

**Health Insurance Coverage of the  
Rural and Urban Near Elderly  
Working Paper No. 27  
October 2003**



## **HEALTH INSURANCE COVERAGE OF THE RURAL AND URBAN NEAR ELDERLY**

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### **Working Paper #27**

October 2003

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This study was funded by a grant from the federal Office of Rural Health Policy, Health Resources and Services Administration, DHHS (Grant #CSUR00003-04). The conclusions and opinions expressed in the paper are the authors' and no endorsement by the University of Southern Maine or the funding source is intended or should be inferred.

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## **EXECUTIVE SUMMARY**

**BACKGROUND:** The problem of health insurance coverage for the near elderly has received substantial policy attention in recent years, including proposals to allow pre-Medicare persons to buy into the Medicare program. In general the health insurance coverage rates for this age cohort are comparable to, or better than, that of younger adults. However, the near elderly are at greater risk for developing chronic health conditions and having high medical care expenses (Monheit, Vistnes & Eisenberg 2001). Consequently, any lapse in health insurance coverage is likely to increase the vulnerability of this group.

This study examined the differences in rates and sources of health insurance between rural and urban individuals aged 55 to 64 using the 1996-1998 Medical Expenditure Panel Survey (MEPS). Information from this study will be particularly useful if and when policymakers reconsider options for extending health insurance coverage to the near elderly. Information on differences among the urban and rural near elderly in their insurance status (i.e. uninsured, private, public, individual) and the factors that contribute to the risk of being uninsured could be especially relevant and useful to discussions of coverage expansion strategies.

**METHODS:** This study used data from the 1996-1998 Medical Expenditure Panel Survey (MEPS) to address two principal research questions related to health insurance coverage for the rural near elderly. First, we measured rates of employer-based, non-group, and government health insurance coverage for the 55-64 age group in rural, compared to urban areas to determine whether there are significant differences in coverage based on geography. Second, we examined what specific socioeconomic, employment, health and/or other characteristics place the rural near elderly at risk of being uninsured and whether or not these factors were the same as for urban people in this age group. MEPS is an overlapping panel survey conducted by the Agency for Healthcare Quality and Research (AHRQ) to collect detailed information on health insurance, health status, health care use and expenditures, as well as other detailed socioeconomic information from a representative sample of the United States' population. We pooled three panels from the MEPS Household Component to create a file of approximately 48,500 unique respondents, of whom 3,287 were aged 55-64 in the first month of the year they were surveyed (January, 1996-1998).

## **FINDINGS**

### ***Insurance Coverage Status***

The rate of health insurance coverage at a point in time is significantly lower among the rural near elderly than their urban counterparts: 16% of rural adults aged 55-64 are uninsured compared to only 13% of urban adults in this age group. The sources of insurance coverage also differ. In the first month of the survey, only 64% of rural near elderly adults have private group coverage compared to 72% of urban near elderly. The rural near elderly are slightly more likely than those in urban areas to have non-group health insurance and nearly 30% more likely to have public insurance coverage (primarily Medicare or Medicaid). However, the higher rates of non-group and public coverage are not sufficient to offset the group coverage disparities between rural and urban residents.

The health insurance coverage disparities between the rural and urban near elderly are consistent across multiple measures of insurance coverage status. For example, near elderly rural residents are almost 40% more likely to have lacked health insurance coverage at some point during the survey year than near elderly urban residents (26% versus 19%). In addition, the near elderly living in rural areas are more likely to be uninsured for the entire year (14% versus 10% for urban). These differences are mirrored in the uninsured rates for near elderly workers, with 17% of those in rural areas ever being uninsured compared to 11% in urban areas. This reflects the sizeable difference between the number of rural (61%) and urban (77%) near elderly workers who are eligible for health insurance through their workplace. When rural near elderly workers are eligible for health insurance coverage through an employer they are more likely to enroll in that coverage than their urban counterparts (90% versus 85%). This may be because the rural near elderly have fewer opportunities for alternate insurance coverage, such as from a spouse's employer.

### ***Characteristics Related to Being Uninsured***

Rural and urban near elderly share some of the characteristics that place them at risk of being uninsured. The magnitude of risk is higher for a number of rural subgroups, however. For example, both the rural and urban near elderly in fair or poor health are three to four times more likely to be uninsured than those in good or better health. Although those in fair or poor health are at elevated risk of being uninsured, the rate is significantly higher among the rural (compared to urban) near elderly. Similarly, having less than a high school diploma or earning below 200% of poverty are associated with higher uninsured rates among the near elderly, and these effects are particularly pronounced in rural areas.

Among near elderly workers, those who work part-time (less than 40 hours per week) have twice the uninsured rate of those working full-time. Although the uninsured rates do not differ by residence among full-time workers, those working part-time are significantly more likely to be uninsured if they live in a rural area (24% versus 16%). Among urban workers, being self-employed increases the risk of being uninsured for this age group; among rural workers, however, the likelihood of being uninsured does not differ for those who work for themselves or another employer. Working for less than \$10 per hour or for a business with less than 20 workers is associated with being uninsured for near elderly workers, characteristics that are significantly more common among rural workers aged 55-64 than among those in urban areas.

Our multivariate findings indicate that income is significantly associated with being uninsured during the survey year, for both rural and urban near elderly. We also found that lacking a spouse, having lower educational attainment, and being in poorer health each independently increase the risk that near elderly in each geographic category would be uninsured. Some characteristics that have been associated with higher uninsured rates in previous studies are significant predictors of being uninsured for the urban near elderly but not those in rural areas. For example, age is positively associated with the likelihood of being uninsured in the urban model, with the odds rising six percent for every year increase in age. In addition, belonging to a racial or ethnic minority group more than doubles the odds that an urban individual in the 55-64 age group will be uninsured. Also, women in this age group are 50% more likely than men to lack health insurance if they live in an urban area. And, although not mentioned in prior research on the near elderly, family size has a positive association with being uninsured for the urban near elderly. For the rural near elderly, however, none of these characteristics are independently associated with being uninsured.

We find that the effect of being employed is different for the rural and urban near elderly. Among those in urban areas, having a job is negatively associated with the likelihood of being uninsured during the survey year. Compared to those who are unemployed or out of the labor force, urban near elderly workers are 60% less likely to lack health insurance. However, in rural areas there is no significant relationship between employment status and the likelihood of being uninsured.

Employer size and employee wages are the most important predictors of differences in the likelihood of being uninsured among rural and urban near elderly workers. These findings echo prior research that has attributed the differences in rural-urban insurance coverage among workers of all ages to these two factors (Coburn et al. 1998).

