

Extending Universal Health Care Access to the
Rural Poor: Has China Shown Us the Way?

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I. INTRODUCTION

Access to quality and affordable health care for rural Americans is a growing issue. Today, more than twenty percent of Americans living in non-metropolitan areas do not have health insurance.¹ Lack of health insurance is a critical factor in treating disease; those without health insurance are less likely to have a regular health care provider, less likely to seek preventive care, and are less likely to obtain medical tests and prescriptions.² The millions of rural Americans without insurance lack adequate access to preventive care and often neglect to treat chronic conditions.³ To make matters worse, rural areas experience higher poverty rates and earn lower wages, exacerbating the effects of relatively low levels of employer-based insurance coverage.⁴ This effect has only been amplified by the recent economic downturn. The result is that rural areas rely more heavily on Medicaid and other public coverage than their urban counterparts.⁵

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1. Jane Bolin & Larry Gamm, *Access to Quality Health Services in Rural Areas – Insurance: A Literature Review*, RURAL HEALTHY PEOPLE 5, available at <http://www.srph.tamhsc.edu/centers/rhp2010/03Volume2access-insurance.pdf>

2. *Id.* at 10.

3. *Id.* at 5-8, 9.

4. *Id.* at 6; see also Dr. Joe Blankenau et al., *The Causes and Consequences of the Rural Uninsured and Underinsured*, *Health Care Reform*, 3 CNTR. FOR RURAL AFF. 1, 1 (Apr. 2009), available at <http://files.cfra.org/pdf/Causes-and-Consequences-of-Rural-Uninsured.pdf>.

5. Bolin & Gamm, *supra* note 1, at 6. In 1997, employer-sponsored insurance in urban counties was found to be 70%, while only 55% of employer's in rural counties sponsored

The problem is not unique to the United States. After China moved to a market economy in the 1980's, millions of poor rural Chinese that previously enjoyed universal access to health insurance as part of the Cooperative Medical System lost their coverage.⁶ As in the United States, the cost of care was rising rapidly, increasing at nearly sixteen percent per year.⁷ Medical expenditures were causing rural poor to drop below the poverty line.⁸ With the dissolution of the communes came "a medical free-fall for the rural population."⁹ The rural medical system crumbled. One commentator notes that "while the Maoist era brought health to Chinese people, the reform era . . . almost liquidated its achievements for quick money."¹⁰ By the early 1990's, fewer than ten percent of rural Chinese had medical insurance.¹¹

In response to this crisis, the Chinese government launched the New Cooperative Medical System (NCMS) in 2003.¹² The past decade has seen a dramatic turnaround. By 2011, more than 836 million rural Chinese enrolled in the system, representing ninety-five percent of China's rural counties.¹³ Coverage for poor rural Chinese was nearly universal by

employee insurance. *Id.*

6. Winnie Yip & William C. Hsiao, *Non Evidence-Based Policy: How Effective is China's New Cooperative Medical Scheme in Reducing Medical Impoverishment?* 68 *SOC. SCI. MED.* 201, 204 (2009). *available at* http://www.hsph.harvard.edu/health-care-financing/files/yip_and_hsiao_2009_-_non-evidence_based_policy.pdf; Xiaoyun Sun et al., *Health Payment-Induced Poverty Under China's New Cooperative Medical Scheme in Rural Shandong*, 25 *HEALTH POL'Y & PLAN.* 419, 420 (2010).

7. Yip & Hsiao, *supra* note 6, at 205.

8. Sun et al., *supra* note 6, at 420. In one Chinese county, out-of-pocket medical expenses caused nearly forty-five percent of its population to drop below the poverty line. *Id.*

9. Dale Jiajun Wen, *China's Rural Reform: Crisis and Ongoing Debate*, 43 *ECON. & POL. WKLY.* 86, 89 (2009).

10. *Id.*

11. Sun et al., *supra* note 6, at 420.

12. *Id.*

13. Kimberly S. Babiarz et al., *China's New Cooperative Medical Scheme Improved Finances of Township Health Centers But Not the Number of Patients Served*, 31 *HEALTH AFF.* 1065, 1066 (2012).

