

The Importance of Health Insurance and the Safety Net in Rural Communities

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Access to health insurance and health care are critical for people living in rural communities, where the safety net is fragile. However, rural communities face challenges as they enroll uninsured people in the health insurance marketplace, educate newly insured individuals on how to use insurance, and coordinate care for those who remain uninsured.

Prior to the passage of the Patient Protection and Affordable Care Act of 2010 (ACA), the percentage of the population that was uninsured was growing faster in North Carolina than in the rest of the country. To help address the issue, The Duke Endowment convened health care leaders, government agencies, public and private funders, and safety-net organizations from across the state to discuss how North Carolina could work more collaboratively at state and local levels to improve access to care for the growing number of uninsured individuals. As a result of those conversations, as well as recommendations from the 2005 *North Carolina Healthcare Safety Net Task Force Report* of the North Carolina Institute of Medicine (NCIOM), Care Share Health Alliance was created to be a statewide resource. Care Share's goal is to expand and support the health care safety-net infrastructure and to facilitate the development of comprehensive community collaborations that can provide care for low-income uninsured people. Often called collaborative networks, these community collaborations link uninsured people to a primary care medical home, recruit providers, coordinate donated care and services, help to reduce unnecessary emergency department visits, and work to create a sustainable continuum of care for uninsured individuals. Since 2008, Care Share has supported safety-net organizations and community collaborations that serve uninsured people by collecting and disseminating best and promising practices and by partnering with stakeholders to implement ACA outreach, education, and enrollment efforts.

North Carolina's Successful Enrollment Efforts

In the period 2011-2012, one-fifth (20.2%) of nonelderly North Carolinians, or 1.6 million people, were uninsured. People who live in rural areas are about as likely to be uninsured as are those who live in urban areas (20.8% versus 19.5%). However, in 2011-2012, rural North Carolinians were

more likely to be covered by Medicare (21%) or Medicaid (18%) and were less likely to be covered by employer-sponsored insurance (40%) compared to people in urban areas (15%, 11%, and 48%, respectively) [1].

Despite these and other challenges, North Carolina had a very successful first open enrollment period. Between October 1, 2013 and April 29, 2014, North Carolina enrolled 357,584 people via the health insurance marketplace; this put North Carolina 5th in the country for enrollment, behind California, Florida, Texas, and New York [2]. The vast majority (91%) of these North Carolinians qualified for tax credit advanced payments, for a total health insurance subsidy of \$606 million [3]. Although state-specific information was not available, a national Kaiser Family Foundation survey showed that 57% of people who purchased coverage through the health insurance marketplace were previously uninsured. Most of these previously uninsured individuals reported having gone without coverage for 2 years or more, and for many uninsured individuals, passage of the ACA was a motivator in seeking coverage [4]. Additionally, since North Carolina made the decision not to expand Medicaid at this time, the number of North Carolinians who are projected to fall in the Medicaid coverage gap ranges from approximately 300,000 [5] to 500,000 [6]. People in the coverage gap are likely to face barriers to needed health services, and if they do require medical care, they will face potentially serious financial consequences. Thus the safety net of clinics and hospitals that has traditionally served the uninsured population will continue to be stretched [5].

To date, county-level enrollment data are not available to evaluate enrollment in rural areas compared to urban areas. If this information were made available by the marketplace, the data could better inform rural leaders about how to implement best practices, more effectively reach special populations, and target limited outreach and enrollment resources to achieve the greatest impact.

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Preparing for Year 2 Open Enrollment

Many outreach, education, and enrollment lessons were learned in 2013-2014. North Carolina stakeholders met often to share experiences, completed state and national surveys, evaluated their work, collected consumer outcome stories, and participated in community forums to better understand what worked, what did not, and why. During this time, Enroll America—a nonprofit, nonpartisan organization focused on maximizing the number of Americans who are enrolled in and retain health coverage—recognized North Carolina for the state’s collaborative efforts to implement outreach, education, and enrollment strategies by bringing diverse stakeholders together to coordinate logistics and maximize application assistance efforts [7, 8].

North Carolina had both paid and volunteer in-person assisters (also called navigators or certified application counselors), as well as agents and brokers, available in all 100 counties. These individuals conducted outreach and enrollment events, answered consumers’ questions about the process, helped consumers sort through their insurance options, and helped them successfully enroll in a qualified health plan. Additionally, a statewide scheduling system was developed, which allowed consumers to schedule appointments with a navigator or certified application counselor through a local nonprofit organization.