**SUMMARY AND POLICY IMPLICATIONS:** Although the near elderly tend to have relatively low uninsured rates, the greater health care needs for this age group compared to younger individuals has made insurance coverage for the near elderly an important public policy issue. Because we find that the rural near elderly are both more likely to be uninsured and to be in fair or poor health, it will be critical for policymakers to consider the effects of rural residence on strategies for improving coverage for this cohort. Adding to the policy concerns about improving coverage for this age group, studies have indicated that when the near elderly become uninsured they may have a much more difficult time regaining health insurance than younger groups. This issue may be even more problematic in rural areas as our findings indicate that 14% of the rural near elderly are uninsured for the entire survey year, compared to 10% of the urban near elderly.

In recent years a number of different policy strategies have been proposed for increasing health insurance coverage for U.S. residents as a whole, and the near elderly in particular. Regardless of the strategy selected, efforts to improve coverage may affect the rural and urban near elderly in different ways. For example, policies that aim to increase near elderly enrollment in non-group health plans may face significant challenges in rural areas. Although the rural near elderly are more likely to get their health insurance from the non-group market, the characteristics of the rural uninsured aged 55-64 will make increasing this type of coverage a particular challenge. Because the rural near elderly are in poorer health, individual insurance premiums for this group are likely to be quite high and many may be unable to obtain coverage at any cost (Johnson 2001). And although more rural than urban near elderly are likely to be eligible for tax credit proposals such as the Bush Administration's plan to target those with incomes below 200% of the federal poverty level, it is unclear whether the size of the credits will be sufficient to encourage broad enrollment for those at this income level.

Efforts to increase the availability of group coverage for near elderly workers such as small group reforms or the development of purchasing cooperatives could be of great benefit to the rural near elderly if they manage to encourage a greater number of employers to offer coverage. Since some of the disparity in coverage between rural and urban near elderly workers may be related to the much lower offer rates in rural areas (61% versus 77%), strategies that offer incentives for currently uninsured businesses to begin providing coverage could help the rural near elderly obtain coverage. The fact that the take up rate for near elderly employees is significantly higher in rural than urban areas suggests that near elderly workers who live in rural areas may be willing to enroll in an employer-based plan if one were made available to them. Even if small business proposals merely reduce the erosion of employer-

based coverage, this will be important for the rural near elderly who are much more likely than urban workers to have a job with a small employer. However, it is important to note that for both the rural and urban near elderly more than 60% of the uninsured are not working and consequently would not benefit from employer-based strategies.

Proposals to allow certain near elderly individuals to buy into public insurance programs such as Medicare or the Federal Employee Health Benefits Plan have the potential to dramatically improve access to health insurance for the rural near elderly. However, because these proposed strategies have emphasized the importance of remaining cost neutral, individuals would bear the full cost of enrollment. Economic simulations have predicted that only a very small percentage of participants would be poor or near poor, based on the premiums required to make a Medicare buy-in cost neutral (Johnson, Moon & Davidoff 2002). The percentage of enrollees from these income groups increases dramatically, however, if premiums are based on income. These findings, coupled with the known fact that the rural near elderly generally have lower incomes, suggests that premium subsidies will be particularly important to assuring rural participation in any public insurance buy-in option.

And finally, the uninsured rural and urban near elderly differ in some key ways that would affect the implementation of health insurance expansions for this age cohort. Although workers aged 55-64 face the same types of barriers to health insurance regardless of their residence, factors such as working for low wages or a small business are more prevalent in rural areas. In addition, when considered as a whole, the characteristics that place the rural near elderly at risk of being uninsured are significantly different than for those in urban areas. Consequently, policymakers should be mindful of the unique risks for being uninsured that the rural near elderly face, in order to craft solutions that meet the health insurance needs of this population.

## INTRODUCTION

The problem of health insurance coverage for the near elderly has received substantial policy attention in recent years, including proposals to allow pre-Medicare persons to buy into the Medicare program. In general, the health insurance coverage rates for this age cohort are comparable to, or better than, most younger adults. However, the near elderly are at greater risk for developing chronic health conditions and having high medical care expenses (Monheit, Vistnes & Eisenberg 2001). Consequently, any lapse in health insurance coverage is likely to increase the vulnerability of this group.

In 2001, approximately 13% of people between the ages of 55 and 64 (the “near elderly”) were uninsured (Hoffman & Wang 2003). Although they are less likely to be uninsured, the rate of employer-based coverage for this cohort is much lower than for those between age 44 and 55 (67% compared to 74%, *ibid.*) leading analysts to be concerned that the continuing erosion of employer-based health insurance coverage may disproportionately affect this cohort in the future. In addition to declines in the number of employers offering coverage, changes in employment patterns (e.g. higher job turnover rates), and escalating costs for comprehensive individual insurance plans, suggest that this cohort could face reduced access to health insurance coverage in the future.

There is limited information about how the insurance status of the near elderly may differ in rural and urban areas. Prior research suggests that being uninsured may be a particular problem for the near elderly in rural areas. We know, for example, that a greater proportion of rural than urban people falls within this age group. In addition, rural residents (of all ages) are less likely to have employer-based coverage due to the labor market characteristics of rural areas (Coburn, Kilbreth, Long, and Marquis 1998; Frenzen, 1995; Hartley, Quam, and Lurie 1994). Furthermore, certain characteristics that increase the risk of being uninsured specifically for the 55-64 age group, such as income below poverty, lower wages, and displaced worker status (Urban Institute 1997), are more prevalent in rural areas.

The purpose of this study was to examine the differences in rates and sources of health insurance between rural and urban individuals aged 55 to 64 using the 1996-1998 Medical Expenditure Panel Survey (MEPS). Information from this study will be particularly useful if and when policymakers reconsider options for extending health insurance coverage to the near elderly. Information on differences among the urban and rural nearly elderly in their insurance status (i.e. uninsured, private, public, individual) and the factors that contribute to the risk of being uninsured could be especially relevant and useful to discussions of coverage expansion strategies.

## **BACKGROUND**

In 2001, approximately 13% of people between the ages of 55 and 64 (the “near elderly”) were uninsured (Hoffman & Wang 2003). Although they are less likely to be uninsured than younger adults, the near elderly tend to have different sources of health insurance coverage. For example, the rate of employer-based coverage for this cohort is much lower than for those between ages 44 and 55 (67% compared to 74%, *ibid.*) Part of the reason that the near elderly are less likely to be covered by employer-based health insurance is that many individuals in this population begin to transition away from the full-time labor force. Approximately half of those between 55 and 61, and only one-fourth of those between 62 and 64, work full time. Retiree health insurance, and more recently COBRA<sup>1</sup> legislation, has allowed some of these individuals to maintain group coverage as they transition from full-time employment. However, several studies have documented a dramatic decline in the number of employers offering retirement health insurance over the past decade raising the prospect that insurance coverage among the near elderly may be declining (Kaiser Family Foundation 2002; United States General Accounting Office 1997).

