

Review & Commentary on Health Policy Issues for a Rural Perspective - November 1<sup>st</sup>, 2002

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## Health Insurance Fails The Heartland

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From "The Health Care Crisis Among Wisconsin Dairy Farmers," *Wisconsin Family Farm Facts No. 17* from the Program on Agricultural Technology Studies, University of Wisconsin, 9/02:

"Wisconsin dairy farmers and their families lack the health insurance coverage that most Wisconsin families take for granted. Five basic facts illustrate the crisis of health insurance coverage that plagues Wisconsin's dairy farmers."

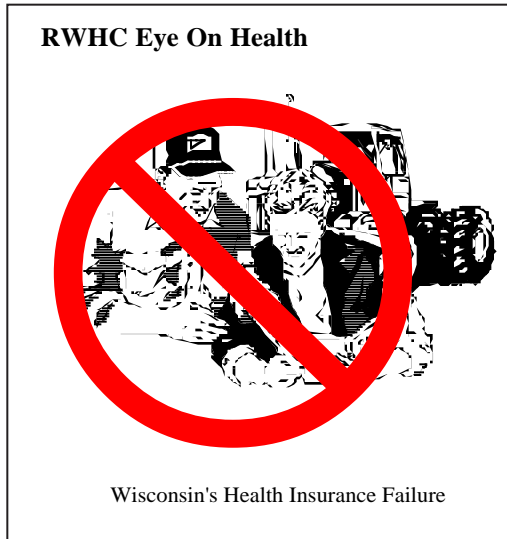
- "Dairy farming is one of the riskiest occupations.
- Almost 20% of Wisconsin dairy farm families are completely uninsured.
- About another 25% of Wisconsin dairy farm families have at least one uninsured family member.
- Four out of five Wisconsin dairy farm families have no preventive care coverage. Most of those with insurance have only major medical coverage with high deductibles.
- These rates of being uninsured, underinsured, and lacking preventative care coverage for dairy farmers and their families are far above the state average for non-farm households."

"Wisconsin dairy farmers work in one of the most dangerous occupations in the United States, and thousands of them and their families are at an even higher risk because they do not have adequate health insurance coverage. This situation is not only bad for Wisconsin's farm families but also for the vitality of the dairy sector, an industry that generates billions of

dollars of farm and manufactured product sales and is the backbone of the state's agricultural sector."

"This fact sheet looks at this critical issue, using the results of a PATS survey that was sent to a random sample of 1,600 Wisconsin dairy farms in the spring of 2001, with a response rate of 56.1% (N = 869)."

**"Uninsured Dairy Farmers** Almost 1 out of 5 (18%) of the dairy farmers who responded to the PATS 2001 Wisconsin Dairy Farm Poll had no insurance at all. This rate is more than twice the state average of uninsured (7.4%) reported by *The Capital Times* for all Wisconsin residents and more than four times the rate (4%) reported by the Department of Health and Family Services. Dairy farmers are almost twice as likely as other farmers to be uninsured. Dairy farmers without insurance coverage are most likely to be recent entrants into the business, young, operate a small enterprise, and/or have dependent children."



**"Underinsured Dairy Farmers** Almost one in four dairy farmers (23%) did not have health insurance for everyone in their family. The term *underinsured* refers to a household in which at least one family member, either the farm operator, spouse or children under age 18 living in the household, was not covered by health insurance. They tend to have medium-size operations and to be older than the other two groups."

**"Dairy Farm Families with Health Insurance**—Only 59% of the dairy farmers surveyed had health insurance coverage for all family members (*fully insured*). However, health insurance for these farm families was often not comparable to their urban counterparts who obtain their coverage through an outside employer. Almost two-thirds (64%) of the dairy farmers reported that they direct-purchased their health coverage from a private insurance provider. This type of health insurance coverage tends to be

more expensive and lower quality than the coverage of most Wisconsin residents. Many of the insurance policies that farmers purchase directly lack coverage for preventive care, which means more out-of-pocket expenses for health costs.”

“Another 28% of farm families received their health insurance through a family member’s off-farm employment, and less than 1 in 10 (6.4%) of farm families received their insurance through their local cooperative.”

