



Underinsurance among Farm and Ranch Families and Other Small Business People Undermines Benefits of Insurance Coverage

I. Introduction

Health insurance coverage is often the measure of access to health care. However, not all health insurance plans provide adequate financial protection and access to health care. Employer-based group insurance policies are the source of health insurance for most Americans, but such policies are not usually available to farm and ranch families and other selfemployed people. They are thus often forced to purchase individual policies in the non-group market.

These non-group policies are extremely expensive and often offer limited benefits, thereby leaving people “underinsured” and at risk of incurring substantial medical expenses. The burden of these healthcare costs threatens not only the financial security of their families but also, as revenue available for supporting these businesses is drained off to pay for medical care, the sustainability of their farms and ranches or other small businesses. These problems will only worsen in the currently deteriorating economic environment. The agricultural industry generates billions of dollars for our US economy and yet policy makers are not aware of one of the major threats to the family farm and small businesses generally: lack of affordable and adequate health insurance coverage.

As insurers shift costs to consumers in the form of higher deductibles, co-payments, and uncovered services, the insured are at growing risk of incurring medical bills they cannot afford. This may be especially true in rural areas, where residents have lower incomes, are less healthy and are older than people living in urban areas, and are less likely to have comprehensive private insurance. Thus, both lack of insurance and inadequate insurance can result in unaffordable medical bills for patients, which leads to health access and financial problems. For providers, these unaffordable bills result in unreimbursed costs and bad debt. While Medicare and Medicaid are still the principal payers for rural providers, it is estimated that one-quarter of revenues generated at rural health clinics come from commercial insurers. Rural providers have reported that in many instances patients with private health insurance and high deductibles or coverage exclusions receive no insurance reimbursement for clinic services. Increasingly, rural providers are indicating that inadequate reimbursement from private health insurance is contributing to their financial woes.



II. Key findings from five surveys of health insurance coverage for farm families

1. Survey of family farmers and ranchers in seven Great Plains states: Iowa, Minnesota, Missouri, Montana, Nebraska, North Dakota, and South Dakota. The Access Project contracted with the National Agricultural Statistical Services of the USDA to conduct the randomized telephone survey of 2,017 farm and ranch operators. This survey was conducted in 2007.
2. Survey of family farmers and ranchers in California by The Access Project. This survey, also conducted with the USDA, used the same randomized methodology as the survey of family farmers and ranchers in the Great Plains states (cited above). The survey, which was conducted in 2008, had 1,787 respondents.
3. Survey of Iowa farm families conducted by AgriSafe of Spencer Hospital and the AgriSafe Network. This survey measured underinsurance among a random sample of 2000 Iowa farms in 2001 and 2000 Iowa farms in 2004, of which approximately 41% participated (1,637). It was also conducted in partnership with the USDA National Agricultural Statistical Services field office.
4. Survey of Kansas farm families on medical debt and access to health care conducted by The Access Project in 2006. The study included 281 randomly selected Kansas farmers.
5. Survey of Wisconsin Farmers by The University of Wisconsin Program on Agricultural Technology Studies. The study surveyed 869 dairy farmers in 2002.

Findings: Source of Health Insurance

Much research has documented that non-group policies tend to cost more and provide less coverage. Nationally, only 8% of the American population has health insurance through non-group policies. However farmers have disproportionately high rates of coverage purchased in the non-group market.

- In the Great Plains states, 36% of respondents had insurance coverage through non-group policies.
- In California, 30% of respondents had coverage through the non-group market.
- In Iowa, 55% of respondents had coverage through the non-group market.
- In Wisconsin, 64% of the dairy farmers had coverage through the non-group market. More than one-half (58%) of those with insurance had only major medical policies.



Findings: Cost of Health Insurance

In the Great Plains states, 44% of respondents spent more than 10% of their income on health insurance premiums and out-of-pocket medical expenses. 23% of respondents said they felt health care costs contributed to their financial problems. This group spent on average 42% of their income on premiums and out-of-pocket costs. On average, those with non-group insurance spent \$11,200 on insurance premiums and out-of-pocket costs, compared to \$5,600 for those who obtained insurance through off-farm or off-ranch employment, and \$3,600 for those who obtained insurance through government sponsored programs. About 20% of survey respondents had outstanding debt that resulted from unaffordable medical bills.