A number of studies have looked at different dimensions of being uninsured for the near elderly, including the characteristics associated with being uninsured, patterns of gaining and losing different types of health insurance, and the impact of being uninsured on access to health care services. These studies have compared uninsured rates for different segments of the near elderly population such as workers and non-workers (Monheit, Vistnes & Eisenburg 2001) or males versus females (*ibid* 2001; Brennan 2000). However, no studies to date have compared coverage rates and sources for the rural and urban near elderly or measured whether the characteristics associated with being uninsured differ for the two residence groups.

Prior research indicates that the problem of insurance coverage among the near elderly is likely to be more significant in rural areas. In general, studies have found that rural residents of all ages have higher uninsured rates than urban residents (Erberhardt, Ingram & Makuc 2001; Haley & Zuckerman 2000; Pol, L 2000; Schur & Franco 1999). This is attributed in large part to the fact that fewer rural than urban individuals have employer-based insurance coverage (Coburn et al. 1998; Frenzen 1995; Hartley, Quam, and Lurie 1994). Also, because retiree health insurance coverage can be an important source of health insurance for this population, differences in access to retiree benefits could affect rural and urban coverage rates. Although not explicitly measuring rural and urban differences, studies examining the decline in retiree health insurance have found that lower wages and smaller firm size, both characteristic of rural

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<sup>1</sup> Consolidated Omnibus Budget Reconciliation Act of 1985

workers and employers, are associated with reduced availability of retiree health benefits. Finally, although individual health insurance is an important source of coverage for the pre-Medicare age group, rural residents tend to have lower incomes (Economic Research Service 2002) which may make these higher cost plans unaffordable for many.

Federal reforms, such as the Consolidated Omnibus Budget Resolution Act of 1985 (COBRA) and the Health Insurance Portability and Accountability Act (HIPAA), designed to improve the continuity of health insurance coverage (particularly for this age group) have restrictions which may penalize rural residents. For example, COBRA continuation coverage is required only for firms that offer health insurance and have more than 20 employees, employer characteristics that are less common in rural areas. Similarly, portability of insurance from group to individual market under HIPAA is limited to persons with continuous group coverage for the last 18 months. As rural residents are less likely to have access to group coverage in the first place, HIPAA is likely to provide them with fewer protections than it would for urban residents. In addition, both COBRA and HIPAA plans may be too costly for those at lower income levels and, as indicated above, rural residents tend to be overrepresented among the poor and near poor.

### ***Prior Studies***

A number of studies over the past decade have examined the health insurance coverage of the near elderly and the factors associated with having different types of coverage as well as the risks of being uninsured. Many of the sociodemographic characteristics found to increase the likelihood of being uninsured are the same as those typically found for lower age groups. For example, Johnson & Crystal (1997) found that the near elderly with lower educational attainment, poorer health status, those with no spouse in the household, and members of racial or ethnic minority groups were more likely to be uninsured. Other research has found similar relationships between at least of some of these characteristics and being uninsured for the near elderly (Jensen 1992; Brennan 2000; Monheit et al. 2001). In addition, each of these findings has been supported by the Urban Institute's tabulations of the 1998 Health and Retirement survey as presented by Johnson (2001).

Studies of the impact of being employed on health insurance coverage of the near elderly have yielded mixed results (Monheit et al. 2001; Jensen 1992). Using data from the 1983-1986 SIPP, Jensen found that being out of the workforce significantly increased the risk of being uninsured during the survey period. Monheit et al (2001) found that not working reduced the likelihood of having employer-based coverage, and that in 1987 uninsured rates for working

and non-working near elderly differed for some ages, depending on their gender. However, in a comparison to the 1987 data, they found that in 1996 the risk of being uninsured for working and non-working near elderly individuals did not differ because the latter group had higher rates of public and non-group coverage that compensated for the lack of coverage through an employer (Monheit et al. 2001).

Research has demonstrated that, unlike other age groups, women who are near elderly are significantly more likely to lack health insurance than men are (Jensen 1992; Johnson & Crystal 1997; Brennan 2000). For example, the Kaiser Commission on Medicaid and the Uninsured (2001) found that 16% of females aged 55-64 lacked health insurance in 1999 compared to 13% of males in that age group. Monheit and al. (2001) attribute this to the fact that among the near elderly, female workers are much less likely than male workers to be offered employer-based coverage. According to Johnson (2001), female employees are much less likely to be eligible for retirement health benefits. And, although in the past near elderly women had high rates of non-group coverage, between 1987 and 1996 the proportion with this type of coverage declined by almost 50% (Monheit et al. 2001).

## **METHODS**

This study addressed two principal research objectives. First, we measured rates of employer-based, non-group, and government health insurance coverage for the 55-64 age group in rural, compared to urban areas to determine whether there are significant differences in coverage based on geography. Second, we examined what specific socioeconomic, employment, health and/or other characteristics place the rural near elderly at risk of being uninsured and whether or not these factors were the same as for urban people in this age group.

### ***Data***

This study used data from the 1996-1998 Medical Expenditure Panel Survey (MEPS) to measure differences in health insurance coverage between rural and urban adults, aged 55-64. MEPS is an overlapping panel survey conducted by the Agency for Healthcare Quality and Research (AHRQ) to collect detailed information on health insurance, health status, health care use and expenditures, as well as other detailed socioeconomic information from a representative sample of the United States' population. We pooled three panels from the MEPS Household Component<sup>2</sup> to create a file of approximately 48,500 unique respondents, of

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<sup>2</sup> More detailed information on the MEPS can be found at: [http://www.meps.ahrq.gov/Data\\_Public.htm](http://www.meps.ahrq.gov/Data_Public.htm)

whom 3,287 were aged 55-64 in the first month of the year they were surveyed (January, 1996-1998).

Selecting the MEPS as our data source had both advantages and limitations for addressing our research questions. On the one hand, the careful sampling design and weighting methods of the MEPS survey contribute to the generalizability of the results to metropolitan and non-metropolitan areas and populations across the nation. In addition, few other data sources capture the depth and breadth of information that is available through the MEPS, particularly about the health insurance topics targeted in this study.