“Even for the dairy farm families with health insurance coverage for all family members, most only had major medical policies that covered catastrophic events with a high deductible for basic treatments. These policies often lack preventive care that meets the daily needs of these farmers and their families. In fact, only 1 out of every 4 underinsured or fully insured had coverage that paid for any preventive care.”

**“Challenges to the Health Insurance Crisis**—Attempts to address the health insurance needs of farm families and other uninsured or underinsured Wisconsin citizens have been pursued, and are worth a brief review. In general, the programs have features that may limit their participation:”

**“Badger Care**—Less than 5% of the dairy farmers surveyed participated in the Badger Care Program, a statewide program currently targeted at uninsured children. While Badger Care works for some families, there are several barriers that limit eligibility for many farm families: depreciation (on assets) is

treated as income, falsely inflating the incomes of farmers; only families with children under 19 living in the household are eligible; and, some rural physicians do not accept payment through this program.”

**“Insurance Pools**—A number of proposals exist to encourage health insurance pooling in which small business owners (2-50 employees) are included in a common insurance pool to spread out the risk. Participants/members negotiate collectively with a health insurance provider for coverage terms at an affordable rate. Among the proposals in Wisconsin are the State’s Private Employer Health Care Coverage Program (PEHCCP) and some local proposals for ‘purchasing alliances’. Two issues, however, are likely to limit the usefulness of these programs in providing health care coverage for dairy farmers.”

- **“Eligibility:** Most of these proposed programs, by state law, are for businesses with two or more employees, which exclude many small dairy farms that would be classified as having a single employee.”
- **“Affordability:** Because farming is an occupation associated with high risks, insurance companies would charge high rates for a pool that included only farmers.”

**“Medical Savings Accounts (MSAs)**—An MSA allows self-employed individuals to set up a medical savings account, much like a retirement account, that is tax-free as long as the money is used for medical expenses. To be eligible for this program, the MSA must be accompanied by a qualifying insurance policy with high deductibles (\$1,650 for an individual, \$3300 for a family). While this program may help reduce costs for those farm families who already direct purchase health insurance policies, it does not seem to provide much relief for those without insurance.”

**“Conclusion**—The fact that Wisconsin has a relatively small percentage of the total population that is uninsured masks critical problems of inadequate health care insurance for certain populations such as Wisconsin’s dairy farmers. As long as these differences exist, policy makers will be challenged to find resourceful ways to make certain that health insurance coverage is affordable, available and accessible for all Wisconsin citizens.”

“Because there is not a ‘one-size-fits-all’ solution to this problem, multiple strategies need to be developed that allow quality health care to be provided for Wisconsin dairy farmers and others in rural areas. When the lack of adequate, affordable, and accessible health insurance enhances the likelihood that dairy

The **Rural Wisconsin Health Cooperative**, begun in 1979, intends to be a catalyst for regional collaboration, an aggressive and creative force on behalf of rural communities and rural health. RWHC promotes the preservation and furthers the development of a coordinated system of rural health care, which provides both quality and efficient care in settings that best meet the needs of rural residents in a manner consistent with their community values.

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farmers will choose to exit from, or not even enter, the business, there is often a loss of skilled labor and economic activity from rural areas. This exodus not only affects the economic viability and quality of life of the communities in which they live, but also the whole agricultural sector and the entire state as well.”

tions for which catastrophic care coverage is provided.”

“ ‘Instead of having an employee simply pay a minimal out-of-pocket co-pay of \$10 or \$20, consumer-driven plans force individuals to put a little more thought into how and why they use a service,’ said Jon Rauser, president of The Rauser Agency Inc., a Milwaukee insurance brokerage. He cited as an example an athletically oriented person who may be in perfect health, but chooses to get occasional shots of cortisone or physical therapy treatments in order to remain active in a particular sport or activity. ‘Those treatments would generally be covered by money in a health account of a consumer-directed plan,’ Rauser said. ‘If I have a medical savings account, then I’m thinking twice about how that money is spent,’ he said.”

“Other consumer-driven plans categorize prescription drug benefits or physician and hospital benefits into different tiers based on monthly premiums. Employees then choose the tier they want. The savings for employers comes from stabilizing their expenditures shifting more responsibility to employees. ‘From an employer’s perspective, it’s one of the best answers out there,’ said Mueller. ‘It’s an acknowledgment that here’s a fixed amount of money for health insurance and the employee must make some decisions. It’s not only a trend, it’s here to stay.’ ”

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## Health Insurance Mess—Private Sector Fix?

