MENDING THE FABRIC OF SMALL TOWN AMERICA: HEALTH REFORM & RURAL ECONOMIES

Sidney D. Watson[*]

> *We'd rather be farming, but we can't afford that life anymore. We want to have children, and things like health insurance are just too costly to maintain on a small farmer's income. We decided to get local jobs, but there are only a few companies that are big enough to provide health insurance around here.*
> Kendra and Steve Koblentz,
> Rolla, Missouri, population 18,488[1]

> *My husband Rob was self-employed at our family printing company, and we had very little savings when he became sick.*

[*] Professor of Law, Saint Louis University School of Law, Center for Health Law Studies. My special thanks to the members of the Missouri Rural Crisis Center for educating me about rural communities and rural economies. Their leaders—Rhonda Perry, Roger Allisonand Tim Gibbons—are some of the best teachers I have had. Thanks to Amy Smoucha, of Missouri Jobs with Justice, for introducing us, and to the Missouri Foundation for Health for supporting our work. Thanks also to Saint Louis University J.D/M.P.H. students Yolonda Campbell and Jamille Fields for extraordinary research and editing help, and to J.D. student Mary Beekman for research assistance. As always, thanks to research librarian Lynn Hartke for all sorts of help and good cheer.

[1] Jon Bailey, Sally Kohn & Angie Evans, *Sweet the Bitter Drought: Why Rural America Needs Health Care Reform*, CENTER FOR COMMUNITY CHANGE, Sept. 2009, at 7, *available at* http://files.cfra.org/pdf/Sweet-the-Bitter-Drought.pdf. For population statistics, see *Rolla, Missouri*, CITY-DATA.COM, http://www.city-data.com/city/Rolla-Missouri.html (last visited Sept. 13, 2010).

> *Rob's cancer treatment, which included three surgeries, five rounds of chemotherapy—and home health care—came to almost half a million dollars. Insurance from my job at J.C. Penney was supposed to pay 80%, but we had to fight with them, and they only paid 60% for most of the treatment. As Rob got sicker the medical bills piled up. We sold our cattle to raise some cash, but still got behind on our house payments. If not for the patience of my in-laws, we would have lost our home.*
> Lynette Swartz
> Freeman, Missouri, population 500[2]

> *I'm a veteran and a POW with VA benefits and Medicare. I've worked my whole life, and I've still got problems with getting health care. I can get great service and coverage if I can get to the right facility. Problem is the closest place for me to use is 70 miles away in Paducah or 110 miles away in Memphis, and when my wife needs services then we have to try to make our appointments at the same time and day so we don't go broke on the cost of gas getting there.*
> Sam Huey
> Union City, Tennessee, population 10,876[3]

With an economic foundation of small businesses, self-employment and low wages, rural communities have been poorly served by a health insurance system that relies primarily on employer-based coverage. Small businesses do not have the economies of scale that make employer-sponsored insurance affordable for larger firms. The individual health insurance market is typically too expensive to offer the quality of coverage that families need to protect them when catastrophic illness strikes. Many rural families end up uninsured or underinsured with coverage that costs too much and provides too little. Inadequate health insurance coverage hurts families, providers, and communities by making it hard for small towns to attract and keep health care providers and other businesses.[4]

---

[2] Sidney D. Watson, Margarida Jorge, Andrew Cohen & Robert W. Seifert, *Living in the Red: Medical Debt and Housing Security in Missouri*, THE ACCESS PROJECT, 2007, at 3, *available at* http://www.accessproject.org/adobe/living_in_the_red.pdf.

[3] Bailey, *supra* note 1, at 9. Population statistics from Wikipedia, *available at Union City, Tennessee*, WIKIPEDIA.ORG, http://en.wikipedia.org/wiki/Union_City,_Tennessee (last visited Sept. 13, 2010).

[4] *See* Andrew F. Coburn et al., *Choosing Rural Definitions: Implications for Health Policy*, RURAL POLICY RESEARCH INSTITUTE (Mar. 4, 2007), http://www.rupri.org/Forms/RuralDefinitionsBrief.pdf. The Rural-Urban Continuum Codes, developed by the U.S. Department of Agriculture (and also referred to as the Beale Codes) groups rural areas according to their degree of urban organization and adjacency to metropolitan areas. *See also* Jennifer D. Lenardson et al., *Profile of Rural Health Insurance Coverage: A Chartbook*,

The new health reform law, the Patient Protection and Affordable Care Act of 2010, also referred to as "ACA" or "the Affordable Care Act," fundamentally changes private and public insurance in this country.[5] It guarantees access to health insurance, makes insurance more affordable, and improves the quality of insurance coverage. Some of its most significant reforms restructure the small group and individual insurance markets upon which rural America depends. The new law is predicted to expand health insurance coverage to almost all Americans, including over 94% of rural Americans.[6] ACA will have a dramatic effect on rural health insurance, rural health care delivery, and rural health.

This article provides a historic look at why our existing health insurance system has failed rural America, the solutions embedded in ACA, and the issues that rural communities will confront as health reform is implemented. ACA promises great things for rural health and rural America. However, legislation is only as good as its implementation.

Understanding the issues that confront health and health care in rural America requires understanding the problems of rural America from at least two perspectives. Section I and Section II address each of these perspectives, and Section III discusses the effect ACA will have on these problems.

Section I describes rural health and health care from the perspective of health and social policy. Rural Americans tend to be sicker and suffer from more chronic illnesses and disabilities than urban Americans.[7] They are also

---

RURAL HEALTH RESEARCH AND POLICY CENTERS (June 2009), http://muskie.usm.maine.edu/Publications/rural/Rural-Health-Insurance-Chartbook-2009.pdf. For a discussion of rural commuting, see Leann M. Tigges & Glenn V. Fuguitt, *Commuting: A Good Job Nearby?*, *in* CHALLENGES FOR RURAL AMERICA IN THE TWENTY-FIRST CENTURY 166, 166–76 (David L. Brown & Louis E. Swanson eds., 2003). *See also* Katherine Porter, *Going Broke the Hard Way: The Economics of Rural Failure*, 2005 WIS. L. REV. 969, 1016 (2005).

5 The Patient Protection and Affordable Care Act was signed into law on March 23, 2010. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified in scattered sections of 26 U.S.C. and 42 U.S.C.). On March 29, 2010, the President also signed the Health Care and Education Reconciliation Act of 2010, which includes a series of amendments to H.R. 3590. Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (to be codified in scattered sections of 26 U.S.C. and 42 U.S.C.). These two laws together are typically referred to as the Health Reform Law, ACA, or the Affordable Care Act.

6 Timothy D. McBride, *Impact of the Patient Protection and Affordable Care Act on Covered Persons as Amended*, RURAL POLICY RESEARCH INSTITUTE, Dec. 22, 2009, at 1–2, 4, *available at* http://www.rupri.org/Forms/McBride_Insurance_Amended_Dec09.pdf.

7 *See* Lois Wright Morton, *Rural Health Policy*, *in* CHALLENGES FOR RURAL AMERICA IN THE TWENTY-FIRST CENTURY 290, 291–92 (David L. Brown & Louis E. Swanson eds., 2003). Rural residents are more likely to experience a limitation of activity caused by chronic conditions. Obesity is more common, as are diabetes, heart disease, and high blood pressure. Kevin J. Bennett, Bankole Olatosi & Janice C. Probst, *Health Disparities: Rural-Urban Chartbook*, SOUTH CAROLINA RURAL HEALTH RESEARCH CENTER (2008), http://rhr.sph.sc.edu/report/(7-3)%20Health%20Disparities%20A%20Rural%20Urban%20Chartbook%20%20Distribution%20Copy.pdf; John R. Pleis & Margaret Lethbridge-Cejku, *Summary Health Statistics for U.S. Adults:*

more likely to be uninsured, more likely to be covered by Medicaid and Medicare, and less likely to have private health insurance.[8] At the same time, rural communities suffer from such a dire shortage of health care providers that even those who have health insurance or money to pay for care often cannot find a provider to treat them. These three interlocking problems—illness, lack of insurance, and lack of access—provide the social context for health reform in rural America.

Section II describes how rural economies differ from urban economies. It also explains why the rural economy that relies primarily on small business, self-employment, and low wage jobs is poorly served by a health insurance system that relies primarily on employer-sponsored health insurance, which creates stress for both patients and providers.

Section III examines how the new Patient Protection and Affordable Care Act directly addresses the social and economic problems that have undermined rural health insurance and health care. It explains the health insurance reform provisions of ACA by focusing on the most important issues to rural communities. Lastly, this section also identifies the implementation issues that are likely to be most significant to rural communities.

I. HEALTH AND HEALTH CARE IN RURAL AMERICA

Almost fifty million Americans, 16% of the population, live in rural America.[9] In West Virginia, almost half the state's residents (43%) are rural,[10] and in seven states, the number of rural residents equals or exceeds urban dwellers.[11] While the percentage of Americans living in rural areas has declined over the last hundred years, the number of Americans living in rural areas has grown.[12]

Rural America ranges from the flat agricultural lands of the Missouri to the mountains and valleys of West Virginia. It includes the bayous of Louisiana

---

National Health Interview Survey, 2006, 10 VITAL & HEALTH STATISTICS 235 (Dec. 2007), *available at* http://www.cdc.gov/nchs/data/series/sr_10/sr10_235.pdf.

8 Lenardson et al., *supra* note 4, at 2.

9 *Population Distribution by Metropolitan Status, States (2007-2008), U.S. (2008)*, STATEHEALTHFACTS.ORG, http://www.statehealthfacts.org/comparetable.jsp?ind=18&cat=1&sort=38 (last visited Sept. 13, 2010).

10 *See id.* In Wyoming, Vermont, and Montana, 67% or more of the population lives in rural areas. In Mississippi, North Dakota, Kentucky, and South Dakota, rural residents number 50% or more of the population. *Id.* In Missouri, 23% of the population is rural. *Id.*

11 *See id.*

12 *See* David A. McGranahan, *How People Make a Living in Rural America*, *in* CHALLENGES FOR RURAL AMERICA IN THE TWENTY-FIRST CENTURY 135, 135 (David L. Brown & Louis E. Swanson eds., 2003) ("[I]n all but a few states, rural (nonmetropolitan) areas now have larger populations than they had in 1920."). For most of the nation's history, most Americans were rural Americans. For a history of rural America and the role of the rural economy in American life, see DAVID B. DANBORN, BORN IN THE COUNTRY: A HISTORY OF RURAL AMERICA 69 (1995).

and the bush communities in Alaska. What these far-flung, diverse areas have in common that makes them rural are sparse populations and long distances.[13] Some rural areas—typically referred to as rural-adjacent—are too far away from metropolitan areas and too sparsely settled to be considered suburban, but still close enough so that residents can, if necessary, commute to population centers for jobs and educational opportunities.[14] More remote rural areas—often called rural-not-adjacent by social scientists—are more distant from metropolitan areas[15] and are thus more dependent on the rural economy for jobs and services. The most sparsely populated areas—those with fewer than 2500 people—are even more isolated, thinly populated, and sometimes described separately as remote-rural areas.[16]

Among public health and health services researchers, there is a three-part mantra about rural health and health care. Rural people are sicker, they are less likely to have private health insurance, and rural communities suffer from a shortage of health care providers. These three interlocking problems provide the backdrop for any discussion of rural communities and health reform.

