ Behavioral health services are defined in the ACA as essential health benefits, which include no annual or lifetime dollar limits, increasing the availability of care people can access with their insurance coverage. The availability of insurance and access to these health care services is crucial for rural residents, as these populations are sicker, poorer, and more likely to suffer from multiple chronic conditions than urban residents.

IMPLICATIONS



Gaining access to health insurance coverage in rural communities has always been a challenge. Poverty, an economy based on mostly small- and midsize employers, low wages, and limited access to employer-sponsored insurance all represent barriers to obtaining insurance. The passage of the ACA had alleviated some of the barriers, and for the first time, many rural residents gained health insurance coverage. While rural communities have gained momentum in bringing awareness and education about health insurance options, barriers still exist in rural residents gaining health insurance. Assisting individuals and households with addressing important, immediate needs such as energy and food

assistance can help remove barriers from these common competing priorities, thus opening opportunities for obtaining insurance coverage. In addition, many rural residents still encounter high premiums, provider shortages, and limited insurance carriers and plan options in the Health Insurance Marketplaces, and reside in states that did not expand Medicaid (though the possibility of Medicaid expansion policy modifications nationally could present new barriers). Developing a further understanding of system factors that affect health insurance coverage in rural areas can assist in informing policy and designing programs to increase insurance coverage and facilitate access to care.

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