A substantial limitation of the MEPS, however, is that the public use files contain limited measures of rural residence. In choosing the MEPS, we were limited to defining rural using the Office of Management and Budget's classification of Metropolitan/Non-metropolitan counties. As a result, we are unable to examine differences in coverage across different types of rural areas, although prior research has demonstrated that insurance coverage differs among rural residents depending on their distance from urban areas.<sup>3</sup> In addition, the relatively small sample of non-metro respondents may decrease our ability to detect differences between rural and urban respondents. Despite these limitations, the MEPS is the best source of national data with which to examine the central questions posed by this study.

### ***Variable Definition***

Our principal independent variable in these analyses is rural or urban residence. There are multiple methods for defining rural and urban areas that are commonly used in analyzing national data.<sup>4</sup> This study employs the U.S. Office of Management and Budget (OMB) classification which has designated each U.S. County as "metropolitan" or "non-metropolitan" based on population estimates. This definition is frequently the only rural-urban measure included in public use files of national health data sets and hence is commonly used to conduct rural-urban comparisons of health insurance coverage. As we note above, this definition prevents us from distinguishing between differing degrees and types of rurality.

The dependent variable in this study is health insurance coverage, and in particular, the uninsured rate among the near elderly. Health services researchers have used a variety of methods to count the uninsured (Lewis, Ellwood & Czajka 1998). To capture the dynamic nature

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<sup>3</sup> Ziller et al. (2003); Schur & Franco (1999).

<sup>4</sup> Ricketts, T. C., Johnson-Webb, K. D., & Taylor, P. (1998, June). Definitions of Rural: A Handbook for Health Policy Makers and Researchers. (A Technical Issues paper prepared for the Federal Office of Rural Health Policy Health Resources and Services Administration, US DHHS). University of North Carolina at Chapel Hill: Federal Office of Rural Health Policy.

of health insurance coverage we chose to measure the uninsured in several ways. First, we counted the uninsured and measure their characteristics at a specific point in time, that is, the first month in each respondent's initial survey year (January 1996 – 1998). Second, we measured the proportion of near elderly individuals who remain uninsured throughout the entire survey year. Finally, because the pool of uninsured individuals is constantly changing, we identified near elderly individuals who lacked health insurance coverage at any time during the survey year.

In addition to rural or urban residence, we included a number of covariates in our analyses that were selected because prior research has found them to be associated with health insurance coverage in general and for the near elderly specifically. These covariates include measures of employment status, poverty status, employer size, socio-demographic measures such as education and minority status, and health status. Poverty status is an annualized variable created by AHRQ based on full-year household income information as a percent of the Federal Poverty Level (FPL). With the exception of poverty status, each of the variables we used was measured during the first interviewing round of each survey year. Because our principal dependent variable is whether an individual lacked health insurance at any time during the survey year, some changes in these characteristics that could affect the dependent variable (such as job loss or reduction in hours worked) may have been missed.

### ***Analytic Strategy***

To address our research questions concerning rural-urban differences in the rates and types of health insurance coverage among the near elderly, we use a multi-stage analytic approach employing bivariate and multivariate methods. We weighted the data using the poverty and mortality-adjusted weights provided by AHRQ statisticians in order to correct for known bias in the sampling design. All statistical tests were calculated in SUDAAN to account for the cluster design of the MEPS sample and to yield valid standard errors for the weighted data.<sup>5</sup>

Our bivariate analyses examine the differing rates of health insurance coverage for the rural and urban near elderly, including sources of coverage and uninsured rates. In addition, we compare the sociodemographic and employment characteristics of the rural and urban near elderly to assist us in understanding any coverage disparities and possible policy remedies. All differences were tested by Chi Square and the p-values are reported in Tables 1 through 4.

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<sup>5</sup> SUDAAN® is a software product developed by the Research Triangle Institute for analyzing clustered data. More information about the product can be found at: <http://www.rti.org/sudaan/>

Unless stated otherwise, any differences reported in the text of this paper are statistically significant at the .05 level or less.

Because we anticipated that the characteristics associated with being uninsured may differ for employed and non-employed individuals, our multivariate analyses looked both at the full sample of near elderly respondents in MEPS, as well as the sub-sample of workers in this age group. Using logit analyses, we determined what characteristics were associated with whether or not an individual had ever been uninsured during the survey year. The covariates that prior studies have linked to health insurance coverage were included in separate models for the rural and urban near elderly as well as a model that pooled the two groups. By modeling individuals from each residence type separately, it was possible to determine not only what characteristics predict being uninsured, but also whether these characteristics were different for the rural and urban near elderly. The results of these analyses are presented in Tables 5 and 6.

Because the factors associated with being uninsured appeared to be different for the two residence types, we used a likelihood ratio test to determine if the overall difference in the rural and urban models was statistically significant. For the full sample of near elderly, the results of the likelihood ratio test were  $\chi^2 = 56.9$ ,  $df = 26$ , with a  $p$ -value  $\leq .001$ , indicating that there were significant differences in the characteristics predictive of being uninsured for the two residence types. Therefore, we determined that results for the rural and urban near elderly were best presented in separate models. Among workers, however, the likelihood ratio test was not statistically significant so these results are presented as a pooled model.

## **FINDINGS**

### ***Insurance Coverage Status***

As indicated in Table 1, the rate of health insurance coverage is significantly lower among the rural near elderly than their urban counterparts: 16% of rural adults aged 55-64 are uninsured compared to only 13% of urban adults in this age group. The sources of insurance coverage also differ. In the first month of the survey, only 64% of rural near elderly adults have private group coverage compared to 72% of urban near elderly. The rural near elderly are slightly more likely than those in urban areas to have non-group health insurance and nearly 30% more likely to have public insurance coverage (primarily Medicare or Medicaid). However, the higher rates of non-group and public coverage are not sufficient to offset the group coverage disparities between rural and urban residents.