First, rural people are sicker and suffer from more chronic illnesses and more disabilities.[17] They tend to be older and poorer than urban residents,

---

[13] Drawing the line between rural and urban communities can be tricky because there is no single, universally preferred definition of rural that serves all policy purposes. Rural researchers and social scientists tend to rely on the Office of Management and Budget's (OMB) designation of "nonmetropolitan" and "metropolitan" counties, counting all "nonmetropolitan" counties as rural. *See* Andrew F. Coburn et al., *Assuring Health Coverage for Rural People through Health Reform*, RURAL POLICY RESEARCH INSTITUTE (Oct. 30, 2009), http://www.rupri.org/Forms/Health_ReformBrief_Oct09.pdf. Counties are the most commonly used geographic component of rural definitions. OMB classifies counties as metropolitan if they are located within a metropolitan area, which in turn is defined as a large population nucleus of over 50,000 people. Suburban counties that have a high degree of economic and social integration with the population nucleus of the metropolitan area are also classified as metropolitan. A chief advantage of the OMB definition is that counties are simple to understand and their boundaries are stable over time. Moreover, data are updated annually on metropolitan and nonmetropolitan criteria. This is the definition that will be used through this article. Terms like "rural areas" and "rural locations" will refer to county level units and references to "small towns" include the counties in which they are located. The second most frequently used definition comes from the U.S. Census Bureau, which classifies any town or village of more than 2500 as urban. However, this seemingly outdated view of the line between rural and urban was adopted in 1906 without any explanation. Because of its very narrow definition of rural, it is not widely used by other federal agencies or researchers. *See* Porter, *supra* note 4, at 1016. For an excellent discussion of the various definitions of rural, see *id.* at 988–89.

[14] *See* Coburn et al., *supra* note 4; Lenardson et al., *supra* note 4; Tigges & Fuguitt, *supra* note 4, at 166–76.

[15] *See* Lenardson et al., *supra* note 4, at 38 (citing Graeme Hugo et al., *New Conceptualisation of Settlement for Demogragy: Beyond the Rural/Urban Dichotomy* 18 (2001), http://www.iussp.org/Brazil2001/s40/S42_01_Hugopapx.pdf).

[16] *See* Lenardson et al., *supra* note 4, at 2.

[17] *See* Morton, *supra* note 7, at 291–92; Bennett, Bankole & Probst, *supra* note 7; Pleis & Lethbridge-Cejku, *supra* note 7.

which are both characteristics of that contribute to worse health.[18] Many are often less educated; thus, they are less likely to appreciate how healthy eating and a healthy lifestyle can contribute to better health.[19]

Second, rural people are more likely to be uninsured, more likely to be covered by Medicaid and Medicare, and less likely to have private health insurance.[20] The rate of uninsured individuals in rural and urban areas appears to be similar—20% for all rural areas and 19% for urban communities. However, as population density and distance from urban centers increases, uninsured rates increase from 21% in remote rural areas to 23% in the smallest and most remote rural areas with populations less than 2500.[21] Uninsurance is even higher among rural minorities,[22] the poor,[23] and those with less than a high school education.[24]

Rural uninsured rates would be even higher if not for Medicaid and the State Children's Health Insurance Program (SCHIP)—nearly 40% of rural children are covered by Medicaid and SCHIP.[25] Over the last decade, expansions in children's eligibility have nearly doubled rural children's rates of Medicaid and SCHIP coverage.[26] While these expansions have also increased coverage for urban children, gains have been more dramatic in rural areas where fam-

---

[18] *See* Nina Glasgow, *Older Rural Families*, *in* CHALLENGES FOR RURAL AMERICA IN THE TWENTY-FIRST CENTURY 86, 86–96 (David L. Brown & Louis Swanson eds., 2003) (stating 15% of rural residents are older than sixty-five, compared to 12% in urban areas). *See* STATE HEALTH FACTS, *supra* note 9 (discussing that 20% of rural Americans live in poverty compared to 18% of people in urban areas).

[19] *See* Morton, *supra* note 7, at 298–99 (noting the role of smoking and obesity on rural health).

[20] Lenardson et al., *supra* note 4, at 2.

[21] *Id.* This breakdown of rural, rural-adjacent, and small rural is one developed by the Rural Urban Continuum Codes, which is developed by the Office of Rural Health Policy of the Department of Health and Human Services (HHS). It takes the OMB "nonmetropolitan" and "metropolitan" classification as the beginning point for defining rural and urban areas, but adds in census tract data to be able to identify small towns and rural areas within large metropolitan areas. Coburn et al., *supra* note 13, at 4.

[22] *See* Lenardson et al., *supra* note 4, at 10. The uninsured make up 29% of minorities in remote rural areas, 28% in rural-adjacent areas, and 26% in urban areas. *Id.*

[23] *See id.* at 8. The percentage of poor adults who are uninsured is high in both rural and urban areas. For those living below 100% of the federal poverty line (FPL), the uninsured rate is 45% in remote rural, 50% in rural-adjacent and 46% in urban areas. For adults earning between 100% and 199% of the federal poverty level , the figures are almost as dramatic with 43% in remote areas, 37% in adjacent areas, and 41% in urban areas. The rates of uninsurance drop substantially to 15% for all areas for people earning over 200% FPL. *Id.*

[24] *Id.* at 15. Forty-one percent of rural residents in remote locations who do not have a high school diploma are uninsured, as are 40% in rural-adjacent and urban areas. *Id.*

[25] *See id.* at 5 (39%).

[26] *See id.* at 5 (from 21% to 39%).

ily incomes tend to be less.[27] Children in rural areas now have lower uninsured rates than do urban children—9% compared to 11%.[28]

However, gains in Medicaid and SCHIP coverage for rural children tend to mask the depth of uninsurance among rural adults. Roughly 25% of rural adults are uninsured,[29] and only about 20% have Medicaid.[30] Stringent categorical eligibility rules in the Federal Medicaid Act restrict coverage to adults who are parents, permanently or totally disabled, or age sixty-five or older; all other adults are disqualified except in the few states that have special waivers.[31] Even the poorest adults who fit within the Medicaid eligibility categories still may not qualify for coverage because of low income eligibility rules set by the states. In thirty-four states, parents earning as little as 100% of the federal poverty level (FPL)—a $18,310 annual income for a family of three—earn too much to qualify for Medicaid.[32] In West Virginia, a family earning one-third this amount has too much income for the parents to be Medicaid-eligible.[33]

Lastly, rural communities suffer from such a dire shortage of health care providers that even those who have health insurance or money to pay for care often cannot find a provider to treat them. More than 80% of rural communities are designated as Medically Underserved Areas, a designation given by the U.S. Department of Health and Human Services (HHS) to areas with a shortage of

---

[27] Lenardson et al., *supra* note 4, at 5. Public coverage for urban children increased during the same period from 16% to 32%. *Id.* In urban areas, 18% of residents earn at or below the poverty line; in rural areas it is 20%. *See* STATE HEALTH FACTS, *supra* note 9. In West Virginia, the urban/rural differential is even more dramatic; the poverty rate in metropolitan areas is 16% compared to 24% in rural communities. *Id.*

[28] Lenardson et al., *supra* note 4, at 5. The increase in public coverage resulted in a decrease in urban children uninsured from 15% to 11%. *Id.*

[29] *Id.* Rates for rural adults are 24%. *Id.* Rates for urban adults are 22%. *Id.*

[30] *See id.* Twenty-four percent of rural adults age eighteen to sixty-four have public insurance. *Id.* The rate of Medicaid coverage is actually lower because a small percentage of these adults have Medicare. Lenardson et al., *supra* note 4, at 5.

[31] Social Security Act, 42 U.S.C. §§ 1902(a)(10)(A)(ii), 1905(b)(4), 1396(a) (2006). In forty-two states, childless adults who are not disabled cannot qualify for Medicaid. Marc Steinberg, *Working Without A Net: The Health Care Safety Net Still Leaves Millions of Low-Income Workers Uninsured*, Special Report (Families USA, Washington, D.C.), Apr. 2004, at 1, 3, *available at* http://www.familiesusa.org/assets/pdfs/Holes_ 2004_update_revb622.pdf. For a discussion of Medicaid eligibility for adults and children, see Sidney D. Watson, *The View from the Bottom: Consumer-Directed Medicaid and Cost-Shifting to Patients*, 51 ST. LOUIS U. L.J. 403, 409 (2007).

[32] *Medicaid and State Funded Coverage Income Eligibility Limits for Low-Income Adults*, 2009, STATEHEALTHFACTS.ORG, http://www.statehealthfacts.org/comparereport.jsp?rep=54&cat=4 (last visited Sept. 13, 2010). For federal poverty guidelines, see *The 2009 HHS Poverty Guidelines*, U.S. DEP'T OF HEALTH & HUMAN SERVS., http://aspe.hhs.gov/poverty/09poverty.shtml (last visited Sept. 13, 2010).

[33] *Id.* West Virginia's Medicaid income eligibility for parents is 33% of the federal poverty line. *Id.*

health care resources.[34] While 20% of Americans live in rural America, only 9% of physicians practice there.[35] Rural areas have about half the number of primary care physicians and specialists and only a third as many psychiatrists as urban areas—the shortages being even more severe in more remote areas.[36] Shortages encompass all types of medical professionals: physicians, dentists, pharmacists, registered nurses, and ancillary medical personnel.[37] Mental health and dental care are particularly hard hit. Twenty percent of rural counties lack mental health services, and almost 90% of the nation's Mental Health Professional Shortage Areas are rural.[38] As a result of these shortages, 14% of rural patients must travel more than thirty minutes to receive routine and primary care, while only 10% of urban patients must do so.[39]

Rural medical personnel, like rural residents in general, are older than their urban counterparts.[40] Nearly 30% of rural registered nurses are over fifty-five, the median age of rural physicians is forty-eight, and more than half of rural general surgeons are over fifty.[41] Of clinically active physicians who

---

[34] *The 2008 Report to the Secretary: Rural Health and Human Services Issues*, THE NAT'L ADVISORY COMM. ON RURAL HEALTH AND HUMAN SERVS., Apr. 2008, at 11, *available at* ftp://ftp.hrsa.gov/ruralhealth/committee/NACreport2008.pdf [hereinafter *The 2008 Report*].

[35] John D. Gazewood, Lisa K. Rollins & Sim S. Galazka, *Beyond the Horizon: The Role of Academic Health Centers in Improving the Health of Rural Communities*, 81 ACAD. MED. 793, 793–94 (2006).