2012— approximately ninety percent of the rural population had health insurance.¹⁴ Nevertheless, it is unclear whether the achievement of nearly universal coverage through the NCMS has actually provided poor rural Chinese better access to quality and affordable health care. Given that the U.S. will soon expand Medicaid coverage to uninsured rural Americans through the Patient Protection and Affordable Care Act (PPACA), this article considers the extent to which the Chinese example sheds light on the potential impact the new law may have on rural Americans.

This article argues that universal care through expanded government insurance does not necessarily lead to greater health care access for the rural poor. First, it briefly examines the historical background from which the NCMS arose. Second, it outlines policy and strategies the new system implemented to achieve its goals. Next, the article examines some of the successes and shortcomings of the new system. Finally, the article considers whether American efforts to create universal care through the PPACA may experience some of the same shortcomings as the NCMS.

II. HISTORICAL BACKGROUND OF RURAL CHINESE HEALTHCARE

From the 1950's through the 1980's, China provided medical care to rural Chinese through the Cooperative Medical Scheme.¹⁵ The program emphasized preventive and basic care and at its peak covered about ninety percent of China's rural population.¹⁶ The program was so successful that it was featured as a model for the world at the 1978 World Health Organization conference "Health for All by the Year 2000."¹⁷ In 1982, however, China abolished communes and began to privatize their

14. *Id.*

15. Yip & Hsiao, *supra* note 6, at 205.

16. *Id.*; Sun et al., *supra* note 6, at 420.

17. Babiarz et al., *supra* note 13 at 1066.

economy.¹⁸ The Cooperative Medical Scheme collapsed as a result. Village doctors became private practitioners and earned income from patients on a fee-for-service basis.¹⁹ Because government subsidies for health facilities fell to ten percent of the facilities' total revenues by the early 1990's, the government implemented strict price control and set prices for basic health care below cost.²⁰ To recover the difference, providers hiked up drug and diagnostic services cost.²¹ The price of health care soared, growing at sixteen percent per year.²² The 2003 National Health Survey confirmed this disturbing trend and found that forty-six percent of rural Chinese that were sick enough to need medical care chose not to do so, with forty percent of this group citing cost as the reason.²³ In less than twenty years, the Chinese rural health system went from being the world health model for economic development to a system in which poor people could not access basic health services because of cost.

III. THE NEW COOPERATIVE MEDICAL SYSTEM: A NEW DIRECTION FOR RURAL CARE

In 2003, the central Chinese government implemented the New Cooperative Medical System (NCMS) in response to these challenges.²⁴ The goal was to achieve universal care for the nation's entire rural population through health insurance.²⁵ The NCMS also aimed to reduce

18. Sun et al., *supra* note 6, at 420.

19. Yip & Hsiao, *supra* note 6, at 205.

20. *Id.*

21. *Id.*

22. *Id.*

23. Yip & Hsiao, *supra* note 6, at 205.

24. Sun et al., *supra* note 6, at 420.

25. Hongwek Xu & Susan E. Short, *Health Insurance Coverage Rates in 9 Provinces in China Doubled from 1997 to 2006, With a Dramatic Rural Upswing*, 30 HEALTH AFF. 12 2419, 2420 (2011).

illness-induced poverty in rural households.²⁶ To achieve this goal, policy-makers focused on reimbursing for inpatient care as opposed to outpatient care, reasoning that outpatient care was less likely to reach poverty-inducing cost levels.²⁷ Thus, the NCMS has higher patient reimbursement for acute, inpatient care than outpatient care.²⁸ The insurance program has voluntary enrolment and is funded by a combination of household contribution and government-matched funds.²⁹ To enroll in the program, members pay a flat rate premium of twenty Yuan.³⁰ The central government provides an annual subsidy of forty Yuan for each enrollee and requires the local government to match the forty Yuan.³¹ The government planned to increase the subsidy to 200 Yuan per beneficiary by the end of 2011.³² To discourage adverse selection (for example, sicker people opt-in while those who are healthy opt-out), the scheme requires all persons living in one household to join NCMS together.³³

Reimbursement procedures vary by region and are somewhat complex.³⁴

26. *Id.* Health payment-induced poverty is poverty attributable to health payments. It occurs when health payments in a given year push a household below the poverty line or further below the poverty line. *Id.* at 421.

