Summary

Basic rural issues remain constant. For all the national reform discussion, the predominant issues in rural health care are the same as they have been for many years. Mainly, these issues involve how to get health care providers and services into rural areas and keep them there.

Broad-based reforms can have special rural impacts. Most general health system reforms affect both rural and urban areas alike. Nonetheless, some reforms are likely to have somewhat different impacts or raise additional concerns in the context of rural care.

Likely impacts are related to rural characteristics. Rural areas have several characteristics that influence the effects of reforms. These include lower incomes, poorer health, higher percentages of elderly people, fewer local providers, and lower rates of insurance--especially insurance obtained through large employers with ERISA-exempt health plans--than urban residents. Rural areas vary among themselves in these characteristics as well.

Many incremental reforms could benefit rural areas. All else equal, incremental insurance reforms aimed at easing insurance access for harder-to-insure people (e. g., guaranteed issue) should tend to benefit rural residents. Community rating has more complex potential effects because of rural health care fees are often lower than urban fees (which affects insurance premium prices) and because of the use of geographic adjustments in many rating schemes.

ERISA complicates the equation, however, because rural areas are at a relative disadvantage under ERISA. If reforms cause more employers who currently offer insurance to self-fund to obtain ERISA exemptions, or more small businesses to gain ERISA privilege, rural residents will probably see the costs of their insurance rise disproportionately. The reason for this is that rural residents are more likely than urban people to purchase insurance individually, and because the rural population is disproportionately composed of high-risk people.

The likely advantages of MSAs **in rural areas depend on their design.** Reforms that permit medical savings accounts to be established by individuals are reportedly attractive to some rural residents who prefer self-sufficiency to insurance and are currently uninsured

for this reason. However, proposals that permit only employers to establish MSAs are not likely to benefit rural residents much.

Managed care has the potential to improve rural access to affordable, good-quality care. When it's good, managed care supports local providers (e. g., by providing modem information technologies) and enhances rural residents' access to coordinated care, linking local and distant care resources. At present, however, neither managed care plans nor providers are usually enthusiastic about rural managed care. Some states are using their leverage as purchasers to encourage managed care plans to "pool" urban enrollees with rural enrollees (who are generally less profitable to serve), through participation requirements for HMOs serving Medicaid beneficiaries and state employees, and through state purchasing alliance requirements.

Managed care also raises special risks of provider abandonment in rural areas. The primary concerns about managed care and large multiprovider delivery systems are that they may take over providers in a rural areas, then abandon the area if it is not profitable; that they may direct patients away from local providers, exacerbating problems of long patient travel times and local hospital closure; and that they threaten the autonomy that is highly valued by many rural physicians.

Most of the rural-specific impacts predicted above are highly speculative. Good evidence and solid experience on the effects of these reforms--most of them only recently implemented by states--generally don't exist yet, and states' experiences are likely to differ (especially in the area of managed care). Evaluation is important to understanding effects, and would aid the federal debate on reform impacts, but little evaluation is occurring.