2. **The** effects of reforms aimed at the health care delivery system. Many delivery system reforms are intended either to encourage or restrain the managed care market and the way the delivery system is responding to this market. Many of the issues in this category are secondary effects of managed care (e. g., effects on provider viability).

There is very little literature on the impact of the specific types of health changes and reforms in rural areas that are currently being debated by Congress. Most of the information in this paper is drown from conversations with researchers, policymakers, and other experts; and from a small workshop at which several state legislators and other policymakers shared and contrasted their states' experiences with the impact of broad reforms on rural areas (see appendix A).2 These experts and policymakers were not randomly selected, and they do not necessarily represent all experiences and opinions. Nonetheless, the issues they raised, and the diversity of experiences they presented, imply that systemwide reforms can have different impacts on rural than on urban areas, and that these differences merit attention.

Rural Characteristics

Rural America has unique characteristics that have long-recognized effects on the accessibility and availability of health care (33). For example:

. Rural residents are poorer, more likely to be elderly or children, and more likely to be disabled--i. e., have higher health risks--than urban residents.

. Rural individuals are more likely than urban persons to be uninsured for their health care. When they are insured, rural residents are more likely than urban dwellers to be covered through public or individually purchased insurance rather than through an employer.

. Employed rural residents are more likely than urban ones to work for small firms, which in turn are less likely than large firms to offer health insurance benefits (8;10). Furthermore, among small firms, rural firms are less likely than urban ones

[2]The workshop, held at the Office of Technology Assessment (OTA) on May 5, 1995, was sponsored jointly by OTA and the Milbank Memorial Fund.

to offer benefits (13; 17). This factor is a major contributor to the lower rates of rural health insurance coverage.

. Fewer health professionals are willing to establish practices in rural than in urban areas. Specialty health services are often not available locally, and primary care services are often provided by nonphysician practitioners (e. g., nurse practitioners, physician assistants). In 1992, 106 U.S. counties, with a combined population of 300,000 people, had no physicians at all (35).

. Hospitals in rural areas tend to be small and have higher proportions of uninsured or publicly insured patients than urban hospitals (33). Some are the sole providers within large geographic areas. Rural hospitals and other health providers are often valued by residents as much for their importance as a source of jobs and a community focal point as for their medical contributions.

These generalities aside, rural (nonmetropolitan) areas vary enormously in the characteristics of their specific populations. The rural Midwest, for example, has a much higher prevalence of elderly residents than does the rural West. Conversely, a very high proportion of rural western residents are children (33). Persistently poor rural counties tend to be clustered in the South, and "frontier" counties with extremely sparse populations are located mostly in the West.

Although many of the kinds of reforms currently being debated nationally have been implemented by some states, implementation is generally too recent to yield solid evidence of their rural-specific impacts. Thus, predicting potential impacts depends on states' more general experiences and impressions of their reforms so far, and an analysis of how the characteristics of rural areas are likely to affect impacts on rural residents.

Incremental Insurance Reforms

Reforming the health insurance market is an important state strategy for making health care more accessible to people. A few states (e.g., Hawaii, Washington) have previously been very ambitious in this area, passing legislation that requires either individuals or employers to purchase insurance. In 1995, however, this trend has reversed. With changes in the political environment and legal barriers to implementation of such

global reforms, most states passing such legislation have repealed it or delayed implementation. Instead, states have tended to pursue more incremental strategies.

These incremental reforms aim at making the health insurance market more efficient and equitable. Among the most commonly discussed reforms in this category are:

1. those that restrict insurers' ability to avoid insuring people who are at high risk of getting sick, and

2. those aimed at changing the tax system so that people who save for their medical expenses, or who purchase their insurance themselves, can reap the same tax benefits as people whose employers have purchased insurance on their behalf.