In California, 31% of respondents spent more than 10% of their income on health insurance premiums and out-of-pocket medical expenses. 20% of respondents said they felt health care costs contributed to their financial problems. This group spent on average 37% of their income on premiums and out-of-pocket costs. On average, those with nongroup insurance spent \$8,500 on insurance premiums and out-of-pocket costs, compared to \$4,630 for those who obtained insurance through off-farm or off-ranch employment, and \$4,620 for those who obtained insurance through government sponsored programs.

In Iowa, one fourth of farm households spent more than 25% of their income on health care. Iowa farm families who purchased their insurance in the non-group market paid twice as much in premiums and out of pocket costs compared to those with employer-based coverage. Iowa farmers who were covered through non-group policies were more likely to become uninsured in the near future. In Kansas, nearly 3 in 10 (29%) respondents under the age of 65 had medical debt.

Findings: Access to Care

In the Great Plains states, 17% of respondents said they or a household member delayed seeking needed health care. Of these, about 70% said the primary reason for the delay was because care was unaffordable. 42% of respondents had dental insurance, compared to 60% of non-elderly adults nationally who had private dental coverage in 2004. Only 12% of those who purchased coverage in the non-group market had dental insurance, compared to 64% of those who obtained insurance through off-farm or off-ranch employment.

In Wisconsin, 4 out of 5 Wisconsin dairy farm families had no preventive care coverage. Most of those farmers had only major medical coverage.

In Kansas, younger farm families typically purchased minimal catastrophic or high deductible health care coverage that did not adequately prepare them for illness or



accident. About a quarter (24%) of those with debt delayed dental visits, 32% delayed doctor visits, and 11% delayed filling prescriptions.

In Iowa, those who purchased coverage in the non-group market were less likely to have dental and prescription drug coverage.

Table 1: Benefits of Health Plan by source of insurance coverage among Iowa Farmers

	Employer-based health insurance	Non-group health insurance
Prescription drug coverage	91%	68%
Dental coverage	50%	14%

Almost 25% of Iowa farmers with non-group coverage had only major medical plans that included high deductibles. High deductibles limit a family's ability to use preventive care. Both men and women with non-group coverage were less likely to receive important preventative services than those farmers covered by an employer-sponsored plan.

Table 2: Use of Preventative Services by source of insurance coverage among Iowa farmers.

	Employer-based health insurance	Non-group health insurance
<i>All survey respondents</i>		
Office visit in past year	83%	77%
Blood pressure in past year	83%	78%
Cholesterol in past year	52%	47%
<i>Women age 19-64 years</i>		
Gynecological exam in past year	70%	55%
<i>Children under 11 years</i>		
Well child visit in past year	61%	44%

Findings: Satisfaction with Health Insurance Coverage

Iowa families with non-group insurance were significantly less satisfied and less likely to understand their health plan. Farmers may perceive that their plan is comprehensive only to discover after a medical event that their plan is inadequate and requires high out-of-pocket expense.



Table 3: Concurring responses to following statements by source of insurance coverage among Iowa farmers.

	Employer-based health insurance	Non-group health insurance
Paying for health care services is a financial burden	69%	83%
Health insurance adequately covers the health care needs of my household	70%	51%

According to a dairy farmer in the 2002 Wisconsin study, “I think (health) insurance is terrible. We pay \$987 per month for 3 people with a \$1,000 deductible for each person. That takes a lot of our income.”

III. Policy Recommendations and Justifications

Health insurance is critical for farmers, ranchers, and other self-employed and small business people to access appropriate health care. Certain policy changes could improve the situation for these populations in the context of the current health insurance market. In addition, in the context of national health reform, NRHA advocates for longer-term, comprehensive changes in the way health insurance is provided.

Recommendations for Policy Changes in the Existing Non-Group Markets

1. Advocate for reforms in the non-group insurance market.

Insurance regulation is mainly regulated by states. In many states, the non-group market is not well regulated and often lacks essential consumer protections. NRHA supports better regulation and protections in this market. Needed reforms include guaranteed issue (sale of insurance to everyone, including those with pre-existing conditions); guaranteed renewability; community rating or modified community rating (exclusion of health status as a factor in setting insurance premiums); transparency in the insurance market (for example, by requiring insurance companies to make information public about medical loss ratios, size of reserves, and net profit by book of business); and rate review (to ensure that premium increases are justified).