27. Xiaoyun Liu & Shenglan Tang et al., *Can Rural Health Insurance Improve Equity in Health Care Utilization? A Comparison Between China and Vietnam*. 11 INT'L J. FOR EQUITY IN HEALTH 10, 7 (2012), available at <http://www.equityhealthj.com/content/11/1/10>.

28. Xiaoyan Lei & Wanchuan Lin, *The New Cooperative Medical Scheme in Rural China: Does More Coverage Mean More Service and Better Health?* 18 HEALTH ECON. 25, 26 (2009).

29. Xiaomei Pei & Gerald Bloom, *Balancing Efficiency and Legitimacy: Institutional Changes and Rural Health Organization in China*, 45 SOC. POL'Y & ADMIN. 662, 667 (2011).

30. Babiarz et al., *supra* note 13.

31. Lei & Lin, *supra* note 28, at 27.

32. Babiarz et al., *supra* note 13.

33. Sascha Kotzchücher and Peter Lässig, *Transformative State Capacity in Post-Collective China: The Introduction of the New Rural Cooperative Medical System in Two Counties of Western China, 2006-2008*, 8 EUR. J. E. ASIAN STUD. 61, 79 (2009).

34. Lei & Lin, *supra* note 28, at 28. The central government gives local government four choices for reimbursement models. In the first and most popular model (65% of rural counties implement this model), inpatient services are reimbursed according to formula, while outpatient services and preventive care are paid for through a medical savings account.

Reimbursement is significant because the rate at which rural Chinese are reimbursed for medical services affects whether the poor can or cannot afford treatment. The NCMS reimburses rural Chinese patients directly rather than reimbursing providers.³⁵ Inpatient services are generally reimbursed according to a formula, while outpatient services are reimbursed using either a medical savings account for each family, a formula, or not at all.³⁶ The models incorporate some type of reimbursement cap and a deductible at different rates.³⁷ What they share in common is low reimbursement for preventive care, including insurance coverage for physical examination and treatment of chronic diseases.³⁸ The reimbursement structure reflects the NCMS's desire to target hospitalization and other catastrophic care in order to alleviate financial hardship and help prevent illness-induced poverty.³⁹

IV. WHERE THE NCMS HAS SUCCEEDED

The NCMS succeeded overwhelmingly in extending health insurance to rural poor. The program expanded rapidly after its implementation in 2003. By 2011, the program enrolled more than 836 million people representing ninety-five percent of China's rural counties.⁴⁰ By 2012, the NCMS

Id. There is a deductible and a reimbursement cap for using a medical savings account. *Id.* In the second model (6.7% participation) there is no medical savings account designated for outpatient or preventive care. Rather, services are reimbursed according to a formula. *Id.* There is no deductible and no reimbursement cap. *Id.* The third model (11.17% participation) reimburses inpatient and outpatient services for catastrophic diseases with separate deductibles and reimbursement caps. *Id.* [The study provides no definition for what is and is not a "catastrophic" disease.] The fourth and final model (16.87% participation) reimburses inpatient services only. *Id.*

35. *Id.* at 28; *id.* at 40; *see also* Babiarz et al., *supra* note 13 at 1066 (stating "the New Cooperative Medical Scheme reimburses patients . . . after patients satisfy a per visit copayment").

36. Lei & Lin, *supra* note 28, at 28.

37. *Id.*

38. *Id.*

39. Sun et al., *supra* note 6, at 420.

40. Babiarz et al., *supra* note 13.

provided nearly universal insurance coverage; approximately ninety percent of the rural population chose to enroll.⁴¹ One study finds that overall utilization of both inpatient and outpatient services have increased since the new system was implemented.⁴² Systemic studies indicate some evidence that the NCMS has succeeded in reducing healthcare costs for those needing inpatient care. “The program decreased patients’ out of pocket spending for higher-cost health services . . . by more than [eighteen] percent.”⁴³ Although the reimbursement structure focuses on inpatient care as opposed to outpatient care, participation in the NCMS increased the probability that a patient utilized preventive care by sixty to eighty-five percent.⁴⁴