While it was clear that organizations serving the entire state were trying to reach rural areas, they did not have sufficient resources to serve everyone who needed assistance. The only statewide philanthropic organization that targeted its funding to rural communities was the Kate B. Reynolds Charitable Trust [1]. Local, state, and national organizations helped to leverage funding for navigators and federally qualified health centers, but these efforts were largely targeted to communities where Enroll America had a presence, to areas where community or hospital foundations were willing to contribute, and/or to urban areas that had the largest numbers of uninsured people.

The NCIOM Task Force on Rural Health heard presentations from representatives of organizations that were working to provide outreach, education, and enrollment assistance in rural areas. The successes of such efforts were often due to the roles played by physicians, their staff, and health care organizations. Table 1 outlines strategies for how health care organizations can engage with patients and the community in this ongoing enrollment effort.

These strategies are invaluable as rural leaders prepare for the 2nd open enrollment period, scheduled for November 15, 2014 through February 15, 2015. However, rural communities will continue to face unique challenges as they strive to enroll uninsured individuals. Limited resources for in-person assistance, geographic makeup, transportation barriers, and the potential for inclement weather during the enrollment period will require creative thinking and continued collaboration. Table 2 outlines the outreach, education, and enrollment challenges identified by rural leaders [1].

TABLE 1.
Success Strategies for Outreach, Education, and Enrollment in Rural Communities

Health care providers can be important outreach ambassadors. People trust their physicians, nurses, pharmacists, and other health care providers, so it is important to enlist the provider community to disseminate information about the ACA and appropriate referral sources to their patients.
Educate the office staff in health care organizations so that they will engage patients and help refer them to appropriate resources (either inside the organization or to other in-person assisters).
Health care organizations should look at their own populations (in-reach) to identify people who are uninsured and who may benefit from the new coverage options. Once these individuals are identified, the health care organization should reach out to help them understand the new options.
Find other trusted people in the local community to educate community members about the new insurance options. This can include the faith community, schools, businesses, local government, or other community leaders.
Repeat the purpose of the ACA as often as possible. People often need to hear the information about the ACA multiple times before they begin to understand it and/or consider enrolling into coverage.
It is important to go to where uninsured people are; do not expect them to come to you. Aside from hospitals and health clinics, North Carolina agencies have had success reaching uninsured people in churches or other faith-based organizations, at farms or livestock shows, and through cooperative extension programs, libraries, community colleges, and other gathering places.
Work with rural newspapers to disseminate information about local education or enrollment events. The local media look for local stories, so it is important to explain the local connection when talking to the media.

Note. ACA, Affordable Care Act.

Source: North Carolina Rural Health Action Plan: A Report of the NCIOM Task Force on Rural Health [1].

Other Barriers Affecting Enrollment in Rural Communities

Rural beneficiaries may experience barriers that are unique to or more prevalent in rural areas. For example, people living in rural areas have less access to high-speed Internet [9]. Rural beneficiaries also are more likely to report transportation barriers, which could make it difficult for them to get to central locations for enrollment events. Further, the receipt of public benefits carries a stigma for many families, and this is arguably more of an issue in rural areas than in urban areas [10]. It is not yet clear whether the subsidies available through the health insurance marketplace will carry the same stigma as do other types of public benefits. In addition, although the proportion of people who are uninsured may be larger in rural communities, population density is also less in rural areas, so there are fewer total people who are uninsured in rural areas than urban areas. Thus many of the existing outreach, education, and enrollment efforts have focused initially on urban areas [1].

Impact of Getting People Insured

Impact to People

Rural health leaders experience firsthand how lack of health insurance negatively impacts community health, and they have worked tirelessly for decades to collaborate at the state and local levels to address the question of how best to

care for uninsured people. People who lack health insurance coverage have a harder time obtaining the care they need because of cost. National studies show that people who are uninsured are less likely to obtain preventive screening or care for chronic conditions. Uninsured individuals are thus more likely to be hospitalized for preventable conditions, to be diagnosed with late-stage cancer, and to die prematurely than are those with insurance coverage [11]. North Carolina data confirm that adults without health insurance are more likely to report being in fair or poor health, less likely to visit a doctor for a routine visit, less likely to see a doctor when they need care, and less likely to report having a personal doctor than are those with insurance coverage. They are also less likely to have a prescription filled [1].

Although having health insurance will certainly improve these circumstances, some newly insured people are learning that their plans are not as affordable as they initially thought. For example, some people can afford their premiums with subsidy assistance, but they cannot afford the

copayments, deductibles, or prescription costs associated with their new plans. Some of these individuals are returning to collaborative networks and safety-net organizations, often seeking answers to their questions and/or asking to be re-enrolled in the network in order to receive free or reduced-cost health services.