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From “Can consumer-directed plans slow down health costs? Experts: They’ll help, but they aren’t a total cure” by Phill Trewyn in *The Business Journal of Milwaukee*, 10/11:

“As more employers adopt consumer-directed health plans to control escalating insurance costs, brokers and consultants agree the plans are not a cure-all for escalating health care costs.”

“ ‘There is no silver bullet,’ said Bob Heaps, senior vice president at Aon Consulting in Milwaukee, terming the plans only a partial answer. Consumer-directed health plans place more responsibility with employees to decide when and how to utilize their health insurance, but they don’t address labor shortages, Medicare and Medicaid reimbursement shortfalls, and advancing technology—all commonly accepted reasons for escalating health care costs.”

“ ‘But the plans are able to impact how health care services are utilized,’ Heaps said. ‘The mentality of medical benefits in this country centers around entitlement,’ he said. ‘We have to change that mentality, and consumer-drive products can do that.’ ”

“ ‘About a third of all spending on health care is discretionary,’ said Jim Mueller, president and chief operating officer of Frank F. Haack & Associates Inc., an insurance brokerage in Wauwatosa. ‘If it’s my money that’s being spent and not the employer’s money, that kind of thinking can eat away at unnecessary utilization,’ he said.”

“In one plan model, medical savings accounts, employees can tap an account with a fixed amount of money designated for ordinary health expenses or preventive care. Once that account is depleted, the employee pays a high deductible for any additional health expenses, not counting serious condi-

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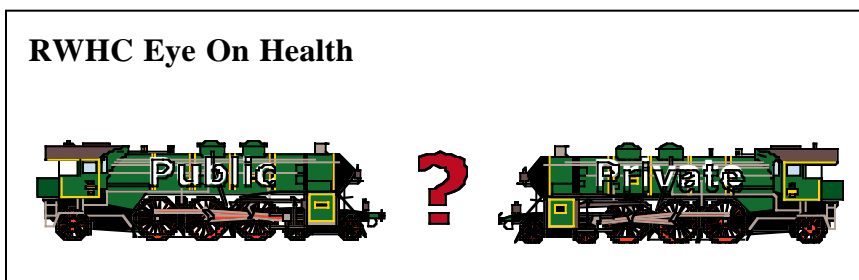
## Health Insurance Mess—Public Sector Fix?

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From “AFL-CIO health plan gains steam. Some businesses support it; others oppose ‘payroll tax’ ” by Phill Trewyn in *The Business Journal of Milwaukee*, 10/11:

“Some business executives are embracing a statewide health care plan championed by the Wisconsin AFL-CIO that would be financed by a payroll tax. The comprehensive health plan, designed to address escalating health care costs, would be run by a state commission.”

“Two of the state’s leading business groups oppose the AFL-CIO’s concept. Wisconsin Manufacturers & Commerce says mandating every employer to fund the plan would be unfair to small businesses. The Wisconsin Chapter of the National Federation of In-



dependent Business is against ‘an assessment on payrolls,’ said state director Bill Smith.”

“Despite the business lobby group’s concerns, some business owners and executives regard the plan as a possible solution to 20 to 30 percent annual increases in insurance premiums. ‘I’m a staunch Republican, small-government guy, but I’ve reached my breaking point,’ said Dick Marsek, owner of Maintenance Services Co., a rebuilder of machine tools in West Allis. ‘We need a solution, and a bold solution.’ ”

“Executives at Waukesha Engine, with 870 employees in Waukesha, and Mercury Marine, with 3,500 employees in Fond du Lac, aren’t dismissing the plan, but have yet to back it. ‘We haven’t endorsed any specific plan at this point, but we have to do something,’ said Jim Hubbard, chief of staff at Mercury Marine. Mercury Marine has been confronted with health insurance cost increases of 30 percent over the past two years. ‘Anything that lowers health care costs is worth looking at,’ Hubbard said.”

“The AFL-CIO plan calls for a commission that would develop and oversee a comprehensive health insurance plan. Wisconsin employees, public and private, would be covered by the plan, as would their dependents. The plan would be financed by an employer-paid assessment on each employee, determined by the commission. Employers could still offer—and unions could still bargain for—employer payment of co-pays and deductibles.”