[36] Meredith A. Fordyce et al., *2005 Physician Supply and Distribution in Rural Areas of the United States*, THE UNIVERSITY OF WASHINGTON RURAL HEALTH RESEARCH CENTER (Nov. 2007), http://depts.washington.edu/uwrhrc/uploads/RHRC%20FR116%20Fordyce.pdf. There were fifty-five primary care physicians per 100,000 residents in rural areas in 2005, compared with seventy-two per 100,000 in urban areas. *Id.* The number decreases to thirty-six per 100,000 in isolated, small rural areas. *Id.*

[37] *The 2008 Report*, *supra* note 34, at 11. For example, the number of rural counties designated in whole or part as dental shortage areas increased by nearly 160% from 1981–2005. *Id.* at 12.

[38] Larry D. Gamm, Linnae L. Hutchison, Betty J. Dabney & Alicia M. Dorsey, eds., *Rural Health People 2010: A Companion Document to Healthy People 2010*, SOUTHWEST RURAL HEALTH RESEARCH CTR., 2003, at 166, *available at* http://srph.tamhsc.edu/centers/rhp2010/Volume1.pdf.

[39] *Medical Expenditure Panel Survey*, THE AGENCY FOR HEALTH RESEARCH AND QUALITY, http://www.ahrq.gov/about/cj2006/ meps06.htm (calculations done by Main Rural Health Research Center) (last visited Sept. 13, 2010).

[40] Meredith Fordyce et al., *The Aging of the Rural Generalist Workforce: Are Some Locations more Vulnerable than Others?*, THE UNIVERSITY OF WASHINGTON RURAL HEALTH RESEARCH CENTER, May 2009, *available at* http://www.aamc.org/meetings/pwc/archives/presentations09/doescher.pdf.

[41] Jon M. Bailey, *The Top 10 Rural Issues for Health Care Reform*, CTR. FOR RURAL AFFAIRS 1, 3 (Mar. 2009), http://files.cfra.org/pdf/Ten-Rural-Issues-for-Health-Care-Reform.pdf. Frederick M. Chen et al., THE UNIVERSITY OF WASHINGTON RURAL HEALTH RESEARCH CENTER, *U.S. Rural Physician Workforce: Analysis of Medical School Graduates from 1988-1997* (2008), *available at* http://www.depts.washington.edu/uwrhrc/uploads/RHRC%20FR113%20Chen.pdf.

graduated from medical school between 1988 and 1997, only 11% practice in rural areas.[42]

Many national and professional trends work against recruiting young doctors to rural areas.[43] Factors, such as the decline in the number of primary care physicians, the lifestyle preferences of younger doctors, and the increasing amount of student debt all make it hard to recruit rural health professionals.[44] Only about 3% of recent medical students plan to practice in small towns and rural areas.[45]

Rural hospitals are also aging, shrinking, and in short supply. Rural America lost almost 10% of its hospitals in the 1980s and 1990s.[46] Today, 17% of rural communities are at risk of losing their hospital.[47] When rural hospitals close, communities not only lose local emergency rooms and hospital services, but they have even more difficulty recruiting physicians to provide routine care.[48]

The rural hospitals remaining are older, smaller, and less technologically advanced than urban hospitals. Most rural hospitals were built in the 1950s using federal Hill Burton Act funds that are no longer available.[49] Many rural hospitals have financial margins too low to support investments in critical plant and technology upgrades,[50] and overall admission rates at rural hospitals have declined as rural residents bypass their local hospital for the more sophisticated services provided by urban hospitals.[51] Over the last two decades, the small

---

42 Chen et al., *supra* note 41, at 8.

43 *See* Fordyce et al., *supra* note 40.

44 H.K. Rabinowitz et al., *Medical School Programs to Increase the Rural Physician Supply: A Systematic Review and Projected Impact of Widespread Replication*, 83 ACAD. MED. 235–43 (2008).

45 *2009 Matriculating Student Questionnaire (MSQ) All Schools Summary Report*, AMERICAN MEDICAL ASSOCIATION, at 19, *available at* http://www.aamc.org/data/msq/msq2009.pdf. In 2009, 1.0% of medical students indicated they would work in small towns and 1.8% of medical students indicated they would work in rural areas. *Id.* at 19.

46 Morton, *supra* note 7, at 293.

47 Joe Blankenau et. al., *The Causes and Consequences of the Rural Uninsured and Underinsured*, 3 CTR. FOR RURAL AFFAIRS 1, 6 (2009) (Seventeen percent of 246 rural counties were vulnerable to losing their hospitals because on average their hospitals had lost money over a three year period).

48 Morton, *supra* note 7, at 293. Losing a hospital can have a domino effect because physicians rely on hospitals to build a foundation for their practice. *A Shared Destiny: Effects of Uninsurance on Individuals, Families, and Communities*, INSTITUTE OF MEDICINE, Mar. 2003, at 5, *available at* http://iom.edu/~/media/Files/Report%20Files/2003/A-Shared-Destiny-Community-Effects-of-Uninsurance/Uninsured4final.pdf.

49 Roger A. Rosenblatt, *A View from the Periphery-Health Care in Rural America*, 351 NEW ENG. J. MED. 1049, 1050 (2004).

50 *See CAH Financial Indicators Report: Summary of Indicator Medians by State*, FLEX MONITORING TEAM, OCT. 2009, *available at* http://www.flexmonitoring.org/documents/DataSummaryReportNo6_Aug09.pdf.

51 Morton, *supra* note 7, at 293.

rural hospitals that have survived have typically done so by downsizing even further. Many converted to Critical Access Hospital (CAH) status; this status provides more favorable Medicare reimbursement and twenty-four hour emergency room coverage, but it also requires limiting services to twenty-five or fewer beds, and hospital stays to less than ninety-six hours.[52] Hospitals in larger, rural areas have survived primarily by merging or networking with other rural or urban hospitals.[53]

Health policy offers a bleak description of the social dimensions of rural health. Rural people are sicker, poorer, and less educated. Rural folks are more likely to be uninsured or to rely on public insurance. Rural communities suffer such a severe shortage of health care professionals and institutions that even those with health insurance or money to pay for care often cannot find a provider to treat them. Understanding the nature of rural economy and rural business helps in understanding why the existing private health insurance system does not work in rural America and how financial stresses have undermined rural health providers.

II. RURAL ECONOMIES AND PRIVATE HEALTH INSURANCE

Rural economic development is different from urban economic development. Long travel distances and thin populations mean that the rural business structure and job opportunities are markedly different. It also means that the employer-sponsored health insurance system—the mainstay of private health insurance in America—is poorly suited to the rural economy. This section offers a description of rural jobs and a brief history of private health insurance to demonstrate how when the two intersect, rural Americans end up paying more for private health insurance but get less. The economic structure of rural America has fueled both high levels of uninsurance and underinsurance.

People originally moved to rural America to take advantage of its natural resources. Farming, ranching, hunting, and trapping provided cash income as well as supported a subsistence lifestyle. Mining and timbering added more cash jobs.[54] Over the last eighty years, though, rural employment in farming, mining, and timber has declined substantially.[55] Increased manufacturing has come to play a more important role in rural economies by accounting for 21% of rural earnings in 2000.[56] However, rural manufacturing has been particularly

---

52 Rosenblatt, *supra* note 49, at 1050.

53 Morton, *supra* note 7, at 293; Rosenblatt, *supra* note 49, at 1050.

54 McGranahan, *supra* note 12, at 135.

55 *Id.* at 143–44. Farming now accounts for 5% of the rural economic base. *Id.* at 137. For a discussion of how rural economies have changed, see Porter, *supra* note 4, at 974–75. *See also id.* at 977–78 (stating that farming accounts for 10% of rural jobs although among farm households, nearly 90% of total household income originates from nonfarm sources).

56 McGranahan, *supra* note 12, at 137.

hard hit in the most recent economic downturn with rural communities losing, in the last few years, 5% of their manufacturing jobs.[57]

Today, most rural Americans, like urban dwellers, work in the services sector—banking; business services like accounting, government, retail, and restaurants; and, in some areas, tourism.[58] In fact, rural Americans are more likely than urban Americans to work in the service sector—64% compared to 58%.[59] While some service sector jobs offer high pay and good benefits, rural communities seem to get more than their share of the low pay kind.

Rural work—more so than urban work—tends to be low wage, part-time, and seasonal. Almost 40% of rural workers earn less than $10 an hour.[60] Twenty-two percent of workers who live in remote rural locations are employed only part-time.[61] This is why poverty is more widespread in rural America.

Over 80% of rural workers are employed by very small businesses or are self-employed.[62] Nearly half of the workers living in remote rural areas work for very small firms that employ fewer than twenty workers compared to only 37% of urban workers.[63] Almost a third of workers in rural counties are self-employed compared to only 24% in urban counties.[64]

Since World War II, employer-sponsored health insurance has been the most widely-used means of providing private health insurance in the United States because it provides a convenient mechanism for pooling together large groups of individuals to share the costs of premiums and the risks of illness and injury.[65] Since employees typically choose a job for a variety of reasons, concerns about adverse selection, where individuals wait to join the insurance pool

---

[57] Mark Drabenstott & Sean Moore, *Rural America in Deep Downturn*, RURAL POLICY RESEARCH INSTITUTE 6 (Mar. 2009), http://www.rupri.org/Forms/CRC_Recession.pdf (rural communities have lost 5% of their manufacturing jobs since the beginning of the recent recession).

[58] *See* McGranahan, *supra* note 12, at 137. In 2000, 64% of rural residents and 58% of urban dwellers worked in the service sector. *Id.*

[59] *Id.*

[60] Lenardson et al., *supra* note 4, at 26. Thirty-eight percent of workers in remote rural areas and 36% of workers in areas adjacent to urban centers earn less than $10 per hour. In urban areas 25% of workers earn this little. *Id.*

[61] *Id.* at 25. Twenty percent of urban workers work part-time. Among rural and adjacent workers, 18% work part-time. *Id.*

[62] *See* Coburn et al., *supra* note 13 (self-employed—33%); Lenardson et al., *supra* note 4, at 26 (small business—49%).

[63] *See* Lenardson et al., *supra* note 4, at 26 (49% in rural nonadjacent areas and 41% in rural adjacent areas).

[64] Blankenau et al., *supra* note 47, at 2. Rural residents are also significantly more likely to be self-employed—33% compared to 21% in urban areas. *Id. See also* Coburn et al., *supra* note 13; *Health Insurance Access in Rural America*, NATIONAL RURAL HEALTH ASSOCIATION, http://www.ruralhealthweb.org/download.cfm?downloadfile=400AC60D-1185-6B66-8811D1B5632FB36B&typename=dmFile&fieldname=filename (last visited Sept. 13, 2010).

