



Access to Affordable Care in Rural America: Current Trends and Key Challenges

Medicaid and the Marketplace are important sources of affordable, comprehensive healthcare coverage for millions of Americans living in rural areas, and the American Rescue Plan bolsters rural coverage options. But challenges in accessing care remain in many rural areas, including provider shortages, infrastructure limitations, and long distances to care.

Gina Turrini, D. Keith Branham, Lucy Chen, Ann B. Conmy, Andre R. Chappel, Nancy De Lew, and Benjamin D. Sommers

KEY POINTS

- Many rural communities face challenges that contribute to persistent health disparities compared to urban areas.
- Uninsured rates among non-elderly adults in rural areas have fallen substantially since the passage of the Affordable Care Act (ACA), from 23.7 percent in 2010 to 16.0 percent in 2019. Despite this progress, uninsured rates in rural areas have been and continue to be about 2-3 percentage points higher than in urban areas over the 2010-2019 period.
- Medicaid expansion played a key role in expanding health insurance coverage; Medicaid coverage rates increased from 12.2 percent of the rural population in 2010 to 17.1 percent in 2019.
- Uninsured rates among rural residents are disproportionately higher in states that have not yet expanded Medicaid. The rural uninsured rate was nearly twice as high in non-expansion states as expansion states (21.5 vs. 11.8 percent) in 2019. More than 440,000 uninsured non-elderly adults in the 13 non-expansion states would gain eligibility for Medicaid if those states expanded.
- Approximately 15 percent of Marketplace enrollees in HealthCare.gov states live in rural areas.* Under the American Rescue Plan (ARP), 65 percent (1.3 million) of the 1.9 million rural uninsured individuals of HealthCare.gov states may be able to find a zero-premium plan on the platform.
- Although uninsured rates have fallen in rural areas, other barriers to care such as geographic distances, infrastructure limitations, and provider shortages contribute to rural health disparities.
- Programs and services such as telehealth, healthcare workforce programs, Community Health Centers, and Rural Health Clinics all help improve access to care in rural communities.

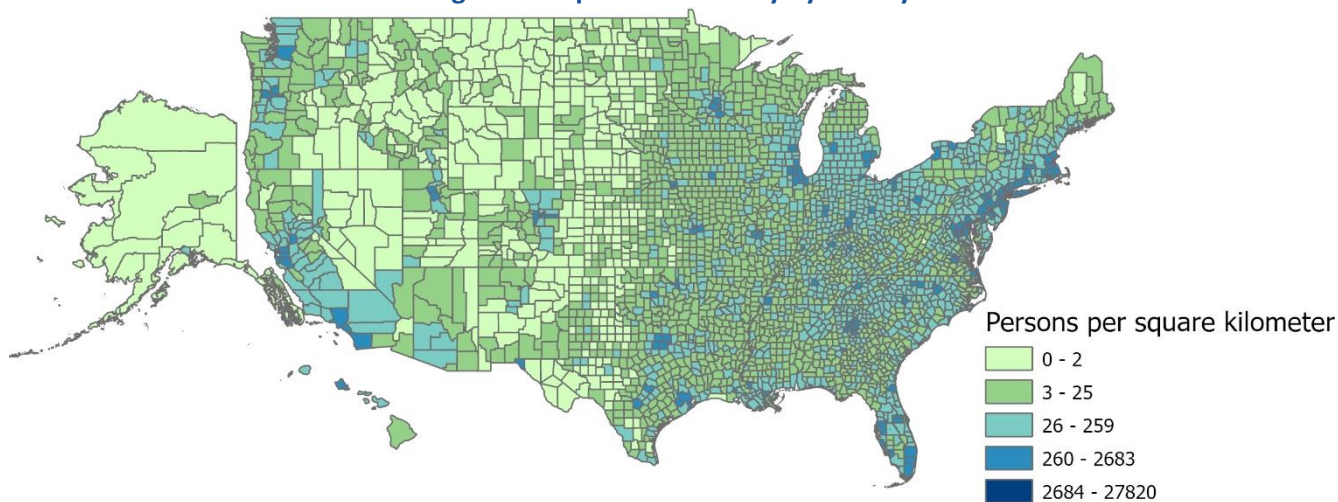
* In this case, HealthCare.gov states examined include both federally-facilitated marketplaces and state-based marketplaces that use the HealthCare.gov platform, including: Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Hawaii (added in 2016), Illinois, Indiana, Iowa, Kansas, Kentucky (added in 2017), Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada (removed in 2020), New Hampshire, New Jersey (removed in 2021), New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania (removed in 2021), South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