“The precedent for a state-run commission has been set with the workers’ compensation and unemployment compensation commissions,’ David Newby, president of the Wisconsin AFL-CIO, said. Newby would like to see legislation drafted to create a commission during the next legislative session, which begins in January.”

“Wisconsin Manufacturers & Commerce is not supporting the AFL-CIO plan,’ said James Buchen, vice president of government relations for the organization. ‘In our view, it has serious drawbacks,’ he said. Mandating every employer in the state to fund the plan, he said, is unfair to small businesses that may not offer health insurance at all. ‘In many cases, small companies are the type of business the state should want to attract, not discourage with additional taxation,’ he said. Buchen is also concerned the appointed commission would be the focal point of political battles between health care providers and employers over funding the health plan. ‘Payers would want to pay less, and providers would want more,’ he predicted.”

“The Wisconsin Chapter of the National Federation of Independent Business shares similar concerns,’ said state director Smith. ‘We’re not going to support an assessment on payrolls,’ he said. ‘The same results the AFL-CIO plan is touting can be accomplished through a small employers’ purchasing pool, without an assessment,’ he said. The purchasing pool concept supported by the NFIB has yet to receive legislative support, however.”

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## CAHs—Medicare Giveth, Medicare Taketh?

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Editorial by Tim Size:

Critical Access Hospitals (CAHs) in Wisconsin and elsewhere are beginning to be threatened with statements by some (not all) Medicare/Medicaid health plans—“sign the contract or you will lose patients to our plan’s sponsoring urban hospitals, basically “take it or leave it.”

The health plan’s offered payment is significantly lower than what CAHs, identified by State and Federal government as necessary providers, would receive as a direct payment from Medicare or Medicaid. There is a growing concern by CAHs and potential CAHs, that as more Medicare and Medicaid (including BadgerCare) patients are channeled through health plans, they will be forced into contracts that significantly undermine CAH Federal-State initiative.

At this time in Wisconsin, we see Medicare+Choice Plans beginning to market in rural areas as these areas previously had some of the lowest Medicare per capita expenditure rates in the country. Obviously, there is not now a lot of rural Medicare+Choice Plans around the country but problems have been more frequently reported with Medicaid HMOs. In addition, we are concerned that many of the Medicare reform proposals make much greater use of health plans, making this a potentially major threat to our efforts to create a stable rural health infrastructure.

It is our understanding that the federal regulations governing Medicaid managed care contracts requires health plans that contract with Federally Qualified Health Clinics (FQHC) or Rural Health Clinics to pay them cost-based reimbursement if the FQHC wishes that arrangement.

It is hoped that the federal Department of Health & Human Services will work to implement similar regulatory protection for CAHs so they do not lose the promise of financial stability so recently acquired.

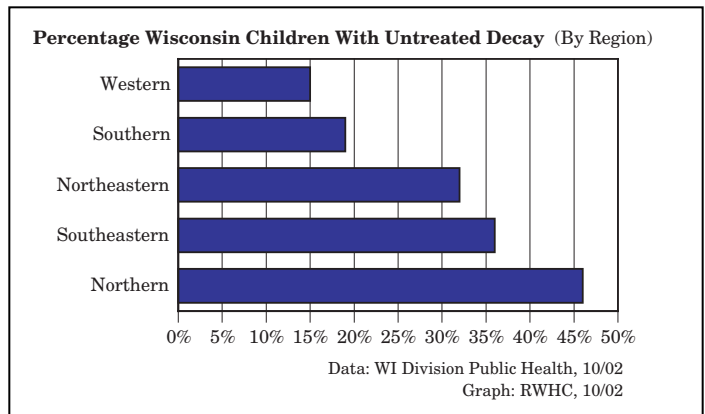
## Dental Status Quo Maintains Status Quo

From "The Growing Challenge of Providing Oral Health Care Services to All Americans by Elizabeth Mertz and Edward O'Neil in *Health Affairs*, 10/02:

"The authors find 'abundant evidence that a sizable segment of the population does not have access' to private care, while the dental safety net is 'poorly defined and underdeveloped.' Dentists' participation in Medicaid is not robust; community health centers and public health facilities have scant dental capabilities; and Medicare offers no dental coverage. 'Radical steps' will be needed to correct 'a growing disconnect between the dominant pattern of practice...and the oral health needs of the nation,' the authors write, including new practice settings for dental care, integration of oral and primary health care, and expanded scope of practice for hygienists and other allied professions."