The program has also increased utilization of services provided by township health services. Township health centers provide health services in rural areas and act as an intermediary between village clinics and county-level hospitals.⁴⁵ These providers have expanded the scope of the services they offer under the NCMS.⁴⁶ For example, many township health centers are required to provide all beneficiaries with an annual medical check-up.⁴⁷

41. Liu & Tang et al., *supra* note 27, at 5.

42. Lei & Lin, *supra* note 28, at 29 citing Wagstaff et al., *Extending Health Insurance to the Rural Population: An Impact Evaluation of China’s New Cooperative Medical Scheme*, 28 J. OF HEALTH ECON. 1 (2009). However, relatively wealthy households are more likely to utilize NCMS insurance than their poorer counterparts. *Id.* This supports some authors’ hypothesis that because patient expenses are reimbursed after treatment, out-of-pocket costs remain prohibitively high. See Kotzchücher & Lässig, *supra* note 33, at 82. As a result, many poor rural Chinese choose not to seek treatment. See *id.* at 39.

43. Babiarz et al., *supra* note 13, at 1070.

44. Lei & Lin, *supra* note 28, at 36. Further analysis reveals that the “effect of NCMS on preventive care might be mainly due to coverage leading to eligibility for a general physical examination,” *id.*, as many rural Chinese counties provide insurance coverage for an annual physical examination. *Id.* at 28.

45. The township health centers are owned by the state and provide public health and primary medical services to rural Chinese. Babiarz et al., *supra* note 13 at 1065. The centers also manage provision of public health services, train clinicians, and supervise local rural health systems. *Id.*

46. Pei & Bloom, *supra* note 29, at 668.

47. *Id.*

Since the program began, township health centers are assigned responsibility for administering the program and must collect household contributions, verify implementation of regulations on prices and procedures, review reimbursement requests, and arrange payment of reimbursements to patients.⁴⁸ A notable success from the provider perspective is that the implementation of the NCMS led to large increases in township health centers' annual revenues.⁴⁹ Finally, the system is an improvement over the old model because the NCMS creates a larger risk-sharing pool at the county level to help offset the costs of providing care.⁵⁰

China's ability to implement such sweeping change in only a decade is a testament to their political efficiency and to their growing tax revenue generated by a thriving economy.⁵¹ While the new system has undoubtedly increased the number of poor rural Chinese covered by health insurance, it is less clear whether the poor actually have better access to health care.

V. SHORTCOMINGS OF THE NCMS

Unfortunately, expansion of medical insurance to the rural poor has not necessarily reduced their actual cost of medical care.⁵² As one author points out, "the strong support for universal public health insurance reflects the assumption that lack of insurance is responsible for poor health, which may in turn lead to medical debt and poverty."⁵³ While there is evidence that the NCMS improved utilization of preventive care, there is no evidence showing that NCMS participation has reduced financial burden on the rural

48. *Id.*

49. Babiarz et al., *supra* note 13, at 1069. However, "these were essentially offset by accompanying expense increases." *Id.* This may be a double-edged sword because it encourages rising costs.

50. *Id.*

51. Yip & Hsiao, *supra* note 6, at 207.

52. *See generally* Lei & Lin, *supra* note 28.

53. Lei & Lin, *supra* note 28, at 38.

poor.⁵⁴ This can be attributed to a failure to change the financial incentives for providers as well as high deductibles and low reimbursement rates for patients.

Despite nearly universal insurance coverage,⁵⁵ the cost of obtaining medical care is still not attainable for many rural Chinese. This shortcoming is attributable to low reimbursement rates, high deductibles and initial out-of-pocket costs, and complicated reimbursement procedures. While “NCMS policy states that it will cover up to 50% of medical expenses,”⁵⁶ patients reported that the actual reimbursement level was much lower.⁵⁷ This is likely the result of reimbursement caps that provide reimbursement only up to a certain cost.⁵⁸ One author suggests that high deductibles may have prevented people from using formal medical services.⁵⁹ Because the NCMS requires members to pre-pay expenses before they are reimbursed, many of the rural poor who cannot afford the up-front costs associated with medical treatment decide to forego treatment altogether.⁶⁰ Finally, NCMS participants have noted that reimbursement procedures are unnecessarily difficult and confusing.⁶¹ To obtain reimbursement, participants need to show “the NCMS enrolment certificate, receipt for all medical expenses, proof of residence status, and sometimes a referral document,”⁶² in addition to waiting in long lines and traveling long

54. *Id.* at 39.