[65] For the history of private health insurance in the United States, see PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 310–31 (1982).

until they get sick and need health care, are reduced. Providing policies to a group also reduces the administrative costs of collecting premiums.[66]

However, the nature of the rural economy—small businesses, low-wages, part-time and seasonal work—all mean that rural workers are less likely to work for an employer who offers health insurance and thus less likely to have employer-sponsored coverage. Only 64% of workers in remote rural areas have employer-sponsored health insurance compared with 69% in urban areas and 67% in rural-adjacent areas.[67]

The prevalence of self-employment also means that rural residents are nearly half as likely to depend on individual policies.[68] Individual policies are especially widespread among farmers who need health insurance as a form of business insurance to prevent losing their land because of medical debt. In a recent survey of Midwestern farmers and ranchers, 36% relied on individual policies.[69]

The prevalence of small business and self-employment in rural America means that rural residents who have private insurance rely disproportionately on the most costly and least generous forms of insurance: individual and small group policies. The original health insurers, through the not-for-profit Blue Cross and Blue Shield plans, used a practice called community rating and charged all individuals the same premium price. Over the years, with the rise of for-profit health insurers, policies are now typically underwritten and premiums are risk rated.

Underwriting occurs when insurance companies decide whether to issue a policy based upon an individual or group's health status, medical history, gender, age, occupation, and other factors. Insurers refuse to write policies for those who have pre-existing conditions or other factors that make them a high risk of actually needing to use their insurance. Risk rating is pricing premiums to vary based upon the insurance company's estimate of the likelihood that the individual or those in the group will need medical care.

---

66 World War II-era wage freezes also encouraged the growth of employer-sponsored health insurance because benefits were exempted from the freeze .

67 Lenardson et al., *supra* note 4, at 28. In rural-remote areas, 64% of working adults are offered coverage through their employer compared to 71% in urban areas. *Id.* This difference persists for full time workers—75% compared to 81%. *Id.* at 29. Small businesses are less likely to offer health insurance than large businesses. *Id.* at 30. Part-time or seasonal workers are typically not eligible for benefits. *Id.* Low wage workers are also less likely to be offered employer-sponsored health insurance as are higher wage workers. *Id.* at 32.

68 Erika Ziller et al., *Out-of-Pocket Health Spending and the Rural Underinsured*, 25 HEALTH AFFAIRS 1688, 1692 (2006).

69 *2007 Health Insurance Survey of Farm and Ranch Operators*, THE ACCESS PROJECT, 1, 4 (2007), http://www.accessproject.org/adobe/issue_brief_no_1.pdf. *See also* Bill Lottero et al., *Health Care in the Heartland: 2007 Health Insurance Survey of Missouri Farm and Ranch Operators*, THE ACCESS PROJECT, 2007, *available at* http://www.accessproject.org/adobe/HealthCareInTheHeartland.pdf. Among Missouri farmers surveyed, 21% reported having individual policies. *Id.* at 8.

Enacted in 1996, the federal Health Insurance Portability and Accountability Act (HIPAA) limits the extent to which insurance companies can refuse to underwrite health insurance plans in the small group and individual markets, but it places no limit on the prices that health insurers can charge, and premiums can vary based upon risk rating.[70] While some states limit the extent to which health insurers can use underwriting and risk rating in the individual and small group markets beyond the limits set by HIPAA, many states have had little or no restrictions on the practice.[71]

Risk rating has an effect on the price of all group and individual health insurance policies, but large employers can spread the risk of a few very sick employees across a large number of other healthier employees. For small employers, especially those with fewer than twenty employees, even one employee with significant health problems can mean premiums that are unaffordable. For an individual seeking an individual policy, a prior illness can become the preexisting condition that results in being turned down for coverage altogether or an unaffordable premium. Health insurance underwriting and risk rating are particularly problematic for rural residents because of their tendency to be older, poorer, less educated, and sicker than urban residents.[72] The stereotypical rural jobs—farming, ranching, timbering, and mining—are the kinds of physical occupations that health insurers rate as high cost because workers are prone to illness and injury.[73]

Risk rating also raises the administrative costs of health insurance in the small group and individual market. It costs the same, probably even more, to underwrite, risk rate, and market a policy to an individual, or a small group of three or four, as it does to a very large group of one thousand.[74] Large employers benefit from these economies of size and pay lower administrative costs than do smaller employers and individuals: administrative costs run about 10% for large groups, 20–25% in the small group market, and up to 30–35% in the indi-

---

[70] *See* 29 U.S.C. §§ 1181–1191c (1996); 42 U.S.C. § 300 (1996). For an overview of HIPAA's health insurance provisions, see BARRY R. FURROW et al., HEALTH LAW 749–52 (6th ed. 2008).

[71] For a detailed analysis of state law provisions regulating individual insurance, see *Failing Grades: State Consumer Protections in the Individual Health Insurance Market*, FAMILIES USA, June 2008, *available at* http://www.familiesusa.org/assets/pdfs/failing-grades.pdf. For information on various state laws regulating the small group and individual market, see *Health Insurance and Managed Care*, STATEHEALTHFACTS.ORG, http://www.statehealthfacts.org/comparecat.jsp?cat=7&rgn=6&rgn=1 (last visited Sept. 13, 2010). *See also Consumer Guides to Getting and Keeping Health Insurance*, GEO. U. HEALTH POL'Y INST., http://healthinsuranceinfo.net/market (last visited Sept. 13, 2010).

[72] *See* Deborah Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL. POL'Y & L. 287, 289–90 (1993) (a primer on how insurance companies underwrite and risk rate policies).

[73] *Id.*

[74] It may cost more to underwrite and risk rate small groups because the risk of loss becomes greater as the group size gets smaller. Actuarial estimates depend upon sufficient group size to use statistical estimates of the risk of loss.

vidual market.[75] This added overhead means that the smallest employers pay, on average, 18% more than very large employers for comparable coverage.[76]

Given the prevalence of small businesses in rural areas and the higher costs they pay for health insurance, it is not surprising a recent study found that average premium costs for employer-sponsored health insurance are higher in rural areas—even after controlling for employee health status and coverage.[77] West Virginia, Wyoming, Maine, and Wisconsin, which all have substantial rural populations, are the states with the highest adjusted premium costs for comparable single employee coverage.[78]

Moreover, the lack of Health Maintenance Organizations (HMOs) in rural areas also pushes up the cost of rural health insurance for large employers as well as small employers and individuals. Preferred provider organizations (PPOs) and indemnity plans are typically the only types of insurance products offered in rural counties, and these types of plans cost substantially more. PPOs cost 18% more and indemnity plans 25% more than HMOs offering the same coverage.[79] A survey of Missouri state workers enrolled in the Missouri Consolidated Health Plan found that rural state employees who only had access to PPO plans paid significantly higher premiums for the same coverage than did urban state workers who had an HMO option—$1353 for rural workers compared to only $815 for urban workers.[80] Another study concluded that the lack of HMO plans explained the higher costs of adjusted premiums in "rural states, such as Montana and Wyoming, than in high cost-of-living, urban states such as Massachusetts, California, and Hawaii."[81]

Finally, insurance company consolidation and the lack of insurance company competition have also contributed to higher rural insurance premiums. A decade ago, numerous insurance companies competed for business. However, over the last thirteen years, more than 400 health insurance companies have merged. Today, one or two large insurers control almost every health insurance

---

[75] NATIONAL RURAL HEALTH ASSOCIATION, *supra* note 64, at 3 (citing Mark Pauly et al., *Individual Versus Job-Based Health Insurance: Weighing the Pros and Cons*, 18 HEALTH AFFAIRS 28, 34–37 (1999)).

[76] Jon Gabel et al., *Generosity and Adjusted Premiums in Job-Based Insurance*, 25 HEALTH AFFAIRS 832, 832 (2006).

[77] *Id.* at 835–36.

[78] *Id.* at 837. The study controlled for local price variations and differences in health status. *Id.* at 834.

[79] Gabel et al., *supra* note 76, at 841.

[80] Survey and data analysis on file with author. Missouri Consolidated Health Plan Survey 2008. All state workers get the same health benefits, but employee premiums and provider networks vary depending upon private health insurer bids for each of the state's eight regions. Two regions are composed of counties classified as metropolitan. The other six regions are primarily composed of counties designated as "non-metropolitan." The survey found that the urban and rural workers had similar health status, age, and family size as urban workers.

[81] Gabel et al., *supra* note 76, at 840.

market.[82] While this decline in health insurance competition has pushed up premium prices nationwide, the effects are particularly striking in smaller, highly rural states; in Alaska, Vermont, Alabama, Maine, Montana, Wyoming, Arkansas, and Iowa one or two insurers control 80% to 95% of the market.[83] With no competition and no choices for employers and employees, there is no pressure to keep premiums from rising.

Not only does rural health insurance cost more, it covers less. The actuarial value of a health insurance policy is the average percentage of medical bills that the health plan will pay for a standardized population. In rural areas, the actuarial value for employer-sponsored coverage is significantly less, covering only 80% of medical costs compared to 84% in urban areas.[84] Iowa, Mississippi, and Montana—three states with a substantial rural population—have the lowest actuarial values.[85] The prevalence of indemnity and PPOs in rural areas, which typically have higher out-of-pocket costs than HMOs, probably contributes to lower value rural policies.[86] It may also be that insurers try to reduce the impact of higher rural premiums by offering less generous coverage.[87] However, for many rural employers and employees, it seems that the only policies available in rural areas have high premiums and poor coverage.

The lower value policies available in rural areas means that privately insured rural residents spend more out of their own pockets on health care. One in five privately insured rural remote resident spends more than $1000 out-of-

---

[82] HEALTH CARE FOR AMERICA NOW, PREMIUMS SOARING IN CONSOLIDATED HEALTH INSURANCE MARKET LACK OF COMPETITION HURTS RURAL STATES, SMALL BUSINESSES 3 (2009), *available at* http://hcfan.3cdn.net/1b741c44183247e6ac_20m6i6nzc.pdf; AMERICAN MEDICAL ASSOCIATION, COMPETITION IN HEALTH INSURANCE: A COMPREHENSIVE STUDY OF U.S. MARKETS: 2008 UPDATE 1 (2008). Ninety-four percent of statewide commercial health insurance markets are deemed to be "highly concentrated" using U.S. Department of Justice guidelines. *Id. See also*, JACOB HACKER, THE CASE FOR A PUBLIC PLAN CHOICE IN NATIONAL HEALTH REFORM (2008), *available at* http://institute.ourfuture.org/files/Jacob_Hacker_Public_Plan_Choice.pdf. Between 1999–2008, as insurance companies have been consolidating, premiums increased by 120% compared to cumulative wage growth of only 34%. KAISER FAMILY FOUND., *Trends in Health Care Costs and Spending* (Mar. 2009), http://www.kff.org/insurance/upload/7692_02.pdf

[83] HEALTH CARE FOR AMERICA NOW, *supra* note 82, at 5. Eight of the ten states with the most concentrated health insurance markets are highly rural states. *Id.* For statistics on rural/urban population distribution by state, see KAISER FAMILY FOUND., *Population Distribution by Metropolitan Status*, ST. HEALTH FACTS, http://www.statehealthfacts.org/comparetable.jsp?ind=18&cat=1&sort=38 (last visited Sept. 6, 2010).