"By many measures, the practice of dentistry has improved for the dentist over the past decade. Hours of work are down, and compensation is increasing. However, there is a growing disconnect between the dominant pattern of practice of the profession and the oral health needs of the nation. To address these needs, the profession will need to take some radical steps toward redefinition, or the responsibility for many for these needs and special populations may shift to other providers and other institutions."

"New restorative techniques, coupled with the middle-class cultural expectation of the annual dental check-up and the disposable income to pay for these preventive and therapeutic services, has led to improved oral health for many parts of the population. Although these improvements in oral health are a great success story for the dental profession, science, and the public, patterns of current and incipient oral disease and disability lie outside much of the traditional focus of practice and policy. Emerging concerns for the nation's oral health include access to care for low-income and underserved minority groups, oral diseases related to tobacco use, chronic facial pain, craniofacial birth defects and trauma, and



the emergent health needs of an aging population that will need services in new locations and forms."

"The recent surgeon general's report cataloged the advances that have been made in the technology and science of oral health care but also clearly showed that there are worsening disparities in the oral health status for certain population groups. Underserved groups include people who are low-income or indigent; live in rural communities; are racial or ethnic minorities, non-English speaking, children, or elderly; and are developmentally disabled or have major medical problems. Each of these populations faces sizable barriers to care, and all are at a notable disadvantage with poorer health outcomes. Socioeconomic status tends to be the most important indicator for use of services and health outcomes, regardless of race and gender, while people with dental insurance have a higher likelihood of visiting a dentist than do those without."

"In no small measure, this is attributable to the current practice model of dentistry, which is structured to serve insured patients or patients who have the disposable income to pay for services out of pocket, in areas served by dental providers. Moreover, dental education trains new providers within the current practice model, leaving little room for developing a different type of practitioner that might

appropriately address unmet needs. There is limited public financing for oral health care services outside of private dental offices. The dental safety net is small compared with the medical safety net, and many safety-net providers are underfinanced, understaffed, and overburdened."

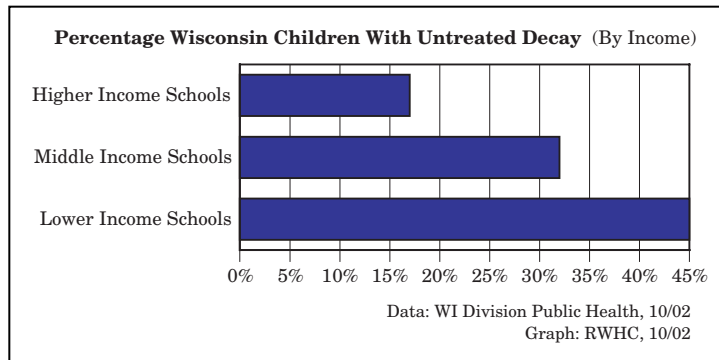
### RWHC Eye On Health



"The problem is not too few dentists but too many kids."



“Practitioners operating in the traditional delivery service model are able to sustain and increase income while working shorter hours, so they have little financial incentive to modify their practice. This lack of incentive, the limited supply of dentists, and the lack of alternatives for delivery and financing of care mean that much of the population with the greatest and fastest-growing set of needs will continue to be underserved by the traditional system of private practice, fee-for-service dentistry.”



**“Meeting the challenges of reducing disparities in oral health care will require fundamental redefinitions of how dental practice is organized, financed, and provided.** In the long run, it would seem that systems of oral health care must be either directly integrated into larger systems of care or more effectively articulated with them. Financing of care must be realigned to pay for proven and effective interventions. Finally, the education of dental professionals must focus on community health and well-being, in addition to individual treatment and private practice.”

“Current Crisis of Care—A system of dental care that will begin to address the unmet health needs of a growing part of the population will likely need to move beyond the existing system of finance, practice organization, and professional utilization. The standard response to the lack of dental services is to suggest increasing the number of dentists. Some increase may be warranted, and perhaps inevitable, but it may be more useful to understand this problem less as a problem of supply of practitioners and more as a poor fit between part of the current practice model, the patterns of disease, and the people needing care. Such a change will raise several critical questions, such as the following: Where do those who have the greatest oral health needs receive other health care? What physical and financial impediments could be removed to facilitate meeting current and future demand? Are there social service or employment settings that might effectively sponsor oral health services? What motivations might bring the underserved more seamlessly into a system of care? How can expectations regarding oral health be raised within the underserved population?”