### **Table 1: Health Insurance Status**

	TOTAL	RURAL	URBAN
Sample N =	3,287	799	2,488
	PERCENT DISTRIBUTION		
FULL SAMPLE			
Coverage at First Month in Survey**			
Private, Group	70.0	63.6	71.8
Private, Individual	5.5	6.3	5.3
Public	10.8	13.9	9.9
Uninsured	13.8	16.3	13.1
Health Insurance Across the Year**			
Covered All Year	79.8	74.0	81.4
Uninsured Part of Year	9.4	12.4	8.5
Uninsured All Year	10.8	13.5	10.1
Ever Uninsured**	20.2	25.9	18.6
WORKERS			
Eligible for Employer Coverage***	73.3	61.4	76.5
Take-up Rate*	85.6	90.0	84.6
Ever Uninsured*	12.2	17.0	10.9

\*p ≤ .05; \*\*p ≤ .01; \*\*\*\*p ≤ .001

The health insurance coverage disparities between the rural and urban near elderly are consistent across each of the uninsured measures that we studied. For example, near elderly rural residents are almost 40% more likely to have lacked health insurance coverage at some point during the survey year than near elderly urban residents (26% versus 19%). In addition, the near elderly living in rural areas are more likely to be uninsured for the entire year (14% versus 10% for urban). These differences are mirrored in the ever-uninsured rates for near elderly workers, with 17% of those in rural areas ever being uninsured compared to 11% in urban areas. This reflects the sizeable difference between the number of rural (61%) and urban (77%) near elderly workers who are eligible for health insurance through their workplace. Interestingly, when rural near elderly workers are eligible for health insurance coverage through an employer they are more likely to enroll in that coverage than their urban counterparts (90%

versus 85%). This may be because the rural near elderly have fewer opportunities for alternate insurance coverage, such as from a spouse's employer.

**TABLE 2: Characteristics of the Rural and Urban Near Elderly Sample and those Uninsured in the Survey Year**

ALL NEAR ELDERLY	(N)	FULL NEAR ELDERLY SAMPLE			EVER UNINSURED		
		TOTAL (3,287)	RURAL (799)	URBAN (2,488)	TOTAL (842)	RURAL (247)	URBAN (595)
Health Status							
Excellent/Very Good		53.0	48.5**	54.3**	30.1	30.6*	29.9*
Good		26.8	26.0**	27.0**	25.0	18.4*	27.6*
Fair/Poor		20.2	25.6**	18.7**	44.9	51.1*	42.5*
Minority Status							
White, non-Hispanic		19.9	11.0***	22.4***	60.0	79.5***	52.2***
Racial/Ethnic minority		80.1	89.0***	77.6***	40.0	20.5***	47.8***
Education							
< High school		25.0	36.4***	22.3***	54.1	66.6**	49.1**
High school		54.1	50.1***	55.2***	38.7	30.7**	41.9**
Some college or more		20.6	13.8***	22.5***	7.2	2.7**	8.9**
Marital Status							
Married, spouse present		69.4	73.3*	68.3*	45.1	52.4*	42.2*
No spouse		30.6	26.7*	31.7*	54.9	47.6*	57.8*
Sex							
Male		47.2	49.2	46.7	44.0*	44.6	43.7
Female		52.8	50.8	53.3	56.0*	55.4	56.3
Family Size							
1 person		18.9	18.1*	19.1*	28.5	30.0	27.9
2 people		55.8	61.1*	54.3*	39.3	45.5	36.9
3 people or more		25.3	20.8*	26.6*	32.3	24.5	35.2
Family Income							
< 100% FPL		10.1	12.3***	9.5***	31.0	31.5***	30.8***
100-200% FPL		14.3	18.9***	13.0***	32.7	42.7***	28.8***
200% FPL or higher		75.6	68.8***	77.6***	36.3	25.8***	40.5***
Employment Status							
Currently working		63.2	60.2	64.1	38.1	39.4	37.6
Unemployed/OLF		36.9	39.8	35.9	61.9	60.7	62.4
WORKERS	(N)	(1,969)	(449)	(1,520)	(280)	(79)	(201)
Hours Worked							
Full-time		69.3	68.3	69.6	53.0	51.6	53.5
Part-time		30.7	31.7	30.4	47.0	48.4	46.5
Hourly Wage							
< \$10 per hour		41.3	52.6***	38.3***	83.3	88.7*	80.9*
\$10 per hour or more		58.7	47.5***	61.7***	16.7	11.3*	19.1*
Employer Size							
< 20 Employees		44.6	56.3***	41.4***	74.7	87.5**	69.4**
20 Employees or more		55.4	43.7***	58.6***	25.3	12.6**	30.6**
Self-employment Status							
Self-employed		21.2	22.7	20.8	28.3	23.1	30.4
Works for someone else		79.8	77.3	79.2	71.7	76.9	69.6

\*Rural-urban differences significant at  $p \leq .05$ ; \*\* $p \leq .01$ ; \*\*\* $p \leq .001$

### ***Characteristics of Rural-Urban Near Elderly***

Table 2 demonstrates that the rural near elderly tend to be in poorer health than their urban counterparts, with 49% reporting that they were in excellent or very good health while more than one-fourth said they were in fair or poor health (compared to 54% and 19% of the urban near elderly, respectively). At the same time, near elderly residents in rural areas possess characteristics that may explain some of their higher uninsured rate, compared to those in urban areas. For example, the rural near elderly are almost 70% more likely to lack a high school degree and nearly 40% more likely to have family income under 200% of the federal poverty level. On the other hand, near elderly adults are more likely to be married and less likely to be a racial or ethnic minority if they live in a rural area as opposed to an urban one, characteristics that prior studies have associated with higher rates of insurance coverage.

Among the near elderly, the likelihood of being employed does not differ based on residence; for both geographic categories more than 60% of adults in this age group report working in the first survey round. In addition, of those currently working, the proportion that works full-time versus part-time is no different among the rural and urban near elderly. Rural and urban near elderly workers are also equally likely to be self-employed, representing roughly one-fifth of workers. As expected, however, the rural near elderly are much more likely to work for lower wages and smaller employers than the urban near elderly are. Fifty-three percent of rural workers in this age group earn less than \$10 per hour compared to only 38% of those in urban areas, while rural employees are a third more likely to work for a firm with less than 20 employees. Prior research has demonstrated that each of these workplace characteristics are related to lower rates of employment coverage in rural areas for workers of all ages (Coburn et al. 1996).

### ***Characteristics Related to Being Uninsured***

The results of our bivariate analyses demonstrate that the characteristics that place rural and urban near elderly at risk of being uninsured are generally comparable, although the magnitude of risk is higher for a number of rural subgroups. For example, both the rural and urban near elderly in fair or poor health are three to four times more likely to be uninsured than those in good or better health (Table 3). However, in rural areas, 51% of the near elderly who report themselves to be in fair or poor health were uninsured at some point in the survey year, compared to 42% of those in urban areas. Similarly, having less than a high school diploma or earning below 200% of poverty are associated with higher uninsured rates among the near elderly and these effects are particularly pronounced in rural areas. Forty-eight percent of the

rural near elderly with less than a high school education were uninsured during the year, compared to 41% of the urban near elderly ( $p \leq .05$ ). Two-thirds of the rural near elderly living in poverty, and 59% of the near poor (100 – 199% FPL) had some lapse in health insurance coverage compared to 60% and 41% in urban areas ( $p \leq .05$  and  $p \leq .01$ , respectively). As one would expect, being unmarried and not working each increases the risk of being uninsured for both the rural and urban near elderly. However, the uninsured rate is higher in rural areas regardless of marital or employment status.