55. Babiarz et al., *supra* note 13, at 1066, citing CHINA HEALTH STATISTICS YEARBOOK (Peking Union Medical College Press 2011).

56. Liu & Tang et al., *supra* note 27, at 5.

57. *Id.*

58. *Id.*

59. Lei & Lin, *supra* note 28, at 39.

60. *Id.*; see also Yip & Hsiao, *supra* note 6, at 221-222. Yip and Hsiao argue that an alternative, first-dollar-coverage approach for primary care will give poor Chinese better access to preventive care and reduce cost in the long-term.

61. Liu & Tang et al., *supra* note 27, at 5.

62. *Id.*

distances to government health centers.⁶³

Given these obstacles, expansion of health insurance coverage does not necessarily mean that rural Chinese have universal access to and utilization of health services.⁶⁴ According to one commentator, “it is not necessarily true that insurance coverage focusing on expensive hospital care is the most effective in providing financial risk protection.”⁶⁵ This suggests that focusing on preventive rather than acute care would have potentially been a better solution if the overall goal is to reduce the cost of healthcare.

Another significant issue is the failure of the NCMS to change provider financial incentives. Increasing insurance coverage is just one piece of the puzzle. While the NCMS has succeeded in extending insurance coverage to a large number of poor rural Chinese, it has failed to address the rising cost of providing care. Providers continue to operate on a fee-for-service basis.⁶⁶ As such, the “response of many individual health centers to economic incentives has led to an unintended change in the balance of activities in the overall rural health system.”⁶⁷ The fee-for-service model encourages providers to deliver a high volume of service rather than high quality service.⁶⁸ The effect is that many poor rural Chinese cannot afford the high cost of treatment despite government-provided insurance.

Furthermore, implementation of the NCMS is “not associated with meaningful changes in the probability of sick people having sought care

63. *Id.*

64. *Id.* at 7.

65. Yip & Hsiao, *supra* note 6, at 221-222.

66. See generally Hong Wang et al., *An Experiment in Payment Reform for Doctors in Rural China Reduced Some Unnecessary Care but Did Not Lower Total Costs*, 30 HEALTH AFF. 2427 (2011). This study implemented an experiment with a mixed payment mechanism for providers based on a salary and bonus system in attempt to lower the cost of delivering care to rural Chinese. *Id.* The payment method was successful in reducing costs. *Id.* at 2432.

67. Pei & Bloom, *supra* note 29, at 672.

68. Hong Wang et al., *supra* note 66.

during the previous year.”⁶⁹ While one study found that the NCMS has led to higher utilization of outpatient services,⁷⁰ another found there was no difference in utilization of outpatient services between those who enrolled in the NCMS and those who did not enroll in the NCMS.⁷¹ This finding is consistent with the NCMS’s focus on inpatient, acute care services and strongly evidences that despite having better access to health insurance, the insurance is not making treatment of chronic conditions or preventive care more affordable for rural Chinese citizens.

As one commentator notes, the “fundamental problem of the NCMS is that . . . policymakers did not recognize that in fact expenses incurred for treating chronic illnesses – not only hospitalizations – are a major factor in medical impoverishment.”⁷² While the NCMS reduces cost for rural Chinese when there is a need for hospitalization, the plan fails to provide adequate coverage for preventive treatment and treatment of chronic conditions. Additionally, extending insurance to millions of poor Chinese, though noble, has done nothing to change the incentives driving the increasing costs of healthcare.⁷³ While the NCMS has made incredible progress by coverage, it has failed to reduce the cost of health insurance to the rural poor because reimbursement rates are low and the cost of care continues to escalate.⁷⁴ The program’s emphasis on providing insurance for acute inpatient care comes at the expense of lack of outpatient services. Thus, the increase in insurance coverage has not significantly increased health care access for poor rural Chinese. The cost of care remains

69. Babiarz et al., *supra* note 13, at 1069.

70. See note 33, *infra*. Lei & Lin hypothesize that the increased utilization of outpatient care was attributable to the requirement that the township health center provide an annual physical check-up to enrollees. Lei & Lin, *supra* note 28, at 36.