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### Active Work Once A Day Keeps Doctor Away

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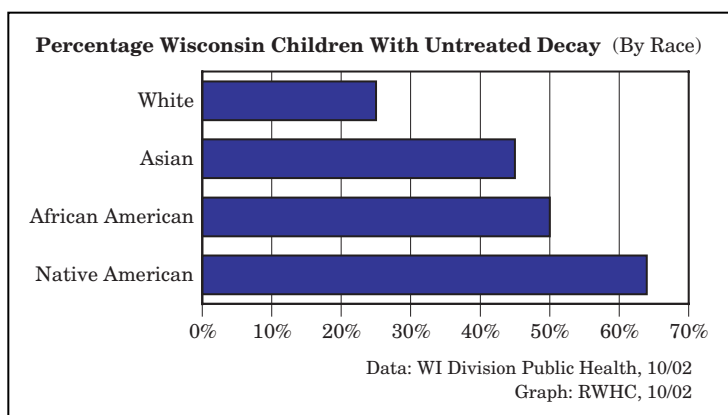
From “Less Wealth, More Health?” by Richard Morin in *The New York Times*, 9/29/02:

“Social scientists have known for decades that wealthier people tended to be healthier people. Now, a clever new study of older Americans turns that conventional wisdom on its head. The study suggests that not only does more money fail to promote health among the elderly, it may indirectly shorten their lives, claim University of Maryland researchers Stephen E. Snyder and William N. Evans in a paper published this month by the National Bureau of Economic Research.”

“Their study attempted to partially answer a classic chicken-and-egg problem: Which comes first, health or wealth? Researchers have long believed that the two are strongly and positively associated and that this relationship may have grown stronger in recent years. Even among older Americans, a substantial bank balance seemed to go hand in hand with good health, previous studies have found.”

“But correlation is not causation. Perhaps affluent people were healthier because they earned more—the magic money theory. Or perhaps healthier people made more money because they were physically able to work harder, had fewer absences, or had more time or financial resources to acquire skills that won them bigger raises and faster promotions.”

“Snyder and Evans looked a difference in individual earnings from the real world that would allow them to



### Wisconsin Health Care Workforce Plan Released--

Department of Workforce Development Secretary Jennifer Alexander and Wisconsin Technical College System State Director and President Richard Carpenter co-chaired this critical initiative to recommend solutions to the health care worker shortage in our state. The committee and workgroups included members representing health care providers, labor, health care associations, consumers, PK-20 education, and state government. The full report is available at < [www.dwd.state.wi.us/ghwcsc/](http://www.dwd.state.wi.us/ghwcsc/)>.

test the effects of income independent of initial health status.”

“They found exactly what they were looking for in the ‘benefit notch’ created in 1977 when the federal government lowered Social Security benefits for new recipients born on or after Jan. 2, 1917. The change meant that someone born on Jan. 2, 1917, would collect about 7 percent to 10 percent less in Social Security benefits than someone whose birthday happened to be Dec. 31, 1916.”

“Specifically, the researchers looked at mortality rates of individuals born in the last three months of 1916 and compared them to those of people born in the first three months of 1917. Each group included about 250,000 individuals. They found no meaningful differences between the two groups in terms of overall health, income, education levels or mortality rates through age 65, when the bulk of them were collecting Social Security.”

“But after age 65, something unexpected happened. Over the next five years, ‘the group with substantially lower Social Security payments actually had a mortality rate about 2 percent lower than the older comparison group,’ said Evans. And this curious pattern continued beyond age 70, they found. That’s exactly the opposite of what should have happened if more money promoted better health.”

“ ‘What’s going on here? We aren’t exactly sure. But we have a hunch,’ Evans said.”

“ ‘In this particular case, when the younger group started to retire, they had lower Social Security payments, which surprised them,’ he said. ‘When we examined their work histories, we found that this younger group were more likely to be working than the

older group. So one possible explanation is that **there is some health benefit to staying engaged and staying in the work force,** at least on a part-time basis—a benefit confirmed in other studies of older Americans.”

