

Research & Policy Brief

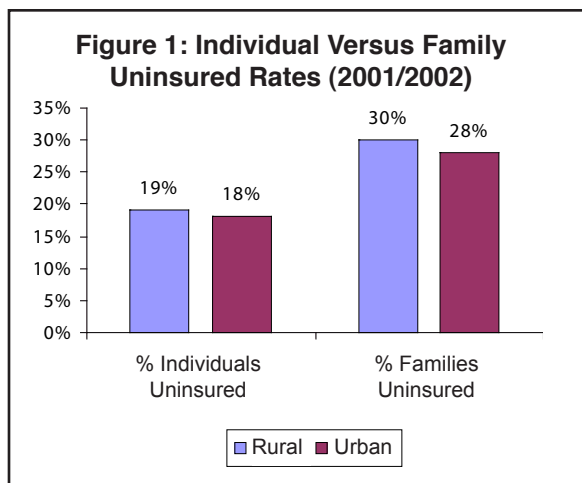
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Rural Families More Likely to be Uninsured and Have Different Sources of Coverage

Background

Research indicates that rural residents are more likely to be uninsured, but prior studies have focused on the insurance status of rural individuals, not family units. Unlike individuals who either have or lack health insurance, families may be fully insured, partially uninsured (some members uninsured while others have coverage), or fully uninsured. Partially uninsured families may have members with public coverage, private coverage, or both. Understanding health insurance patterns within rural families can help in designing effective insurance reform strategies that build on current rural coverage.

This study used the 2001/2002 Medical Expenditure Panel Survey (MEPS), conducted by the Agency for Healthcare Research and Quality (AHRQ), to examine the patterns of insurance coverage within rural families and to assess differences in family-level insurance status for rural and urban families (including comparisons between rural families living adjacent to and not adjacent to an urban area). Among partially uninsured families, we examined rural-urban differences in the sources of family coverage for insured family members (Medicare, Medicaid/SCHIP, private, or a combination).

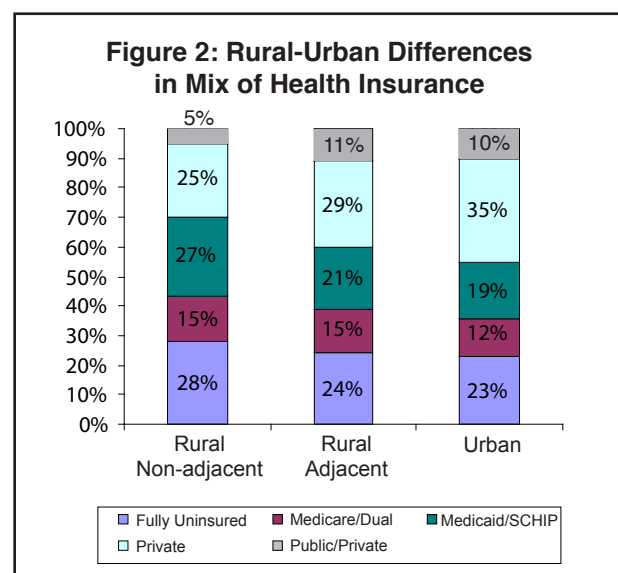


SOURCE: 2001-02 Medical Expenditure Panel Survey (MEPS)

Key Findings

Nearly one-third of non-elderly rural families had at least one member that lacked health insurance coverage in 2001 or 2002, representing an average of nearly 4 million rural families per year. Rural families, particularly those living in counties not adjacent to urban counties are more likely to have an uninsured member (33% of rural non-adjacent families versus 28% urban), and to have all members uninsured (9% rural non-adjacent versus 6% urban).

Three-fourths of uninsured rural families have at least one member with health insurance coverage, and the source of coverage differs from that of their urban counterparts. Rural families are less likely to have a privately insured member (28% versus 35% of urban) and are more likely to have a member with Medicaid/SCHIP (24% vs. 19%) or Medicare (15% vs. 12%). Uninsured rural non-adjacent families have the highest rate of Medicaid/SCHIP-covered members (27%) and the lowest rate of privately covered members (25%).



SOURCE: 2001-02 Medical Expenditure Panel Survey (MEPS)



Although rates of family uninsurance are higher in rural areas, the number of families with an uninsured child is relatively comparable across urban and rural residence. Combined with the higher rates of Medicaid/SCHIP coverage in rural areas, this suggests that efforts to expand public coverage to children in the five years preceding this study period were met with favorable take-up rates among rural families.

Not surprisingly, families headed by a racial or ethnic minority are at greater risk of being uninsured, and this risk increases with rurality (52% for rural non-adjacent vs. 42% for urban minorities and 21% for urban white, non-Hispanic families). Other risk factors include having a head of house with less than a high school education, or one who is self-employed, and having a family income between 100% and 199% FPL.

Summary and Policy Implications

This study confirms that rural residents, particularly those living not adjacent to an urban area, are at greater risk of being uninsured. The magnitude of the uninsured problem in rural areas is underscored when one considers that one out of every three rural families has at least one uninsured member. Thus, the financial vulnerability of rural families to medical costs is much greater than individual-level data on uninsurance suggests.

At the same time, however, the majority of uninsured rural families (three-fourths) have someone in the household with health insurance coverage that could be built upon to cover additional members. For nearly half (42%) of rural non-adjacent families this is a public source of coverage, while urban residents are more likely to have private health insurance or a private/public mix. The lower rate of private coverage among partially insured rural families is likely explained by the factors shown to affect individuals' access to employer-based coverage such as lower wages, smaller business size, and self-employment.

Given these findings, strategies to increase coverage of family members through the workplace are likely to be less effective among rural non-adjacent versus urban families. Instead, expansions of public coverage or tax credits that enable entire families to purchase an individual/self-employment plan would be more effective at ensuring that rural non-adjacent families achieve full

coverage. In the latter case, tax credits, premium supports, or other incentives would need to be generous enough to make coverage affordable for the 52% of uninsured families living below 200% FPL.

Although having an uninsured child is comparable for rural and urban families, non-adjacent families are more likely to have an adult member who is uninsured (31% versus 26% in urban). This may be due to more limited public coverage options for adults living in rural areas. For example, of the 10 most rurally populous states (i.e. states with greatest number, versus proportion, of rural residents)¹, only two have expanded Medicaid/SCHIP to parents earning at or above 100% of the federal poverty level (Ross & Cox, 2005). In fact, only an estimated 26% of rural residents live in a state that has expanded coverage to this level, compared to nearly 46% of urban residents (authors' calculations based on Ross & Cox, 2005 and Census Bureau rural and urban population estimates for 2004).

Minorities also have elevated rates of family uninsurance, particularly in rural non-adjacent areas that are not fully explained by lower incomes. Given that minority populations in rural areas are growing, and at the same time minority rural families appear particularly vulnerable to having an uninsured member, policy-makers need to consider how to best ensure access to care for different racial and ethnic groups. This issue has implications both for minority rural families, but also rural providers who will likely face new challenges providing culturally appropriate care to populations with fewer resources to compensate them.

¹According to 2004 estimates from the Census Bureau, these states are: TX, NC, OH, PA, MI, KY, GA, IL, MS, and TN. Only PA and IL have expanded eligibility to parents.

Reference

Ross, D. C., & Cox, L. (2005, October). In a time of growing need: State choices influence health coverage access for children and families. Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation.

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