INSURANCE MARKET RESTRICTIONS

By early 1995, most states (45 of 50) had enacted some kind of incremental insurance market reforms aimed at restricting adverse selection in the market (16). These reforms generally apply to insurance policies written to cover small groups; in many cases, they also apply to policies sold to individuals. Types of reforms include:

- "guaranteed issue" and "guaranteed renewal"--requirements that insurers must issue policies to all applicants, and must renew those policies even if the enrollee gets seriously ill;

- "portability' '--laws that allow people to keep their insurance coverage when they change to a different job (or, more rarely, when they leave their job and seek coverage under an individual policy);

. limits on insurers' ability to exclude persons from coverage for a period of time due to their pre-existing health care conditions, and

- rating restrictions, which limit the differences in premiums that insurance companies can charge to people solely because of their different risk of needing health care. (Pure "community rating, " for example, requires that all subscribers be charged the same price for the same benefit package, regardless of their age, gender, or other factors associated with health care use and costs.)

These reforms have been popular among states, and they continue to find considerable support among state policymakers (26).

One early concern was that passing these reforms could lead insurers to stop selling policies in a state, a particular concern for small or rural states in which there are already only a few insurers and relatively limited consumer choice. This concern has been alleviated somewhat by experience. For example, when Vermont implemented community rating, the number of insurers willing to offer policies in the state was only reduced by one (from 9 to 8 insurers), despite dire predictions of insurers fleeing the market (37). Furthermore, additional insurers--e. g., CIGNA--are currently trying to move into the market.

A more lasting concern is the effect of insurance reforms on rural consumers' insurance premium costs. The purpose of most reforms is to make insurance more accessible to people who are at high risk of getting sick (or who are already ill) by making insurance prices low enough to be affordable to them. In turn, on average one would expect the costs of insurance premiums for lower risk people to go up. In theory, if costs are being spread over a large insured group, the costs of the large group of relatively healthy people will go up only a little, while the much smaller group of people at high risk of illness will see the costs of their (previously very high) premiums go down considerably. The impact of these reforms is likely to be different for rural than for urban residents for two reasons: their different demographic and health characteristics, and their different sources of health insurance.

As previously mentioned, rural residents are more likely to be elderly or in poor health than the population as a whole. They are also more likely to purchase their insurance through individual policies, the portion of the market in which access to insurance is the most difficult for disabled or high-risk people (since insurers can refuse to insure them, or offer insurance only at extremely high prices). Thus, insurance market reforms such as guaranteed issue and renewal should disproportionately benefit rura1 residents if there is a statewide pool.

The potential effect of community rating is slightly more complex. Like the other incremental insurance reforms, it benefits persons of higher health risk. However, insurance premium prices also vary according to health care costs. Rural areas have lower health care utilization and (often) lower prices. Statewide pure community rating thus could, on balance, result in disproportionately high premium increases in rural (vs. urban)

areas. Many rural advocates thus have supported different community rating pools for different geographic areas, and a number of states (e.g., Kentucky and Maryland) permit rates to be modified based on geographic region. Some policymakers, however, believe that geographic differentials are of dubious ultimate benefit to rural residents, since they may tend to keep health care prices in rural areas depressed and dissuade providers from serving rural regions (36).

State insurance reforms only affect part of the market. Insurance provided by employers who self-fund the employee benefits they provide is exempt from state regulation under ERISA,[3] the federal law governing the administration of employer-funded pension and welfare plans. Nearly half of people who are employed by mid- to large-sized firms and are insured through their employers are in self-funded plans (8) and thus are unaffected by state insurance reform.

Most people covered by ERISA-governed plans are currently employed and thus are probably, on average, less disabled than the remaining pool of people seeking insurance in the general market. Reforms such as community rating can only affect the average premium of this higher-risk group, since the lower-risk, lower cost ERISA group is excluded from the community pool. The consequence is that high-risk individuals still face relatively high premiums, and low-risk people in the community group may see their premiums increase substantially.

Rural residents are likely to be disproportionately affected by ERISA's impact on state health reforms. People who live in rural areas are less likely than urban residents to work in large businesses, which offer most of the self-funded plans. Furthermore, two separate studies have found that even among small businesses, rural businesses are less likely than urban ones to offer health care coverage (13;17). The net result is that far fewer rural residents than urban residents are probably covered by ERISA-exempt plans, and rural residents--with their higher rates of disability--are disproportionately represented in the non-ERISA "community" pool affected by state reforms.