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## American Gothic—The Ongoing Stereotypes

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From “Rural Realities” by Thomas D. Rowley from his online series of commentaries at the Rural Policy Research Institute web site < [www.rupri.org/](http://www.rupri.org/)>, 9/26: “

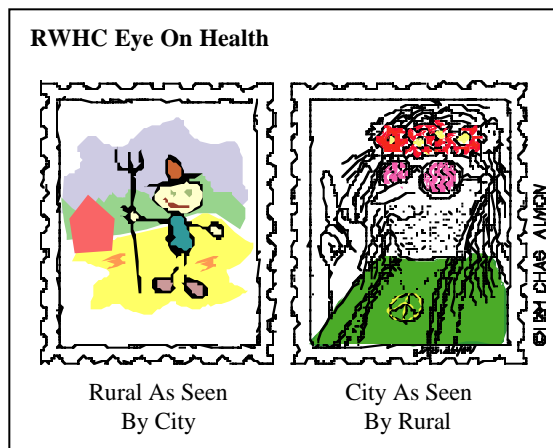
“Here now, a few of the most popular—and pernicious—misperceptions.”

“The first, most obvious, and yet most persistent misperception is that agriculture is THE economy in rural America and therefore agricultural policy is THE rural policy. Such thinking enabled Congress in the recent Farm Bill to favor the production of crops over the revitalization of rural communities by about 180 to 1—dollars, that is.”

“The reality is otherwise. Important as agriculture is to our communities, nation, and the world, the U.S. agricultural economy depends on the non-agricultural rural economy—not vice versa. Indeed, more than 80 percent of the total income earned by farm operator households across the nation comes from work other than farming, and fewer than one-fourth of farm families get the majority of their income from farming. In addition, farmers account for about 5 percent of all rural jobs. Add in all of the jobs that depend on agriculture for their existence and you’re talking about only 25 percent.”

“The second misperception is really two in one—opposite sides of the same coin. On one side, many folks think that all is well in rural America. For them, rural conjures up images of bucolic landscapes and close-knit communities free of poverty, crime, pollution, and all of the ills of big-city living. Through these glasses, rural people are all honest and hard-working—the moral fiber of our country, the backbone of our society.”

“On the flip side, many folks think that all is bad in rural America. For them, rural conjures up backwater places, narrow-minded people, and hard-scrabble living. This, one might guess, is the dominant view at



CBS and Fox, where rural America apparently means hillbillies, hicks, and hilarity.”

“The reality is, of course, somewhere in between. Because rural America is far from homogenous (another misperception), who and what you find there varies quite a lot. As with most places, there is good and there is bad, things that should be celebrated and things that must be fixed.”

“The third misperception is also of the thesis-antithesis variety. Thesis: the problems of rural America are merely the results of market economics. For example, the level of any particular good or service in rural America—whether broadband telecommunications, health care, or venture capital—is what it is because the markets have acted rationally, efficiently, and (according to some) optimally.”

“Antithesis: the problems of rural America are largely the doings of governmental (particularly federal) meddling, incompetence, and downright exploitation. From this perspective, the best thing government can do runs the gamut—from paying larger farm subsidies to putting in broadband to leaving rural America the heck alone.”

“Again, the reality lies in between. Markets do fail, and government does get some things right. “

“The final two misperceptions go hand in glove. Fourth, the ‘rural problem’ is really a dilemma; no satisfactory solution exists. Fifth, it doesn’t matter anyway because rural America will always be there, and even if it weren’t there, we’d get along fine without it. As to the fourth misperception, yes, rural problems continue but some progress has been made and still more can be made—if we clear up the misperceptions and take action based on the realities.”

**11th Annual, \$1,000 Prize  
for the Best Rural Health Paper  
by a University of Wisconsin Student**

The Hermes Monato, Jr. Essay Prize of \$1,000 is awarded annually for the best rural health paper. It is open to all students of the University of Wisconsin. Students are encouraged to write on a rural health topic for a regular class and then to submit a copy to RWHC an entry by April 15th. Previous award winners and titles (and some of papers) as well as judging criteria and submission information are available at: [www.rwhc.com/essay.prize.html](http://www.rwhc.com/essay.prize.html)

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