2. Advocate for changes in the SCHIP and Medicaid programs to take into account the fluctuation in farmers’ income.

Many farm families may already be eligible for public programs which could improve the quality and affordability of health insurance. Although 17-21% of Iowa farm families were eligible for Medicaid or the SCHIP program, only 1% were enrolled. In Wisconsin, less than 5% of the dairy farmers participated in the statewide SCHIP program. Farmers’ incomes fluctuate from year to year, depending for example on weather and market conditions. Many farmers have indicated an unwillingness to enroll their children



in SCHIP for fear that their fluctuating income may make them ineligible the following year.

3. Study the impact of pilot programs to establish insurance cooperatives as alternatives for those purchasing in the individual insurance market.

For example, the Farmers Health Cooperative of Wisconsin is a health insurance cooperative designed to pool farmers in order to provide them with better quality, more affordable health insurance coverage. In Massachusetts, the Fishing Partnership Health Plan was started in 1997. It is a health insurance plan offered through a private insurer but subsidized by the state. It now has over two thousand members of the fishing community and their families receiving health care coverage through the plan. The plan has reduced the rate of uninsured fishing families from 43% to 13%. Studies should be conducted to assess the effectiveness of insurance cooperatives. In particular, studies should assess the need for subsidies to allow pools to operate effectively.

Recommendations for Policy Changes in the Context of National Health Care Reform

1. Continue to conduct research on underinsurance among farmers.

Federal and state dollars used to measure the uninsured must also include the mandate that states evaluate the level of underinsurance among the rural population. Farmers and ranchers represent an accessible sample to assess the adequacy of the non-group market for the self-employed and small business people generally. NRHA advocates for a national study on underinsurance that replicates studies described in this brief. Such a study would be important whether or not health reform is enacted. It will be especially important to continue to monitor the ability of the non-group market to provide comprehensive, affordable and adequate insurance coverage.

2. Advocate for adequate minimum insurance coverage standards, including adequate coverage for preventive, mental health, and dental care.

Insurers should be required to offer products that provide financial protection for people if they need medical care. This includes providing comprehensive coverage, with limits set on enrollees' out-of-pocket costs. Such limits might be set at a percentage of enrollees' net incomes. Coverage should include preventive care, mental health services, dental care, integrated care, and occupational health services. Preventive care is essential in avoiding the occurrence of many diseases and in limiting their severity.

In addition, the unstable farm economy contributes to a high degree of stress among the farming population. Currently, mental health coverage is often lacking in the basic insurance products available to farmers and other self-employed people. Insurance products need to include coverage for mental health services.



The Access Project survey also showed that the costs of dental care also constitute a significant portion of farmers' and ranchers' out-of-pocket spending for health care, while having dental insurance somewhat reduces cost barriers to dental care. However, insurance products in the non-group market are much less likely to cover dental care than insurance obtained through employment. Insurance products in the non-group market need to include dental coverage.

Finally, support for occupational health services is essential for farmers, ranchers and other high risk populations such as fisherman. These groups are exposed to unique risks and need access to health professionals qualified to deliver occupational health care.

3. Support research on the impact of a public plan to compete with private insurance products on the rural health care system.

Many policy makers are currently discussing the inclusion of a public insurance plan that could be marketed as an alternative to private plans for people purchasing insurance in the non-group market. Public plans may take a variety of forms, from fully government-sponsored programs funded through general taxes to private/public partnerships such as the Massachusetts Fishing Partnership discussed previously. In order to understand the potential impact of a public insurance option and make informed policy decisions, the NRHA supports further research and analysis in this area.

4. Support research needed to produce data that can inform policymakers and the public about the long-term effects of medical debt on communities and rural health delivery systems.

Farmers and ranchers in these studies are experience medical debt as a direct result of being underinsured. Medical debt affects not only individuals and their families, but also providers and the surrounding rural economy. For providers, unaffordable bills can result in unreimbursed costs and bad debts. Moreover, as rural providers are often a major component of local economies, their economic difficulties can seriously impact surrounding populations. Additional research is needed to better understand the impact of medical debt on rural communities, with special attention to the non-group insurance policies that place rural health providers and health care systems at financial risk.