Among near elderly workers, those who work part-time (less than 40 hours per week) have twice the uninsured rate of those working full-time. Although the uninsured rates do not differ by residence among full-time workers, those working part-time are significantly more likely to be uninsured if they live in a rural area (24% versus 16%). Among urban workers, being self-employed increases the risk of being uninsured for this age group; among rural workers, however, the likelihood of being uninsured does not differ for those who work for themselves or another employer.

The hourly wage that workers earn and the size of their employer are also strongly associated with being uninsured for near elderly workers. Among workers earning less than \$10 per hour, the likelihood of being uninsured during the year is roughly seven times greater than for those earning \$10 per hour or more (22% versus 3%). While the rural-urban uninsured rate does not differ for the higher wage group, near-elderly workers earning less than \$10 per hour are more likely to be uninsured if they live in a rural area (27% versus 20%). And, as Table 2 demonstrates, rural workers are significantly more likely to earn less than \$10 per hour (53% versus 38%). Similarly, workers at firms with fewer than 20 employees are about four times as likely to be uninsured as those who work for larger firms are (20% versus 5%). Although the uninsured rates for near elderly workers in both employer size categories do not differ based on residence, 56% of rural near elderly workers work for smaller firms compared to 41% of those in urban areas (Table 2).

**Table 3: Percent of Rural and Urban Near Elderly Uninsured, by Characteristic**

CHARACTERISTIC	TOTAL (3,287)	RURAL (799)	URBAN (2,488)
Sample N =			
	PERCENT DISTRIBUTION		
CHARACTERISTIC			
Health Status			
Excellent/Very Good <sup>b</sup>	11.5***	16.4	10.2
Good	18.8***	18.4	19.0
Fair/Poor <sup>a</sup>	44.9***	51.9	42.2
Minority Status			
White, non-Hispanic <sup>c</sup>	15.1***	23.2**	12.5***
Racial/Ethnic minority	40.0***	48.5**	39.6***
Education***			
< High school <sup>a</sup>	43.1***	48.1***	40.8***
High school	38.7***	15.9***	14.1***
Some college or more	7.0***	5.1***	7.4***
Marital Status			
Married, spouse present <sup>b</sup>	13.1***	18.6***	11.5***
No spouse <sup>a</sup>	36.3***	46.2***	33.9***
Family Size			
1 person <sup>b</sup>	30.3***	42.4***	27.1***
2 people <sup>b</sup>	14.2***	19.1***	12.6***
3 people or more	25.6***	30.3***	24.5***
Family Income			
< 100% FPL <sup>a</sup>	62.0***	66.3***	60.4***
100-200% FPL <sup>b</sup>	46.3***	58.7***	41.2***
200% FPL or higher	9.7***	9.8***	9.7***
Employment Status			
Currently working <sup>a</sup>	12.2***	17.0***	10.9***
Unemployed/OLF <sup>a</sup>	34.0***	39.6***	32.3***
EMPLOYMENT CHARACTERISTIC			
	PERCENT DISTRIBUTION		
Hours Worked			
Full-time	8.9***	11.8*	8.1***
Part-time <sup>a</sup>	17.8***	23.6*	16.1***
Hourly Wage			
< \$10 per hour <sup>a</sup>	22.0***	26.8***	20.2***
\$10 per hour or more	3.1***	3.8***	2.9***
Employer Size			
< 20 Employees	19.6***	24.8***	17.7***
20 Employees or more	5.4***	4.6***	5.5***
Self-employment Status			
Self-employed	15.8*	16.3	15.6**
Works for someone else <sup>a</sup>	10.7*	15.9	9.4**

\*p ≤ .05; \*\*p ≤ .01; \*\*\*p ≤ .001

<sup>a</sup>Rural-urban differences significant at p ≤ .05; <sup>b</sup>p ≤ .01; <sup>c</sup>p ≤ .001

## ***What Factors Affect Insurance Coverage?***

### Full Sample

As indicated earlier, the likelihood ratio test showed that the predictors of being uninsured differed for the rural and urban near elderly in the full sample. Consequently, Table 4 presents separate Logit models for the two residence categories. Although we do not present the Logit for pooled sample in table form, we found that despite the inclusion of the covariates listed in Table 4, the rural-urban difference in coverage was not eliminated. Although most of these covariates were associated with the likelihood of being uninsured, when controlled for, the rural variable remained a significant predictor of being uninsured during the survey year. This suggests that the higher uninsured rate in rural areas may be attributable to more than the generally poorer socio-economic conditions faced by the rural near elderly.

Consistent with the results of prior research, we found that income is significantly associated with being uninsured during the survey year, for both rural and urban near elderly. Also in keeping with prior research results, we found that lacking a spouse, having lower educational attainment, and being in poorer health each independently increase the risk that near elderly in each geographic category would be uninsured.

Some characteristics associated with higher uninsured rates in previous studies are significant predictors of being uninsured for the urban, but not rural, near elderly. For example, age is positively associated with the likelihood of being uninsured in the urban model, with the odds rising six percent for every year increase in age. In addition, belonging to a racial or ethnic minority group more than doubles the odds that an urban resident will be uninsured. Also, women in this age group are 50% more likely than men to lack health insurance if they live in an urban area. Although not mentioned in prior research on the near elderly, family size is negatively associated with being uninsured for the urban near elderly. For the rural near elderly, however, none of these characteristics are independently linked to being uninsured.

We find that the effect of being employed is different for the rural and urban near elderly. Among those in urban areas, having a job is negatively associated with the likelihood of being uninsured. Compared to those who are unemployed or out of the labor force, urban near elderly workers are 60% less likely to lack coverage. However, in rural areas there is no significant relationship between employment status and being uninsured. Once family income and other characteristics are controlled for, the effect of employment on health insurance coverage that appears in the bivariate analyses is not significant for the rural near elderly. Thus, although employment itself has an independent effect on being uninsured for the urban near elderly, having a job does not increase the chances of having health insurance for those in rural areas.