[84] Gabel et al., *supra* note 76, at 837 (79.9% and 83.9%).

[85] *See* Gabel et al., *supra* note 76, at 836. These were also states where indemnity plans had a sizable share of the market. *Id.* Actuarial values in these states ranged from 73.4% to 79.8%. *Id.* at 838.

[86] Gabel et al., *supra* note 76, at 840.

[87] *See* JON R. GABEL & JEREMY D. PICKREIGN, RISKY BUSINESS: WHEN MOM AND POP BUY HEALTH INSURANCE FOR THEIR EMPLOYEES 5 (The Commonwealth Fund, 2004). The higher costs in the small group and individual markets are sometimes passed along in the form of higher premiums; however, they just as often end up being passed along in the form of higher deductibles and lesser benefits and coverage. *Id.*

pocket for health care in a year.[88] On average, privately insured remote rural residents pay 39% of their health care costs out-of-pocket, compared with only about a third for urban dwellers.[89] While 6% of urban dwellers are underinsured, the figure jumps to 10% for rural residents living in areas adjacent to urban areas and doubles to 12% for those rural residents living in areas that are not adjacent to urban areas.[90]

High out-of-pocket costs take a toll on rural families' financial well-being and their access to care. While nationwide about half of bankruptcies are related to medical costs and illness,[91] rural bankruptcy filers are substantially more likely to report high out-of-pocket medical spending than are urban.[92] Rural adults are more likely than urban adults to postpone necessary medical care because of cost.[93] The problem is even worse for rural minorities who are almost twice as likely to defer care because of cost than are rural whites.[94]

The high out-of-pocket costs associated with rural health insurance hit farmers particularly hard.[95] In a survey of family farmers and ranchers in Missouri, 15% of insured farmers had medical debt.[96] Twenty-five percent reported that medical expenses "contributed to their financial problems."[97]

In Missouri, farmers who purchased individual policies spent on average $2117 more on premiums and out-of-pocket costs than those who were able to purchase through an employer-sponsored group plan.[98] Farmers using individual insurance reported in overwhelming numbers that they relied on policies with high premiums and high deductibles, which suggests that low deductible plans were not available.[99] The difficulties involved in buying individual poli-

---

88 Ziller et al., *supra* note 68, at 1690. "[Seventeen percent] of rural nonadjacent residents spen[d] more than $1,000" per year out-of-pocket. *Id.* The figure is 13% for urban residents and 14% for rural adjacent. *Id.*

89 Ziller et al., *supra* note 68, at 1691. The figure for urban residents is 32% and for rural nonadjacent is 39%. *Id.*

90 Ziller et al., *supra* note 68, at 1695. Underinsured is defined as out-of-pocket spending on health care that exceeds 10% of family income or 5% of income for families with incomes below 200% of the FPL. *Id.* at 1689.

91 David U. Himmelstein et al., *Illness and Injury as Contributors to Bankruptcy*, HEALTH AFFAIRS. W5-63 (Feb. 20, 2005), http://content.healthaffairs.org./cgi/reprint/hlthaff.w5.63v1.

92 Porter, *supra* note 4, at 1016. "Thirty-eight percent of rural families [filing bankruptcy] reported that they were faced with medical bills exceeding $1,000 in the two years before their bankruptcy. Only twenty-six percent of urban families had similarly high out-of-pocket medical bills." *Id.* Both rural and urban bankruptcy filers report similar levels of health insurance at 71%. *Id.*

93 Bennett et al., *supra* note 7, at 16 (15.1% for rural residents compared to 13.1% for urban).

94 *Id.* at 16.

95 Lottero et al., *supra* note 69, at 3.

96 *Id.* at 3.

97 *Id.* at 1.

98 *Id*. This figure controls for age and health status.

99 *Id*.

cies also pushed farm and ranch families to take off-farm employment in order to get better health insurance coverage, leaving small farmers with less time to devote to their farming.[100]

Underinsurance is also a problem for rural health care providers.[101] It is estimated that 46% of people who are underinsured are delinquent on payments to health care providers.[102] Some of this debt is forgiven as charity, and some is written off as bad debt.[103] However, high rates of uninsurance and underinsurance mean that rural providers have to try to collect out-of-pocket costs from their patients. This state of affairs turns rural hospitals, in particular, into bill collectors trying to collect unpaid bills from their patients.[104] The role of patient-caregiver changes when the local hospital becomes a bill collector. In some rural communities, hospital collection actions account for 30 to 40% of all collection actions filed.[105]

Large numbers of underinsured patients also means that rural providers cannot depend on privately insured patients to be their best paying patients. Generally, private insurance is more lucrative for providers than government programs because private insurance typically reimburses providers at higher rates than do government programs. Many urban providers tend to cost-shift by using the higher payments from their primarily privately insured patients to make up for lower paying publicly insured patients. However, when privately insured rural residents have to pay substantial amounts out-of-pocket, public insurance can actually be better payment for rural providers.[106]

Dependence on public insurance creates financial stress for rural health care providers. Medicare and Medicaid account for about 60% of all rural hospital revenues.[107] However, Medicare has historically paid rural hospitals and doctors less than their urban counterparts. The Medicare hospital payment-to-

---

100 *Id.* at 5.

101 One study found that rural providers provide more "safety net" services for their community members than urban. Jane Bolin & Larry Gamm, *Access to Quality Health Services in Rural Areas – Insurance, in* RURAL HEALTHY PEOPLE 11 (2010), http://www.srph.tamhsc.edu/centers/rhp2010/03Volume2accessprimarycare.pdf.

102 Cathy Schoen et al., *Insured but Not Protected: How Many Adults Are Underinsured?*, HEALTH AFFAIRS *W5-289 (June 14, 2005) http://content.healthaffairs.org./cgi/reprint/hlthaff.w5.289v1. Forty-six percent are facing collection for medical debt. *Id.*

103 For a discussion of how hospitals allocate uncompensated care between charity care and bad debt, see American Hospital Association, *Uncompensated Hospital Care Cost Fact Sheet* (Nov. 2008), *available at* www.aha.org/aha/content/2008/pdf/08-uncompensated-care.pdf.

104 *See* Analysis of Debt Collection Law Suits in 13 Missouri State Court Circuits, 2002–2006. (on file with author).

105 *Id.*

106 Ziller et al., *supra* note 68, at 1698.

107 Penny E. Mohr et al., *Vulnerability of Rural Hospitals to Medicare Outpatient Reform*, 21 HEALTH CARE FIN. REV. 1, 3 (1999).

cost ratio for rural areas is only 90% compared to 100% for urban areas.[108] Medicare spending per capita in rural America is only 85% compared to 106% for urban areas.[109] Consequently, "rural providers earn less than urban providers for the same day's work."[110]

The public payment situation is particularly dire for rural physicians. Nationally, Medicare physician reimbursement rates average only about 80% of private insurance rates.[111] Medicaid reimbursement for physicians is even lower; nationally, Medicaid pays physicians, on average, 72% of Medicare rates and only 66% for primary care services.[112]

While many factors contribute to the shortage of health care providers in rural America, the health insurance situation in rural communities—uninsurance, underinsurance, and dependence on Medicare and Medicaid—play a key role. It is hard to attract physicians, nurses, and other medical staff to areas with high rates of uninsurance and underinsurance. It is hard to keep hospitals when they cannot cover their operating costs.

The economic structure of rural America has fueled both high uninsurance and underinsurance. With an economy of small businesses, self-employment, low-wage, and part-time work, rural workers tend to rely on the small group and individual insurance markets that have the highest administrative costs and that feel the brunt of underwriting practices and risk rating most sharply. Factor in the lack of less expensive HMO plans and general lack of competition among health insurers, and it is no surprise that rural health insurance becomes the most expensive form of private health insurance.

Adequate health insurance coverage is necessary to attract and keep providers in rural communities. Reforming the small group and individual health insurance markets is key to making health insurance accessible and affordable to rural Americans. The Patient Protection and Affordable Care Act of 2010 creates the framework for just such reform.

III. AFFORDABLE CARE ACT AND RURAL HEALTH

The recently passed federal health reform law, the Affordable Care Act,[113] fundamentally changes rural health insurance and will dramatically impact rural health care delivery and rural health. Nationwide, ACA's insurance reform provisions are expected to increase the percentage of Americans with

---

108 Blankenau et al., *supra* note 47, at 3.

109 Blankenau et al., *supra* note 47, at 3.

110 *Id.*

111 MEDICARE PAYMENT ADVISORY COMM., REPORT TO THE CONGRESS MEDICARE PAYMENT POLICY (2009), *available at* http://www.medpac.gov/documents/Mar09_March%20report%20testimony_WM%20FINAL.pdf.

112 KAISER FAMILY FOUND., *Medicaid-to-Medicare Fee Index, 2008*, STATE HEALTH FACTS, http://www.statehealthfacts.org/comparetable.jsp?ind=196&cat=4 (last visited Sep. 13, 2010).

113 *See* sources cited *supra* note 5 and accompanying text.

health insurance by about 10%, from 83.1% to 93.5%, with a slightly higher rate in rural areas—94.1%.[114] Nationally, ACA will increase health insurance by about 10%, but the smallest and most remote rural communities—where uninsurance is most severe—should see increases of as much as 14% to 17%.[115]

ACA will have such a striking impact on rural areas because ACA's reforms target the problems that have beset rural insurance.[116] ACA directly addresses the practices in individual and small group insurance markets that have contributed to high levels of uninsurance and underinsurance in rural America. It guarantees all Americans access to comprehensive health insurance with limited out-of-pocket costs. It guarantees poor and moderate income Americans affordable health insurance by expanding Medicaid to cover all Americans earning up to 133% of the federal poverty line and creating new federal tax credits to make private health insurance affordable for moderate income Americans earning between 133% and 400% of the federal poverty line.[117]

Guaranteeing access to affordable, comprehensive health insurance will not only improve the financial stability of rural families, it will also improve the financial stability of rural health care providers. By expanding insurance to cover almost all rural residents, ACA provides a reliable source of payment for health care providers. By expanding access to private health insurance, ACA reduces rural providers' reliance on Medicare and Medicaid. Other provisions of the Act correct the historical inequities in Medicare funding for rural physicians, hospitals, and other providers[118] and raise Medicaid payment rates for

---

114 *See* Timothy D. McBride, *Impact of the Patient Protection and Affordable Care Act on Covered Persons as Amended*, RURAL POL'Y RES. INST. 2 (Dec. 22, 2009), *available at* http://www.rupri.org/Forms/McBride_Insurance_Amended_Dec09.pdf. ACA will cover more rural Americans largely because a lower proportion of rural dwellers are undocumented immigrants, a group excluded from ACA's reforms. *Id.*

115 *Id. See also supra* text accompanying note 23.