71. Liu & Tang et al., *supra* note 27, at 4.

72. Yip & Hsiao, *supra* note 6, at 220.

73. Hong Wang et al., *supra* note 66.

74. Liu & Tang et al., *supra* note 27.

prohibitively high for many poor rural Chinese.

VI. WILL THE PPACA EXPERIENCE THE SAME SHORTCOMINGS AS THE NCMS?

The United States faces similar health care access challenges for rural populations, as many rural Americans do not have health insurance and cannot otherwise afford access to quality care.⁷⁵ As such, a focus of the PPACA is to increase affordable access to health care for the rural poor. Where China has focused on improving individual affordability by increasing the width and depth of insurance coverage, the U.S. has geared its health insurance reform policies toward “social affordability,” with an emphasis on driving the cost of delivering care down in order to reign in public spending.⁷⁶ In this very important respect, the PPACA fundamentally differs from the NCMS because a critical focus of the law is lowering the cost of providing health care.

One way the PPACA attempts to lower health care costs is through value-based-purchasing. Value-based purchasing intends to change incentives for providers by basing reimbursement on performance rather than volume of patients treated.⁷⁷ Reforms aimed at changing financial incentives for providers were absent from the NCMS, as providers continue to be reimbursed on a fee-for-service basis.⁷⁸ The PPACA attempts to address this concern through value-based purchasing. This provision may

75. See generally Bolin & Gamm, *supra* note 1.

76. Yuanli Liu, *Increasing the Affordability of Health Care: Comparing Reforms in China and the United States* in Charles W. Freeman III & Xiaoqing Lu Boynton, *Implementing Health Care Reform Policies in China: Challenges and Opportunities*, CNTR. FOR STRATEGIC AND INT'L STUDIES, 12 (2011), available at http://csis.org/files/publication/111202_Freeman_ImplementingChinaHealthReform_Web.pdf.

77. KEITH J. MUELLER, *The Patient Protection and Affordable Care Act: A summary of Provisions Important to Rural Health Care Delivery* 22 (2010), available at http://www.unmc.edu/ruprihealth/Pubs/PPACA%20Rural%20Provision%20Summary.06_08_10.pdf.

78. Hong Wang et al., *supra* note 66.

have a lesser impact in rural areas, however, because providers that do not have a minimum number of cases are excluded.⁷⁹ Thus, it is possible that rural providers treating a small number of patients will continue to be incentivized based on fee-for-service volume rather than treatment outcome. The impact value-based purchasing will have on cost reduction remains to be seen.

Another way in which the PPACA differs from the NCMS is an emphasis on improving rural health care infrastructure and resources. Congress included provisions to expand rural healthcare workforce, facilities, services, and insurance options,⁸⁰ as well as providing increased payments through Medicaid and Medicare to incentivize rural practice.⁸¹ These supply-side reforms were largely absent from the NCMS. Indeed, the quality of physicians and health providers in rural China remains a concern.⁸²

While one of the PPACA's goals is to attain universal coverage by extending Medicaid to cover thirty million more Americans,⁸³ China's example demonstrates that insurance coverage does not necessarily lead to better access or utilization of health services by the rural poor. Given the high number of the rural poor dependent on Medicaid,⁸⁴ the success or

79. *Id.* Special rules are established for small rural hospitals and Medicare dependent hospitals. *Id.*

80. Scott Lindstrom, Comment, *Health Care Reform and Rural America: The Effect of the Patient Protection and Affordable Care Act and Rural America: The Effect of the Patient Protection and Affordable Care Act on the Rural Economy and Rural Health*, 47 IDAHO L. REV. 639, 647 (2010).

81. Jon M. Bailey, *Health Care Reform, What's In It? Rural Communities and Rural Medical Care*, 9 CNTR. FOR RURAL AFFAIRS 1, 1 (July 2010), available at <http://files.cfra.org/pdf/Rural-Communities-and-Medical-Care-brief.pdf>; see also Lindstrom, *supra* note 67, citing 42 U.S.C. §§ 292s, 297b, 295f, 295f-1, 295, 254q (2012).