**Table 4: Effects of Socioeconomic Characteristics on the Likelihood of Being Uninsured for Rural and Urban Near Elderly**

	Rural Logit Model			Urban Logit Model		
	Beta Coefficient	SE Beta	Odds Ratio	Beta Coefficient	SE Beta	Odds Ratio
Intercept	-2.62	3.33	--	-3.98	2.21	--
Age (in years)	.03	.04	1.03	0.06*	0.02	1.06
Family Income						
200% FPL or more <sup>a</sup>	--	--	1.00	--	--	1.00
100 – 199% FPL	2.02***	.31	7.56	1.68***	0.18	5.35
Less than 100% FPL	2.03***	.35	7.61	1.14***	.21	3.13
Marital Status						
No Spouse <sup>a</sup>	--	--	1.00	--	--	1.00
Married, Spouse Present	-0.94**	.31	0.39	-1.36***	.19	0.26
Family Size (in persons)	-0.07	.15	0.93	-0.25***	.07	0.78
Employment						
Unemployed/OLF <sup>a</sup>	--	--	1.00	--	--	1.00
Working	-0.10	.33	0.90	-0.89***	.13	0.41
Minority Status						
White, non-Hispanic <sup>a</sup>	--	--	1.00	--	--	1.00
Racial/Ethnic Minority	0.47	.34	1.60	0.75***	.18	2.11
Education						
< High School <sup>a</sup>	--	--	1.00	--	--	1.00
High School	-1.07***	.27	0.34	-0.78***	.15	0.46
Some college or more	-1.84**	.66	0.16	-1.00***	.29	0.37
Health Status						
Excellent/Very Good <sup>a</sup>	--	--	1.00	--	--	1.00
Good	-0.54	.30	0.58	.30	.16	1.35
Fair/Poor	0.83**	.31	2.30	0.79***	.17	2.21
Sex						
Male <sup>a</sup>	--	--	1.00	--	--	1.00
Female	0.09	.33	1.01	0.39**	.14	1.48

<sup>a</sup>Referent

\*\*p ≤ .05; \*p ≤ .01; \*\*\*p ≤ .001

## Workers

For near-elderly workers, the likelihood ratio test indicated that the slopes for the rural and urban Logit models do not differ significantly, thus we present our findings in the single model shown in Table 5. Among near-elderly workers, having a spouse in the home reduces the risk of being uninsured during the survey year by more than 75%. Similarly, controlling for marital status, as the number of family members increases the likelihood of being uninsured decreases. This suggests that the demand for health insurance may be higher for near elderly workers who have multiple dependents.

As with the full sample of near elderly, we find that educational status predicts the likelihood of being uninsured for near elderly workers. Controlling for other workplace and socio-demographic characteristics, those with a high school education are 45% as likely to be uninsured as those without a high school diploma. Although the coefficient for those with some college or more is also negatively associated with being uninsured, this variable does not differ statistically from the referent. However, we believe that this is because the small number of uninsured in this educational category does not have sufficient statistical power to indicate a non-chance finding, not because the relationship does not exist.

We reported earlier that age and sex are each associated with being uninsured for the urban near elderly sample, and these relationships exist for the sub-sample of near elderly workers. For female near elderly workers, the odds of being uninsured are nearly three times higher than for males, even when employment characteristics such as wages and number of hours worked are held constant. Also, as age increases one year, the risk that a near elderly worker will be uninsured during the survey year increases by about 9%.

For the full sample of urban near elderly, being a member of a racial or ethnic minority group increases the likelihood of being uninsured. However, we do not find this association for minority workers, suggesting they may be more likely than non-Hispanic whites to lack health insurance only if they are not currently working (controlling for other characteristics). Similarly, although being in fair or poor health is a significant predictor of being uninsured for both the rural and urban full samples, health status does not appear to have the same effect on insurance status for workers. Part of this difference may be because those in fair or poor health are less likely to be in the workforce or because workers are likely to have greater access to community rated, and therefore more affordable, health plans than non-workers.

As one would expect, full-time workers are about half as likely to be uninsured during the survey year as part-time workers are. However, for understanding the rural-urban differences in insurance coverage, the most important predictors of being uninsured among workers appear to

be employer size and employee wages. Compared to workers in larger firms, those working for firms with fewer than 20 employees are four times as likely to be uninsured. And, for every dollar increase in hourly wage the risk of being uninsured declines by 16%. Without these two variables in the model, the rural variable is positively and significantly associated with the risk of being uninsured. However, once either of these variables is added to the regression analysis, the impact of rural residence becomes statistically non-significant. These findings echo prior research that has attributed the differences in rural-urban insurance coverage among workers of all ages to these two factors (Coburn et al. 1998).

**Table 5: Effects of Socioeconomic Characteristics on the Likelihood of Being Uninsured for Rural and Urban Near Elderly Workers**

	Logit Model		
	Beta Coefficient	SE Beta	Odds Ratio
Intercept	-54.16	2.79	--
Rural Residence	0.23	.29	1.26
Age (in years)	0.09*	.05	1.09
Marital Status			
No Spouse <sup>a</sup>	--	--	1.00
Married, Spouse Present	-1.45***	.30	0.23
Family Size (in persons)	-0.28**	.11	0.76
Minority Status			
White, non-Hispanic <sup>a</sup>	--	--	1.00
Racial/Ethnic Minority	0.52	.30	1.69
Education			
< High School <sup>a</sup>	--	--	1.00
High School	-0.80***	.24	0.45
Some college or more	-0.70	.42	0.49
Health Status			
Excellent/Very Good <sup>a</sup>	--	--	1.00
Good	-0.11	.26	0.90
Fair/Poor	0.50	.28	1.66
Sex			

Male <sup>a</sup>	--	--	1.00
Female	1.00***	.25	2.73
Hours Worked			
Part-time <sup>a</sup>	--	--	1.00
Full-time	-0.72**	.26	0.48
Hourly Wage (in dollars)	-0.16***	.05	0.84
Employer Size			
20 Employees or more <sup>a</sup>	--	--	1.00
< 20 Employees	1.38***	.24	3.97

<sup>a</sup>Referent

\*\*p ≤ .05; \*\*\*p ≤ .01; \*\*\*\*p ≤ .001

### **SUMMARY AND POLICY IMPLICATIONS**

Although the near elderly tend to have relatively low uninsured rates, the greater health care needs for this age group compared to younger individuals has made insurance coverage for the near elderly an important public policy issue. Those aged 55-64 are much more likely to have chronic health problems than younger groups and consequently face higher utilization and health care costs (Monheit et al. 2001; Johnson 2001). Thus, the access barriers and out-of-pocket costs associated with being uninsured are particularly problematic for the near elderly. Compared to those with health insurance, the near elderly who are uninsured are twice as likely to lack a usual source of care and three times as likely to have an unmet medical need, even when other factors are held constant (Brennan 2000). Demonstrating the potential consequences that gaps in coverage may have on the near elderly, Baker et al. (2001) found that among adults in their early 50's to early 60's, being uninsured doubles the risk that an individual will have a decline in health status. Because we find that the rural near elderly are both more likely to be uninsured and to be in fair or poor health, it will be critical for policymakers to consider the effects of rural residence on strategies for improving coverage for this cohort.