116 *See* McBride, *supra* note 114.

117 ACA's individual mandate, which requires individuals to purchase health insurance or pay a tax penalty, is designed to ensure broader participation in health insurance, assuring that healthy and sick people purchase health insurance thus spreading the costs of health insurance premiums more broadly and making premiums more affordable for all. The individual mandate takes effect in 2014. *See* § 1501.

118 The Act revises the Medicare physician fee schedule to increase fees in rural areas. *See* § 3102 (as amended by § 10324(c)). New Medicare bonuses reward primary care doctors that practice in shortage areas. ACA also authorizes a number of Medicare payment enhancements to protect rural hospitals. *See* §§ 3121–3129, 124 Stat. 423–27. ACA authorizes a number of Medicare payment enhancements to protect rural hospitals. *See* §§ 3121–3129, 124 Stat. 423–27. The Act boosts Medicare payments for rural ground and air ambulance and rural home health. *Id*. § 3105 as amended by § 10311. ACA also extends and expands a number of demonstration projects that are experimenting with and evaluating approaches to strengthening rural delivery systems. ACA extends the Rural Community Hospital Demonstration Program for five years, expands eligible sites to additional states and additional rural hospitals, and makes adjustments to payment levels provided in the demonstration. *See id.* § 3123 (as amended by § 10313), 124 Stat. 423, 892–95. Section 3126 expands a demonstration project that allows eligible rural entities to test new models of delivery of health services in rural areas allowing additional counties to participate

primary care services provided by physicians.[119] A variety of provisions expand funding for and create new programs to help attract providers to rural America.[120]

---

and also allows physicians to participate in the demonstration project. *See id.* § 3126, 124 Stat. 425. Section 3129 extends the Flex Grant program through 2012 and allows Flex grant funding to be used to support rural hospitals' efforts to implement delivery system reform programs, such as value-based programs, bundling, and other qualify systems. *See id.* § 3129, 124 Stat. 426–27. ACA also authorizes the Medicare Payment Advisory Commission (MedPAC) to review the adequacy of payment for rural health care providers serving the Medicare program, including an analysis of the rural payment adjustments included in ACA and beneficiaries' access to care in rural communities. *See id*. § 3127. Section 5502 also directs the Secretary of HHS to develop and implement a prospective payment system for Medicare services provided by Federally Qualified Health Centers (FQHC) and includes Medicare-covered preventive services to the list of services that are Medicare reimbursable when furnished by a FQHC. *See id.* § 5502, 124 Stat. 654. PPACA § 10501 clarifies that the Secretary of HHS shall vary payments to FQHCs based on the type, duration and intensity of services and establishes an annual FQHC market basket update. *See id.* § 5502, 124 Stat. 654.

[119] *See id.* §1202. For 2013 and 2014, Medicaid primary care services will be reimbursed at Medicare rates and be fully paid for by federal dollars. *Id.* Medicare will also provide a 10 % payment enhancement for primary care.

[120] ACA provides $11 billion in new funding for FQHCs. *See id.* § 5601, 124 Stat. 676. ACA creates new programs and funding to recruit and retain rural physicians, dentists and allied health providers, including mid-level practitioners. The Act authorizes grants for medical schools to establish programs to recruit students from underserved rural areas who have a desire to practice in their hometowns, to provide these students with specialized training in rural health issues, and to assist them in finding residencies that specialize in training doctors for practice in underserved rural communities. *See id.* § 5316 (as amended by § 10501(e)), 124 Stat. 995. ACA also provides for demonstration grants to establish training programs for "alternative dental health care providers" to increase access to dental services in rural and other underserved communities. *See id*. § 5304, 124 Stat. 621. ACA defines "alternative dental health care providers" as community dental health coordinators, advance practice dental hygienists, independent dental hygienists, supervised dental hygienists, primary care physicians, dental therapists, dental health aides, and any other health professional that the Secretary of HHS determines appropriate. *See id.* § 5304, 124 Stat. 621. The Act also authorizes a variety of programs designed to bring more health care professionals to underserved areas—a description that includes most rural communities. The Act expands scholarship funding for disadvantaged students who commit to work in medically underserved areas as primary care providers. *See id.* § 5402, 124 Stat. 644. It extends loan forgiveness programs for health care professionals practicing in medically underserved areas to include pediatric subspecialists and those who provide mental and behavioral health services to children and adolescents. *See id.* § 5203, 124 Stat. 607 (pediatric subspecialists and providers of mental and behavioral health services to children and adolescents); *see also id.* § 5205, 124 Stat. 611 (allied health professionals). Loan forgiveness is extended to those working in Health Manpower Shortage Areas, medically underserved areas, and those working with other medically underserved populations. *See id.* § 5203, 124 Stat. 607; *see also id.* § 5205, 124 Stat. 611. The Act moves unused medical residency positions and designates them for primary care training, geographically redistributing the slots to states ranking in the lowest 25% for resident-to-population ratio and the top 10% for population living in Health Manpower Shortage Areas. *See id.* § 5503, 124 Stat. 655–69. ACA also provides increased funding for primary care residencies by establishing a grant program to support new and expanded primary care residency programs. *See id.* § 5508, 124 Stat. 668–70. ACA authorizes $25 million for FY 2010, $50 million for FY 2011 and FY 2012, and sums as necessary thereafter. It also provides $230 million in funding under the Public Health Services Act to cover the indirect and direct costs of qualifying teaching health centers related to

Expanding health insurance coverage will not solve all the problems that have contributed to a shortage of health care providers in rural America, but it is a fundamental building block in creating a sustainable rural health care delivery system. This Section explains ACA's health insurance reform provisions, describing how they will provide access to affordable comprehensive insurance in rural America—and elsewhere. It also identifies implementation

---

training primary care residents. *See id*. § 5508, 124 Stat. 668–70. The Act increases funding for Area Health Education Center community-based training and education programs targeting individuals seeking careers in the health professions underserved communities, specifically designating that these are to be rural as well as urban communities. *See id.* § 5403, 124 Stat. 644–48. ACA also authorizes states to award grants to health care providers who treat a high percentage of medically underserved populations or other special populations. *See id.* § 5606 (as amended by § 10501(k)), 124 Stat. 999. However, states may not use Medicaid, Medicare or Tri-Care federal or state monies to fund these grants. *See id*. § 5606 (as amended by § 10501(k)), 124 Stat. 999. ACA also directs the Secretary of HHS to use a negotiated rulemaking process to develop, in consultation with stakeholders, a comprehensive methodology and criteria for designating medically underserved populations and Health Professional Shortage Areas. *See id.* § 5602, 124 Stat. 677.

ACA also provides an assortment of funding to increase the overall number of health care professionals through new training opportunities, more scholarships, new student loan programs, and expanded loan forgiveness. *See id*. §§ 5301–03, 5305–06, 5308–09, 5314–15, 5401–05, 5507–09, 124 Stat. 615–18, 622–28, 629–30, 636–42, 642–61, 663–74 (training); *see also id.* §§ 5206–07, 124 Stat 611–12 (scholarships); §10501(d) and (n)(1) and §§ 5201–02, 124 Stat. 606–07 (loans); §§ 5203, 5205, 5310–11, 5313, 124 Stat. 607, 11, 631–32, 633 (loan forgiveness). *See also id.* §§ 5101–06 (as added by § 10501(k)), 124 Stat 592–680, 999. ACA targets funding not only to increase the physician workforce but also to expand the number of dentists, mental health professionals, nurses and nurse practitioners, physician assistants, allied health professionals, direct care workers, community health workers, and the public health work force. *See id.* §§ 5201, 5203, 5206, 5301, 5305, 5315, 124 Stat. 606–07, 611–12, 615, 622–25 (physicians); *see also id*. §§ 5303–04, 5315, 124 Stat. 618–21, 636–42 (dentists); §§ 5203, 5305–06, 5315, 124 Stat. 607, 625–28, 636–42 (mental and behavioral health professionals); §§ 5202, 5309–11, 5315, 124 Stat. 607, 629–32, 636–42 (nurses); §§ 5308, 5315, 5316 (as added by § 10501(e)), 124 Stat. 629, 636–42, 995 (nurse practitioners); §§ 5301, 5315, 124 Stat. 615, 636–42 (physician assistants);§§ 5205–06, 124 Stat. 611–12 (allied health professionals); § 5301, 124 Stat. 615 (direct care workers); § 5313, 124 Stat. 633 (community health workers); §§ 5314–15, 124 Stat. 636–42 (public health); § 5305, 124 Stat. 622–25 (geriatric pharmacists). ACA provides increased funding to support training for primary care, geriatric care, and long-term care. *See id.* § 5301, 124 Stat. 615 (primary care); *see also id.* § 5305, 124 Stat. 622–25 (geriatric care); *see also id.* § 5302, 124 Stat. 618 (long-term care); *see also id.* § 5207, 124 Stat. 612 (National Health Service Corps). ACA also authorizes demonstration grants to provide low-income individuals, including recipients of State Temporary Assistance for Needy Families (TANF), training and education for health care careers. *See id.* § 5507(a), 124 Stat. 663. Section 5101–02 creates a National Health Care Workforce Commission to assess and report on workforce needs. Section 5102 authorizes grants to enable states to create and carry out comprehensive workforce development. *See id.* §§ 5101–02, 124 Stat. 592–603.

[120] *See* Patient Protection and Affordable Care Act, §1201(2)(A), § 2702, 2703, § 2704(a), § 2705, 124 Stat. 154 (as amended by Health Care and Education Reconciliation Act of 2010), § 2301, 124 Stat. 1081 (requiring guaranteed issue, guaranteed renewal, prohibiting any pre-existing condition exclusion or discrimination based on health status). The prohibition on pre-existing condition exclusions for children takes effect September 23, 2010. The provision for adults takes effect in 2014. *Id.* Insurers are also prohibited from cancelling or rescinding policies except for fraud, misrepresentation, or nonpayment of premiums. § 2712.

issues that are likely to be of particular importance to rural communities, rural patients, and rural providers.

A. Guaranteed Issue, Underwriting, and Risk Rating

The Affordable Care Act guarantees access to private health insurance and prohibits insurance companies from underwriting policies. ACA requires insurance companies to provide health insurance to every individual and employer who seeks coverage.[121] Insurers may not refuse to cover those who have pre-existing conditions, work in high-risk occupations, or who are otherwise likely to need health care.[122] They must renew policies regardless of use of services or health status, and they may not cancel policies except in cases of fraud, misrepresentation, or failure to pay premiums.[123]

ACA also prohibits risk rating in the individual and small group market; plans may not charge higher premiums based upon health status, occupation, or gender. Under ACA, insurance companies may charge higher premiums because of age to a range of three to one for adults.[124] Plans may only vary premiums based upon rating areas and may charge smokers up to 50% more.[125]

Guaranteed access and premium reforms should help all those sicker and older Americans who have been shut out or priced out of health insurance, and they should be especially helpful for the older and sicker residents of rural America. The new prohibitions on risk rating should also make insurance more affordable for farmers, ranchers, miners, and other rural workers who do manual labor that carries with it a relatively high risk of physical injury.