Many collaborative networks are providing important education to newly insured patients to help them understand their health plans. The networks assist people in locating a primary care physician, explain the importance of paying premiums, and educate them about copayments, deductibles, and how best to navigate the health care system. Many of the patients served by collaborative networks have incomes below 200% of the federal poverty guidelines, and this is the first time they have ever had health insurance. There is an incredibly difficult learning curve ahead for patients, providers, and the safety-net system as whole; however, educating newly insured individuals is an important step in improving the health of people in rural communities.

TABLE 2.
Outreach, Education, and Enrollment Challenges for Rural Communities

Many people in rural communities are unaware of the new health insurance options available through the ACA or existing safety-net resources in the community.
Many uninsured people do not understand how health insurance works, in general, or they do not understand the new health insurance options available under the ACA.
Some people in rural communities have a general mistrust of government programs. Many rural people pride themselves on being self-sufficient and do not want a government "handout." In addition, some people are afraid of, or distrust, "Obamacare" and think it is different than private insurance coverage.
Even with subsidies, the premiums are not affordable to some individuals.
Some rural people who are self-employed are ineligible for subsidies because they have deductions that reduce their countable income below 100% of federal poverty guidelines.
A number of uninsured people fall into the coverage gap (eg, they are ineligible for Medicaid but not eligible for subsidies in the marketplace because their income is below 100% of federal poverty guidelines). Several panelists talked about the difficulty in telling people who are ineligible that they are "too poor" to be helped by the ACA. The panelists try to refer the people to safety-net organizations, but the safety-net organizations in many communities are already at capacity and cannot accommodate many new patients or have long waiting times.
Transportation can be a problem for people without their own vehicle. The lack of transportation is a particular problem in rural areas because such areas are less likely to offer transportation.
The North Carolina navigator organizations and federally qualified health centers created a statewide appointment scheduler to assist people in finding an in-person assister who can talk with them about enrollment and insurance options. However, the scheduler does not include all of the other certified application counselor agencies and does not have enough appointments listed to meet the needs of all the people who want to talk to in-person assisters. The number of people and the amount of time are both insufficient to reach all the people who are uninsured.

Note. ACA, Affordable Care Act.
Source: North Carolina Rural Health Action Plan: A Report of the NCIOM Task Force on Rural Health [1].

Impact to Providers

As mentioned previously, North Carolina has 357,584 people who were previously uninsured but who were recently able to purchase coverage through the health insurance marketplace. This increased access to health insurance is not only good for individuals, it is also critical to sustaining a fragile safety-net system that relies heavily on providers who volunteer their time and donate services for uninsured patients [12]. Safety-net organizations and private providers must have a diverse payer mix to sustain their clinics; insured patients free up resources so that clinics can provide health services to those who cannot pay, do not qualify for Medicaid, and/or are ineligible for subsidized health insurance through the marketplace. For example, approximately 88% of the patients currently served by the James D. Bernstein Community Health Center in Greenville are uninsured; this is not a sustainable model for any safety-net provider, as community health centers and free clinics are being forced to seek more funding from grants and/or other sources in order to stay operational. Physicians, hospitals, and other providers may not have the capacity to donate as much free care as they have historically; thus their policies may change, and fewer people may be eligible for free care, charity care, or other safety-net programs. We will need to be mindful of how health reform and environmental changes—such as the shortage of providers serving rural areas, cuts to reimbursements, and more newly insured patients seeking a primary care medical home—will impact a physician's capacity and his or her ability to donate care to those who remain uninsured. This will be a delicate balancing act for everyone involved. Fortunately, rural communities are well positioned to meet this challenge given their experience and ability to collaborate to solve problems, take advantage of new opportunities, and leverage limited resources.

Conclusion

Access to health insurance and high-quality health care are critical to rural communities, where the safety net is fragile and reliant on providers to donate care. Although rural communities face outreach, education, and enrollment challenges, they experienced tremendous success in the first year of implementing one of the most ambitious health system reform initiatives since the creation of Medicare and Medicaid. Rural communities are uniquely qualified to help their uninsured residents get and keep health insurance coverage, either through enrollment in Medicaid or through the health insurance marketplace.

As we plan for the future of rural health, we are excited about the recommendations outlined in the 2014 *North Carolina Rural Health Action Plan*, especially those addressing provider shortages, access to health insurance, and the safety-net system [1]. If implemented well, we believe these initiatives will improve rural health, build stronger communities at both the individual and population health levels, and help to sustain North Carolina's safety-net system. This system is needed today as much as ever to ensure that our most vulnerable neighbors receive access to the quality health care they need. NCMJ

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