Policy debates about health coverage often center on increasing the number of citizens who have health insurance. Studies of farmers and ranchers in the Great Plains states and California suggest that although farmers generally have health insurance coverage, the quality and cost of the coverage is frequently poor. Specifically, farmers and ranchers with coverage obtained in the non-group market are frequently underinsured – that is, they experience a lack of access to adequate and affordable health care despite having insurance. Farmers and ranchers are generally easier to access through survey



research than other self-employed and small business people. However, self-employed and small business people generally are likely to face problems in obtaining adequate health insurance that are similar to those faced by farmers and ranchers.

IV. Conclusion

This brief demonstrates the significance in evaluating the type of insurance coverage people have, and not merely whether they have coverage. Coverage levels for services such as vision, dental care, prescription drugs, mental health, preventive care, and occupational health vary among insurance plans. Data presented in this brief are preliminary and warrant intensive research on the barriers to care, the impact on health status, and the financial strain faced by the underinsured. Additional information must be collected to determine whether non-group plans are adequately covering the health needs of farmers, ranchers, and other small business people throughout our nation.



Bibliography

1. S. Collins, Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial WellBeing of American Families. The Commonwealth Fund. September 2006.
2. P. Cunningham, C. Miller, A. Cassil. Living on the Edge: Health Care Expenses Strain Family Budgets. Center for Studying Health System Change. Research Brief No. 10. December 2008.
3. Health Insurance on the Farm, 2000. N.D. Agricultural Statistics Service, USDA, <http://www.health.state.nd.us/Publications/HlthCare/2000FarmHealthInsurance.pdf>
4. W. Lottero, R. Seifert, N. Kohn. Losing Ground: Eroding Health Insurance Coverage Leaves Kansas Farmers with Medical Debt. The Access Project. August 2006.
5. W. Lottero, C. Pryor et al. Overview of Findings. 2007 Health Insurance Survey of Farm and Ranch Operators. The Access Project. September 2007.
6. Kaiser Commission on Medicaid and the Uninsured. 2002. Underinsured in America: Is Health Coverage Adequate? Washington, DC
7. Kralewski, J.F., Shapiro, J., Chan, H.C., Edwards, K., & Liu, Y.L. Health Insurance Coverage of Minnesota Farm Families. Minn Med, 1990, 73(5, 35-8).
8. R.J. Manski and E. Brown. Dental Use, Expenses, Dental Coverage, and Changes, 1996 and 2004. Agency for Healthcare Research and Quality. MEPS Chartbook No. 17. 2007.
9. Measuring Adequacy of Coverage, State Health Access Data Assistance Center of University of Minnesota, www.shadac.umn.edu
10. Mueller K, Meza J, Carlson E, Jones K, Fraser-Maginn R, Shay B, Xu L. Health Insurance Coverage in Nebraska: Results from the Nebraska State Planning Grant, Nebraska Center for Rural Health Research, <http://www.unmc.edu/rural/SPG/health-insur-ne-results-updated.pdf>, December 2004.
11. C. Pryor et al. How Farmers and Ranchers Get Health Insurance and What They



Spend for Health Care. 2007 Health Insurance Survey of Farm and Ranch Operators. The Access Project. December 2007.

12. C. Pryor et al. Who Experiences Financial Hardship Because of Health Care Costs? 2007 Health Insurance Survey of Farm and Ranch Operators. The Access Project. September 2008.
13. C. Pryor et al. Overview of Findings. 2008 Health Insurance Survey of California Farm and Ranch Operators. The Access Project. May 2008.
14. C. Schoen, S. Collins, J. Kriss, and M. Doty. How Many are Underinsured? Trends Among U.S. Adults, 2003 and 2007. Health Affairs. June 10, 2008.
15. Rural Health Advisory Commission, Office of Rural Health, Nebraska Health and Human Services System, Adopted 2001, December.
16. Ward A. The Concept of Underinsurance: A General Typology. J Med Philos. 2006 Oct. 31(5): 499-531.
17. Whitaker, Julie A., and Doris P. Slesinger. 2002. Health Status, Use of Medical Services and Health Insurance Coverage: A Comparison Between Farmers, Other Self-Employed, and Wage/Salary Workers in Wisconsin. Madison, Wisconsin: University of Wisconsin. Ziller, E., Coburn, A., Hoffman, C., Lux, S., & McBride, T. (2003). Health insurance coverage in rural America: A chartbook. Washington, DC: Kaiser Commission on Medicaid and the Uninsured.