B. Comprehensive Coverage

ACA also guarantees access to comprehensive health insurance that covers the services that people need and requires health insurance to provide increased financial protection from medical costs. All plans sold in the individual and small group market must cover an "essential health benefits package"

---

121 *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 1201(2)(A), 2702, 2703, 2704(a), 2705, 124 Stat. 119,154, 156 (codified as amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 2301, 124 Stat. 1029, 1081–82) (requiring guaranteed issue, guaranteed renewal, prohibiting any pre-existing condition exclusion or discrimination based on health status). Insurers are also prohibited from cancelling or rescinding policies except for fraud, misrepresentation, or nonpayment of premiums. *Id.* §§ 2712, 1201(2)(A), 2701(a). Plans may also vary premiums based upon individual or family coverage. *Id.*

122 *See* §§ 1201(2)(A), 2704, 2705, 124 Stat. 154 (as amended by Health Care and Education Reconciliation Act of 2010); § 2301, 124 Stat. 1081.

123 *Id.* §§ 1201(2)(A), 2703, 124 Stat. 154 (as amended by Health Care and Education Reconciliation Act of 2010); § 2301, 124 Stat. 1081; §§ 1001, 2712.

124 §§ 1201(2)(A), 2701(a), 124 Stat. 154. Plans may also vary premiums based upon individual or family coverage. *Id.*

125 *See id*. §§ 1201(2)(A), 2701(a), 124 Stat. 254.

that includes a multitude of services: preventive care, wellness services, chronic care management, prescription drugs, mental and behavioral health, substance use treatment, hospital care, out-patient care, lab services, habilitative and rehabilitative services, and other services.[126] Insurance covering children must also include dental and vision care.[127] Basic health insurance plans must provide an actuarial value that covers on average 60% of the costs of covered medical services.[128] Insurers may offer three higher benefit levels providing more out-of-pocket protection coverage for 70% to 90% of medical services.[129] All health insurance plans are prohibited from imposing annual or lifetime limits on covered benefits.[130]

ACA also limits patients' out-of-pocket costs. Preventive services must be covered without deductibles or co-payments.[131] Deductibles in the small group market may be no more than $2000 for individuals and $4000 for families.[132] Annual out-of-pocket spending for all policies is capped at the limits for Health Savings Account (HSA) deductibles, which is $5950 for individual cov-

---

[126] *See id.* §§ 1201(2)(A), 2707(a), 1301(b)(1), 124 Stat. 119, 161, 163–64. Section 1302(b)(1) provides:

> Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories: (A) Ambulatory patient services. (B) Emergency services. (C) Hospitalization. (D) Maternity and newborn care. (E) Mental health and substance use disorder services, including behavioral health treatment. (F) Prescription drugs. (G) Rehabilitative and habilitative services and devices. (H) Laboratory services. (I) Preventive and wellness services and chronic disease management. (J) Pediatric services, including oral and vision care. (2) LIMITATION.—(A) IN GENERAL.—The Secretary shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. To inform this determination, the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to the Secretary.

See id. §§ 1302(b)(1), (2), 124 Stat. at 163–64.

[127] Patient Protection and Affordable Care Act §§ 1302(b)(1), (2), 124 Stat. at 163–64.

[128] *See id.* § 1302(d)(1)(A), 124 Stat. 163.

[129] *See id.* § 1302(d)(1)(B)–(D), 124 Stat. 163 (as amended by Health Care and Education Reconciliation Act § 2301, 124 Stat. 1081).

[130] *Id.* §1001(1) (as amended by §10101); § 2713, 124 Stat. 130, 883 (as amended by Health Care and Education Reconciliation Act § 2301(a), 124 Stat. 1081). The prohibition on life time limits on coverage takes effect in 2010. The prohibition on annual limits takes effect in 2014. Until that time plans, may not place "unreasonable" limits on coverage. *See id.*

[131] *See id.* § 1001(1), § 2713, 124 Stat. 130.

[132] *See id.* § 1302(c), 124 Stat. 163. Those who qualify for federal premium tax credits have lower out-of-pocket limits. *See id.* § 1402, 124 Stat. 220.

erage and $11,900 for family coverage in 2010.[133] Low and moderate income Americans earning between 133% and 400% of the federal poverty line who qualify for federal tax credits to help with the cost of private health insurance premiums are also guaranteed additional out-of-pocket protections, which reduces their out-of-pocket liability even further.[134]

These provisions guaranteeing access to comprehensive insurance with increased financial protection are particularly important for rural America where policies have typically provided less generous coverage and more out-of-pocket exposure. Coverage for preventive care, wellness services, and dental care will be particularly important in rural areas where few policies presently cover such services. The new limits on deductibles and annual out-of-pocket caps directly address the problems associated with underinsurance that have hurt rural families, rural businesses, and rural providers. The new rules for the small group and individual market will assist over 80% of rural workers who are employed in either the small group or individual market. Availability of better coverage in the individual market will ease the burden on the 30% of rural dwellers who are self-employed and will reduce the pressures on family farmers and others who often have to give up their own business to get health insurance.

C. Health Insurance Exchanges

One of ACA's most important innovations is the creation of new entities, called Health Insurance Exchanges, which are designed to give people who use the individual and small group health insurance markets the same economies of scale as large employers.[135] The Exchanges will provide information, primarily via the Internet, about plan benefits and costs, and will provide a point of access for people to comparison shop among individual and small group health insurance offerings.[136] All plans offered through an Exchange must meet ACA's new premium and quality standards.[137] The Secretary of Health and Human Services (HHS) is to devise a rating system that would rate health plans offered through an Exchange on the basis of relative quality and price.[138]

---

133 Patient Protection and Affordable Care Act § 1302(c), 124 Stat. 163. Annual caps are set at the limits for Health Savings Account (HSA) deductibles. In 2010 those limits are $5950 for individuals and $11,900 for families, with lower limits for those who qualify for federal premium tax credits.

134 Patient Protection and Affordable Care Act, § 1402(b)(2), 124 Stat. 220.

135 *See id.* §§ 1311–1321, 124 Stat. 173–86.

136 *See, e.g.*, *id.* § 1311(d)(4) and 1311, 124 Stat. 173 (providing for an insurance rating system to allow consumers to compare plan coverage and cost).

137 *See id.* § 1311(d). One option that will be offered through the Exchanges is a nation-wide plan similar to those offered through the Federal Employees Health Benefits Plan (FEHBP) to be negotiated by the agency responsible for the FEHBP. The new FEHPB-like option will include at least two multi-state plans, including at least one not-for-profit plan. *See id.* § 1323.

138 *See id.* § 1311(c)(2).

The Exchanges will not replace employer-sponsored coverage but will be a new option for those who are self-employed, not offered insurance by their employer, or for whom employer-sponsored coverage is too expensive.[139] Individuals may use the Exchanges to shop for individual coverage. Small employers with up to a hundred employees may opt to use the Exchange, giving their employees access to all plans offered through the Exchange that provide the level of coverage selected by the employer.[140]

ACA gives the States primary authority for creating and designing the new Health Insurance Exchanges.[141] States may operate one Exchange offering both individual polices and small group policies, or they may offer two separate Exchanges for the two types of coverage.[142] States may, if they wish, open the Exchange to larger employers with more than 100 employees.[143] States may operate an Exchange on a statewide level, a multi-state level, or a sub-state level serving only one premium rating area.[144] States may also opt out of operating an Exchange altogether, leaving that responsibility—and the design decisions that go along with it—to the federal government. [145]

The Congressional Budget Office estimates that twenty-four million of the thirty-two million Americans who will be newly insured as a result of ACA, will obtain health insurance through an Exchange.[146] Nationwide, about 45.4% of newly covered Americans will use an Exchange, and about 43.8% of newly

---

139 *See id.* § 1311(d)(2), 124 Stat. 173. Those qualified to use the Exchange are individuals purchasing in the individual market and small businesses who opt to use the Exchange to facilitate small group coverage. *See id.* § 1311(b)(1), 124 Stat. 173. Exchange coverage is not available to those who are incarcerated or are not legally residents of the U.S. *See id.* § 1312(f), 124 Stat. 182. Employees whose employer plans do not cover, on average 60% of the cost of covered benefits or that cost the employee more than 9.5% of income have the option to use the exchange. Their employers will pay their usual contribution to the Exchange to help offset the cost of Exchange-offered coverage. Participation in the Exchange is voluntary except that the Federal government may only make available Exchange coverage for members of Congress and their staff. *See id.* § 1312(d)(3)(D)(i), 124 Stat. 182.

140 *See id.* § 1312(a)(2)(A), (B), 124 Stat 182; *see also id.* § 1312(f)(2)(A), 124 Stat. 182.

141 *See id.* § 1311. States may operate an Exchange as a government agency or a private not for profit entity. *See id.* § 1311(d)(1), 124 Stat. 173.

142 *Id.* § 1311(b)(2).

143 *See id.* § 1312(f)(2)(B)(ii), 124 Stat. 182.

144 *See id*. § 1311(f).

145 *See id.* § 1311(f). States that opt to set up state level exchanges are eligible for federal grant funding to support creation of Exchanges. However, once up and operating Exchanges must be supported through fees on health insurance products sold through the Exchange.

146 CBO letter report of March 18, 2010, *available at* http://cbo.gov/ftpdocs/113xx/doc11355/hr4872.pdf. For similar results, see John Gruber, *Health Reform is a Three-Legged Stool*, American Center for Progress (Aug. 5, 2010), *available at* http://www.americanprogress.org/issues/2010/08/three_legged_stool.html.

insured rural residents will use an Exchange.[147] Exchanges will be particularly important in rural America because rural Americans are less likely to be offered employer-sponsored health insurance and thus more dependent on the Exchanges to access individual insurance.[148] The Exchanges should reduce the cost of marketing plans as well as increase the ability to comparison shop among plans. Exchanges should also increase the choice of plans available to those who use the individual and small group market.[149] The Exchanges also create a vehicle for those who are eligible for federal tax credits to help pay the cost of premiums and reduce out-of-pocket cost to access private health insurance coverage.[150]

D. Small Employer Premium Assistance

ACA also provides tax credits to small employers to help them pay for the cost of employee health insurance.[151] Tax credits to purchase health insurance for employees are available to small employers with no more than twenty-five employees and average annual wages of less than $50,000 that purchase health insurance for their employees. To be eligible for the tax credit, an employer must contribute at least 50% of the premium cost.[152] For tax years 2010 through 2013, the tax credit is up to 35%. For 2014 and later, the credit is 50% of the employer's contribution for insurance purchased through a Health Insurance Exchange and is available for two years. The full credit is available to employers with ten or fewer employees and average annual wages of less than $25,000. The credit phases out as firm size and average wage increase. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 25% of the employer's contribution toward health insurance between 2010 and 2013 and up to 35% in 2014 and thereafter.