Adding to the policy concerns about improving coverage for this age group, studies have indicated that when the near elderly become uninsured they may have a much more difficult time regaining health insurance than younger groups. For example, Sloan & Conover (1998) found that of near elderly individuals who were uninsured at the beginning of a survey period, only 37% had health insurance coverage two years later. Another study found that, compared to younger workers, the uninsured near elderly workers are one-half to two-thirds less likely to

obtain private or public coverage over the course of a year (Monheit et al. 2001). The authors of the latter study have suggested this disparity occurs because the near elderly have more difficulty finding jobs that offer health insurance or non-group policies that are affordable (Monheit et al. 2001). They further suggest that our public insurance systems fail to act as an adequate safety net to cover gaps in coverage for individuals aged 55-64. These issues may be even more problematic in rural areas as our findings indicate that 14% of the rural near elderly are uninsured for the entire survey year, compared to 10% of the urban near elderly.

In recent years a number of different policy strategies have been proposed for increasing health insurance coverage for U.S. residents as a whole, and the near elderly in particular. These have included proposals to allow individuals to purchase public coverage such as the Federal Employees Health Benefits Plan, or former President Clinton's plan to allow certain near elderly individuals to buy into Medicare. Others have proposed using the tax system to increase the affordability of health insurance through increases in deductions for individual plan premiums and/or tax credits to purchase private coverage. Still other strategies have emphasized market reforms aimed at reducing premium costs in the individual and small group markets, including the creation of purchasing cooperatives or association health plans. Regardless of the strategy selected, our analyses suggest that efforts to improve coverage may affect the rural and urban near elderly differently.

Policies that aim to increase near elderly enrollment in non-group health plans may have limited effects in rural areas. Although the rural near elderly are more likely to get their health insurance from the non-group market, the characteristics of the rural uninsured aged 55-64 will make increasing this type of coverage a particular challenge. Compared to about 43% of the uninsured near elderly in urban areas, more than half of those in rural areas report that they are in fair or poor health. Consequently, individual insurance premiums for this group are likely to be quite high; for example, interviews with insurers found that those with health problems pay as much as twice the premium for individual coverage and many cannot obtain coverage at any cost (Johnson 2001). And although more rural than urban near elderly are likely to be eligible for tax credit proposals such as the Bush Administration's plan to target those with incomes below 200% of the federal poverty level, it is unclear whether the credits will be of sufficient size to encourage broad enrollment for those at this income level (Gabel, Dhont & Pickreign 2002).

Efforts to increase the availability of group coverage for near elderly workers such as small group reforms or the development of purchasing cooperatives could be of great benefit to the rural near elderly if they manage to encourage a greater number of employers to offer coverage. Since some of the disparity in coverage between rural and urban near elderly

workers may be related to the much lower offer rates in rural areas (61% versus 77%) strategies that offer incentives for currently uninsured businesses to begin providing coverage could help the rural near elderly obtain coverage. The fact that the take up rate for near elderly employees is significantly higher in rural than urban areas suggests that near elderly workers who live in rural areas may be willing to enroll in an employer-based plan if one were made available to them. Even if small business proposals reduced the erosion of employer-based coverage, this would be important for the rural near elderly who are much more likely than urban workers to have a job with a small employer. However, it is important to note that more than 60% of the uninsured rural and urban near elderly are not working and consequently would not benefit from employer-based strategies.

Proposals to allow certain near elderly individuals to buy into public insurance programs such as Medicare or the Federal Employee Health Benefits Plan have the potential to dramatically improve access to health insurance for the rural near elderly. However, because these proposed strategies have emphasized the importance of remaining cost neutral, individuals would bear the full cost of enrollment. Although the higher take up rate for rural workers and the greater enrollment in individual plans suggests that rural near elderly are willing to pay high percentages of their incomes on health insurance, those who remain uninsured have significantly lower incomes. As our findings indicate, income is the single biggest predictor of whether or not a rural individual aged 55-64 will be uninsured with an effect that is greater than for urban residents in this cohort. Three-fourths of the uninsured rural near elderly have incomes below 200% FPL. Economic simulations have predicted that only a very small percentage of participants would be poor or near poor, based on the premiums required to make a Medicare buy-in cost neutral (Johnson, Moon & Davidoff 2002). The percentage of enrollees from these income groups increases dramatically, however, if premiums are based on income. These findings, coupled with the known fact that the rural near elderly generally have lower incomes, suggests that premium subsidies will be particularly important to assuring rural participation in any public insurance buy-in option.

Another important consideration for the rural near elderly will be how spousal coverage options are designed. Proposals that rely on making private policies more affordable to the near elderly would likely produce some cost efficiencies for married near elderly couples because the private market already sells spousal coverage plans, where premiums and deductibles are assessed at the family level. However, public program buy-ins would need to consider whether and how they would offer purchasing options for married couples or if each near elderly member in a family would need to buy-in individually. Although being married has a

protective effect against being uninsured for both the rural and urban near elderly, the uninsured members of this age cohort are more likely to be married if they live in a rural area.

Consequently, decisions about how coverage would be made available to married couples would be particularly important to the rural near elderly.

The rural near elderly would benefit from buy-in options that are available to a broader age group. Some policy analysts have expressed concern that improving access to public coverage may hasten the retirement of near elderly workers at a time when the declining workforce already poses a serious threat to the solvency of Medicare (Rogowski & Karoly 2000). The potential effect on the workforce is judged to be higher the more affordable that alternate coverage options become, because fewer near elderly individuals would have to choose between retirement and maintaining access to affordable health insurance coverage. To prevent some of this workforce deterioration, most Medicare buy-in programs have focused on individuals aged 62-64. In order to reduce the adverse effects on the workforce, policymakers could consider alternative deterrents such as charging higher premiums to those who retire early for non-health reasons, in the same way that Social Security payments are reduced for early retirees.

Regardless of the specific policy strategy, it is clear that the uninsured rural and urban near elderly differ in some key ways that would affect the implementation of health insurance expansions for this age cohort. Although workers aged 55-64 face the same types of barriers to health insurance regardless of their residence, factors such as working for low wages or a small business are more prevalent in rural areas. In addition, when considered as a whole, the characteristics that place the rural near elderly at risk of being uninsured are significantly different than for those in urban areas. Consequently, policymakers should be mindful of the unique risks for being uninsured that the rural near elderly face, in order to craft solutions that meet the health insurance needs of this population.

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