Thus, in the absence of ERISA, many incremental insurance market reforms would probably benefit rural residents more heavily than urban residents. ERISA, however, counters this effect. The net likely effect of incremental reforms on rural areas (relative to their effects on urban areas), therefore, is unclear.

[3] ERISA is the acronym for the Employee Retirement Income Security Act of 1974.

At a broader level, the impact of incremental insurance reforms in rural areas is limited by the willingness of people to buy insurance. Insurance reforms **make the most** difference to people who want to buy insurance but are unable to buy it at any but extreme prices--if at all--because their pre-existing disabilities or chronic illnesses make them very high risks. These reforms don't necessarily make insurance all that much more appealing to people who already have access to moderately priced insurance but feel they still can't afford it, or those whose sense of "rugged individualism" makes them simply prefer to depend on themselves.

TAX INCENTIVES FOR MEDICAL SAVINGS AND INSURANCE

There has been considerable discussion and enthusiasm in 1995 for tax incentives as an approach to addressing problems of insurance access and equity. These incentives take two general forms: medical savings accounts MSAs and tax deductions for the payment of health insurance premiums.

MSAs are savings accounts in which the deposits and interest in the account are untaxed (or qualify for tax credits) as long as the purpose of the deposits is to save for medical expenses. As of May 1995, eleven states had enacted MSA legislation (most of them very recently) (7). The specifics vary considerably among states. For example, some states permit money in the account to be spent on nonmedical expenses at the end of the year, while others do not without substantial penalty. In 6 states, MSA exemptions are coupled with a requirement that the account holder also purchase back-up catastrophic insurance (with a high deductible) for major medical expenses; in the other 5, they are not.

Because state MSAs have been implemented so recently, there is no experience yet with which to evaluate their use and effect. Although MSAs are a popular legislative measure in the states, the strength of the incentive to use them is limited by the fact that to date, only state taxes are affected.

There are some reasons to believe that urban and rural people may take advantage of the option to invest in MSAs at different rates. In theory, at least, MSAs should be attractive to people who place a heavy value on self-reliance and are consequently unenthusiastic consumers of health insurance, even relatively inexpensive insurance. As one state policymaker pointed out: "Those individuals who would potentially use the [MSAs] may well be without insurance right now and are simply paying out of pocket for

the care that they get" (28). Anecdotal evidence suggests that many rural residents may fall into this category.

The potential attractiveness of MSAs as a way to increase health care "coverage" for at least a small segment of the rural population, however, applies only to MSAs that can be established by individuals. Most state MSAs permit individually sponsored accounts (7). Many national proposals, however, envision MSAs more as an alternative method of employer-sponsored coverage. If the design of an MSA law is such that only employers can establish them, they are likely to have little impact on rural residents, who are far less likely to have any employer-sponsored coverage in the first place.

Direct tax incentives to purchase health insurance are an alternative tax-based approach aimed at improving insurance market equity. At present, employers' contributions to their employees' insurance premiums are exempt from federal taxes. Only 25 percent of the cost of insurance premiums purchased by self-employed and other individuals, however, are currently federally tax-exempt (Public Law 104-7).

Clearly, changing the tax treatment of either way of purchasing insurance would have broad effects, both for individuals whose level of taxation changed (for better or for worse), and for those who benefit from public spending (financed by taxes). Changing the tax rules regarding income spent on health insurance would probably have slightly different average effects in rural than in urban areas. Because rural residents are more likely than urban ones to purchase insurance individually, rather than receive it as an employee benefit, they would benefit disproportionately from a policy that increased the deductibility of individually purchased insurance. They would also, in general, be less harmed by an increase in the tax liability for dollars spent on employer-sponsored insurance.

Despite these urban/rural differences in relative effect, it is worth remembering that more people in both regions receive their health insurance through employers than purchase it as individuals. Thus, many of the effects of a change in tax policy would probably be similar for both populations. Those broad effects include not only the effects on individuals whose taxes change, but the effects on those who benefit from public spending.[4]

[4] Despite the impact on state revenues of greater tax exemptions for individually purchased insurance, the policy makers at the OTA workshop clearly believed this approach could improve the level of insuredness of the population. Interestingly, these policymakers tended to support the principle of tax equity even over