Nearly half of workers living in remote rural areas work for very small firms that employ fewer than twenty workers. The new small employer tax credits are targeted to help the primary employers in America's most rural communities and are credited with helping to boost ACA's coverage rate in rural America to levels higher than in urban areas.[153]

---

147 *See* McBride, *supra* note 114, at Table 1. Rural rates of coverage via the Exchanges are slightly lower than urban rates because rural dwellers tend to have lower incomes and thus will depend more on Medicaid coverage. *See id.*

148 *See, e.g.*, *id.* However, rural residents overall will depend less on Exchanges than urban dwellers because rural residents tend to be poorer, thus more likely to qualify for Medicaid. *Id.*

149 *See id.* § 1312(a), 124 Stat. 182.

150 *See* discussion of Health Insurance Exchanges, *supra* and *infra* notes 139–154.

151 *Id.* § 1421.

152 *Id.* For 2010–2013, the employer must contribute at least 50% of the total premium cost or 50% of a benchmark premium. For 2014 and later, the credit is available to employers who purchase insurance through an Exchange.

153 *See* McBride, *supra* note 114, at 1.

E. Premium Pricing

ACA also provides for more oversight of premium increases and requires that more premium dollars go for medical care rather than overhead and profit. Effective in 2010, the Act requires the Secretary of HHS, in conjunction with the States, to create a process for annual review of insurance rate increases. This includes a requirement that insurers submit to HHS and the relevant state a justification for any "unreasonable premium increase prior to implementation of the increase."[154] States are to provide reports to HHS about trends in premium rate increases by rating areas and making recommendations to the new Health Insurance Exchanges as to whether particular health insurers should be excluded from participating in an Exchange based upon a "pattern or practice of excessive or unjustified premium increases."[155] Following creation of the Exchanges, the States and HHS will monitor rate increases both in and out of the Exchanges.[156]

ACA also sets minimum requirements, termed medical-loss ratios, for the proportion of health insurance premium dollars that must go for medical care rather than overhead and profits. Effective in 2011, health insurers in the large group market must spend at least 85% of premiums on medical care, while those in the individual and small group market must spend at least 80%.[157] Health insurers are required to submit reports to the Secretary of HHS that break down expenditures by clinical (i.e. medical) services, quality improvement activities, and all other administrative and overhead costs.[158] The National Association of Insurance Commissioners is charged with establishing uniform definitions of clinical, quality and other costs to be used in reporting and calculating the required percentage to be spent for medical care.[159] For rural communities, where individual and small group insurance are so pervasive, the new minimum medical-loss ratios should push insurers to improve health insurance coverage. In the individual market, only about 65–70% of premiums have gone to pay for medical care, with the rest paying for profits and administrative costs, such as underwriting, risk rating, and marketing—and profits. The small group market has been only slightly better, with average medical loss ratios of 75–80%.

The rules and regulations on how medical loss ratios are calculated and for what geographic areas will have important implications for the quality, cost, and availability of health insurance in smaller, more remote communities. Premium tax credits guaranteeing low and moderate income Americans health in-

---

154 *See* §§ 1003, 2794.

155 *Id.* §§ 1003, 2794.

156 *Id.* §§ 1003, 2794(b)(2).

157 *See id.* §§ 1001, 2718(b). Health insurers failing to meet these benchmarks will have to refund the difference to their policy holders. *Id.*

158 *See id.* §§ 1001, 2718(a).

159 *See id.* §§ 1001, 2718(c).

surance that costs no more than 2% to 9.5% of income and additional out-of-pocket protections.

Most likely, though, ACA's most important contribution to making private health insurance premiums affordable for low and moderate income Americans is new refundable federal tax credits. These credits reduce premium costs for individuals and families who earn between 133% and 400% of the federal poverty line, which is between $14,400 and $43,320 for an individual and $29,327 and $88,200 for a family of four in 2010.[160] Tax credits are set on a sliding scale so they reduce premium costs to 2% of income for those earning 133% of poverty rising gradually to 9.5% of income for those earning 300–400 %.[161] Legal immigrants are eligible for premium tax credits, including those who are in their first five years of residence who are not eligible for Medicaid.[162]

Tax credits will be available to purchase plans through the new Health Insurance Exchanges. Credits will be available to help those who are not offered employer-sponsored health insurance or who have access to the Exchange because employer-sponsored insurance is deemed to be too expensive because it does not have an actuarial value covering 60% of the cost of services covered by the employee's share of the premium exceeding 9.5% of income.

Those who qualify for federal tax credits to help pay premium costs for private health insurance offered through the Exchanges also have additional out-of-pocket protections.[163] First, premium tax credits guarantee low and moderate income Americans access to coverage that offers more financial protection than a basic plan by being tied to policies that offer an actuarial value of 70% of covered services, rather than the basic plan value of 60%.[164] Moreover, those earning between 100–200% of the federal poverty line (FPL) are entitled to additional reductions in cost sharing that increase the plans' actuarial value to 94%. Those earning 150–200% of the FPL are entitled to an actuarial value of 87% of such costs, and those earning between 200–250% of the FPL get coverage at 73%.[165] Out-of-pocket costs are capped at lower levels, set at one-third of the HSA deductible for those earning up to 200% federal poverty line, one-half for those earning 200–300% of the FPL, and two-thirds for those earning 300–400%.[166]

These new premium tax credits are particularly important in rural America where work tends to be low wage, seasonal, and part-time, and employers

---

160 *See id.* §§ 1401(b)(2), 36B(b)(3), 124 Stat. 219 (as amended by Health Care Education Reconciliation Act § 1001(a)(1)(B), 124 Stat. 1034). For the 2010 Federal Poverty Guidelines and an explanation of their history and methodology, see http://aspe.hhs.gov/poverty/.

161 Patient Protection and Affordable Care Act §§ 1401(a), 36B(b)(3), 124 Stat. 213 (as amended by Health Care Education Reconciliation Act § 1001(a)(1)(A), 124 Stat. 1030).

162 *See id*. § 1312 (as amended by § 10104(i)).

163 *Id.* § 1402(b)(2), 124 Stat. 220.

164 *Id.* §§ 1401, 36B(a)(b)(3)(B).

165 *Id.* § 1402(c)(1)(A), (B).

166 *Id.* § 1402(c)(2).

are less likely to offer health insurance. Estimates are that almost 40% of newly insured rural residents will be eligible for these new tax credits and the premium guarantees that go with them.[167]

F. Medicaid

ACA also guarantees all low income Americans access to Medicaid. ACA expands Medicaid eligibility by requiring states to cover nearly all Americans under age sixty-five with incomes up to 133% of the FPL, or $24,348 for a family of three.[168] ACA changes the federal Medicaid law that prohibited states from covering non-disabled adults without children, except through a waiver.[169] It creates a new national floor to help reduce state-by-state variations in eligibility for non-elderly adults, increasing income eligibility in the thirty-four states where parents earning as little as 100% of the FPL earn too much to qualify for Medicaid.[170]

The new Medicaid eligibility operates in tandem with the premium tax credits for private insurance. Together, they guarantee low and moderate income Americans access to health insurance. [171] The poorest Americans qualify for Medicaid, while those at higher income levels qualify for private insurance premium tax credits. Children currently covered by the State Children's Health Insurance Program (SCHIP) with incomes between 100–133% of the FPL will be transitioned to Medicaid, and higher income children will be eligible for premium tax credits through the new Exchanges. SCHIP continues until 2019 to allow time for children to transition to coverage through Medicaid and new private Health Insurance Exchanges.[172]

---

[167] *See* McBride, *supra* note 114, at Table 1 (37.2% of rural residents should obtain coverage using tax credits).

[168] *See id.* § 2001(a)(1), 124 Stat. 271. The new Medicaid eligibility category is defined as those who are not elderly, pregnant, eligible for Medicare, and do not fall into another mandatory eligibility category. Section 2001: ''(VIII) beginning January 1, 2014, who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and are not described in a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family size involved, subject to subsection (k).'' *See id.* § 2001(a)(1), 124 Stat. 271.

[169] *See id.* § 2001 and text accompanying note 34. This new ACA eligibility is mandatory in 2014. In the meantime, states have the option to cover these newly eligible adults and children. *Id.*

[170] *See id.* § 2001 and text accompanying note 35.

[171] ACA provides that the two programs use similar income counting rules. *See id* § 2001. For most children and non-elderly adults there will no longer be an asset test for Medicaid and income will be calculated in a way that is consistent with new Health Insurance Exchange premium tax credit. *See id* § 1401 and § 2001. ACA also provides for coordinate outreach and enrollment between the two programs. *See id.* § 2201.

[172] *See id*.

This Medicaid expansion is possibly the single biggest piece of ACA's health insurance expansion. The Congressional Budget Office estimates about half of newly insured Americans—sixteen out of thirty-two million—will be covered by Medicaid. Medicaid's impact will be most dramatic in rural areas where Medicaid will cover a third of newly insured adults and more than half of all newly insured rural residents.[173] Some of these Medicaid enrollees will be newly eligible adults covered because of ACA's Medicaid expansion. Others will be adults and children who were already eligible for Medicaid but not enrolled either because they did not know they were eligible or because of cumbersome eligibility and enrollment rules that ACA streamlines.[174]

IV. CONCLUSION

ACA is good for rural communities. ACA directly addresses the practices in the individual and small group insurance markets that have contributed to high levels of uninsurance and underinsurance in rural America. The new law restructures the private health insurance market to guarantee access to coverage for all, especially those who depend on small group and individual plans. It addresses the problems of poor quality private insurance and underinsurance by specifying an "essential benefit package" that all insurance policies must cover and by setting limits on patient out-of-pocket medical costs. ACA also creates new Health Insurance Exchanges to increase competition and reduce administrative costs in the individual and small group market. The law makes health insurance premiums affordable for low and moderate income Americans by creating new federal tax credits to help people purchase private health insurance and expanding Medicaid to cover all poor Americans.

ACA will help rural providers. Reforming health insurance to cover almost everyone—with comprehensive coverage that limits out-of-pocket costs—will go a long way to address the systemic financial problems that have undermined rural health delivery, made rural hospitals unstable, and contributed to the shortage of rural physicians and other providers. Comprehensive health insurance for almost all rural Americans means that rural providers will have a source of payment to cover the cost of care. Reliable funding will help support the existing rural health care delivery system and should help attract new providers.

A stable health care infrastructure will make rural communities more attractive to new business. More affordable health insurance for small businesses and the self-employed will help stimulate these businesses that are the core of rural economies.

Health reform is good for rural America.

---

[173] *See* McBride, *supra* note 114, at Table 1. Medicaid expansion will cover 33% of adults in rural areas compared with 29.7% of adults in urban areas. The Medicaid expansion will cover 56.2% of newly insured rural residents and 54.6% of urban residents. *Id.*

[174] *See id.* §§ 2201–02.