82. In general, rural Chinese "barefoot doctors" have low levels of education and are unsophisticated. See generally Lidan Wang et al., *The Problems and Solutions to the Building of the New-type Rural Cooperative Medical Workforce*, 7 ASIAN SOC. SCI. 9 (2011).

83. Bailey, *supra* note 68.

84. Bolin & Gamm, *supra* note 1 at 6.

failure of the PPACA in the context of rural care may hinge on its proposed expansion. Although the Supreme Court upheld the law in its June 2012 decision, it struck down a key provision when it held that the withholding of Medicaid funds from states not in compliance with the law was unconstitutionally coercive.⁸⁵ The impact is that many poor rural Americans may face the same problem that rural Chinese are facing. Namely, in states that opt-out of the Medicaid expansion, the poorest rural Americans may not be able to afford treatment despite the extension of the subsidy; those assumed to be covered by Medicaid when the PPACA was drafted may fall into a new Medicaid “donut hole.”⁸⁶ One commentator argues:

Federal subsidies to purchase insurance through the newly created insurance exchanges are not extended to those below the federal poverty level. Those who fall between 100-133% FPL can access subsidies but are still responsible for covering premiums up to 2% of their income – which may prove untenable for this low-income population. Moreover, this population – faced with a “penalty” or a “tax” – may decide that it is cheaper to not purchase insurance. The result? If states opt-out of the Medicaid expansion, most Americans whose incomes fall below 133% of the poverty line are left without an affordable option for obtaining health

85. Nat’l Fed’n Indep. Bus. v. Sebelius, 132 S.Ct. 2566, 2594-2600, 2607 (2012). A divided Supreme Court upheld the constitutionality of the individual mandate as a tax but invalidated conditioning of federal Medicaid funds on state acceptance of Medicaid expansion. *Id.* The court held, “nothing in our opinion precludes Congress from offering funds under the Affordable Care Act to expand the availability of health care, and requiring that States accepting such funds comply with the conditions on their use. What Congress is not free to do is penalize States that choose not to participate in that new program by taking away their existing Medicaid funding.” *Id.* at 2607.

86. Leah Ralph. *Post Supreme Court Ruling, All Eyes on Medicaid*, BIPARTISAN BEAT BLOG (July 10, 2012), <http://bipartisanpolicy.org/blog/2012/07/post-supreme-court-ruling-all-eyes-medicaid>.

insurance.⁸⁷

Despite the anticipated expansion of insurance through Medicaid, millions of poor rural Americans still may not be able to afford access to health care. Although in China it may be the case that “high population coverage doesn’t automatically mean equal access to and utilization of health services,”⁸⁸ rural Americans are hoping that the PPACA does not come to realize the same shortcomings as the NCMS.

VII. CONCLUSION

As China’s example indicates, universal insurance coverage does not necessarily lead to affordable access to high quality care for the rural poor. The NCMS has succeeded in extending insurance coverage to nearly all poor rural Chinese. Nevertheless, health care costs remain prohibitively high for many of the rural poor despite universal coverage. This can be attributed to low reimbursement rates, high deductibles and initial out-of-pocket costs, and complicated reimbursement procedures. Notably, the NCMS has failed to address perverse provider incentives that drive up the cost of care. The result is that many of the rural poor still cannot afford health care.

The PPACA, by contrast, attempts to reign in health care spending through value-based purchasing. However, the systemic impact these reforms will have on the rising cost of care is uncertain at best. It is also unclear how value-based purchasing reforms will play out in a rural provider context, as the PPACA excludes providers that do not have a minimum number of cases. The success or failure of the PPACA reforms in the context of the rural poor may depend on whether states choose to opt-

87. *Id.*

88. Liu & Tang et al., *supra* note 27, at 7.

out of the Medicaid expansion. A troubling possibility is that in opt-out states, the rural poor will face the same problem many poor Chinese are facing; despite subsidies and extended insurance coverage, high premiums may make health coverage financially unattainable. Whether the American health reform avoids this pitfall remains to be seen.