BACKGROUND

Approximately 61 million Americans live in rural areas, accounting for approximately 19 percent of the overall US population as of 2016.^{1,†} Rural areas and communities are diverse across many dimensions, such as racial/ethnic composition, geography, socioeconomics, availability of healthcare providers, and broadband availability among other characteristics; however, there are some common characteristics and challenges present in many of these areas that may contribute to difficulties accessing health care and to persistent health disparities. For instance, in certain parts of the United States, rural areas are very large and sparsely populated – for example, remote American Indian/Alaska Native tribal areas.

Figure 1 shows population density by county across the United States. While population density is an imperfect proxy for urban vs. rural status, the map shows that large portions of the Great Plains, Southwest, Alaska, and upper New England have very low population densities relative to other regions of the US.

Figure 1: Population Density by County



Source: American Community Survey data from the U.S. Census Bureau from 2014-2018.

Other demographic factors also influence urban-rural disparities in health care. On average, residents of rural communities have lower median incomes² and are less likely to be insured.³ Rural populations tend to be older; rural populations have proportionately more adults age 65 and older and their share is growing.⁴ Older individuals on average are more likely to have chronic health conditions and may face additional challenges with mobility, access to transportation, and traveling long distances to access care. One in five rural residents is Black, Hispanic, American Indian/Alaska Native, Asian American/Pacific Islander, or mixed race, and these racial/ethnic groups in rural areas often experience additional barriers to care and disparities in outcomes.⁵

Selected characteristics of the non-elderly uninsured by rural status are shown in Table 1. In terms of many demographic characteristics, the non-elderly uninsured are similar in rural and urban areas, although the

[†] This estimate is based on 2016 American Community Survey data (link to source [here](#)). There are several definitions of rural areas used by different parts of the federal government. The Census Bureau and the Office of Management and Budget create two of the primary definitions used, which are then modified in the version used by the Federal Office of Rural Health Policy (FORHP) at the U.S. Department of Health and Human Services (HHS). Using geographic boundaries defined as of the 2010 Census, the Census Bureau definition included 59.5 million people as living in rural areas, compared to 46.2 million using the Office of Management and Budget's definition, and 57 million using FORHP's definition. More information about the definitions used by FORHP and other federal agencies is available here: <https://www.hrsa.gov/rural-health/about-us/definition/index.html>

uninsured in rural areas are less likely to be Hispanic or Asian and more likely to be White non-Hispanic. Federal and state healthcare coverage programs like Medicaid, CHIP, Marketplace, and Medicare provide comprehensive health insurance coverage for millions of rural residents and there is an opportunity to cover many more, as described later in this brief.

Table 1. Selected Characteristics of Uninsured Individuals Ages 0-64 in Rural vs. Urban Areas, 2019

	Rural 17.3% of uninsured adults <65	Urban 82.7% of uninsured adults <65
Mean age	34.6 (32.7, 36.6)	34.9 (34.1, 35.6)
Male	52.3% (47.0%, 57.6%)	54.2% (51.8%, 56.6%)
Race/ethnicity		
Hispanic/Latino (all races)	25.8% (19.0%, 34.1%)	41.1%*** (37.8%, 44.5%)
White (non-Hispanic)	55.5% (47.7%, 63.0%)	39.7%*** (36.7%, 42.8%)
Black (non-Hispanic)	8.9% (5.8%, 13.3%)	12.3% (10.5%, 14.4%)
Asian (non-Hispanic)	1.0% (0.4%, 2.3%)	3.4%*** (2.5%, 4.5%)
American Indian/Alaska Native (non-Hispanic, alone or with another race)	6.7% (3.0%, 14.3%)	2.0%* (1.3%, 2.9%)
Other	2.1% (0.8%, 5.1%)	1.5% (1.0%, 2.3%)
Mean annual family income (top coded at \$220,000)	\$45,277 (\$39,745, \$50,809)	\$51,023 (\$47,847, \$54,199)
Delayed or did not receive care due to cost (last 12 months)	30.2% (25.8%, 34.9%)	30.0% (27.8%, 32.3%)
Has usual source of care	71.0% (65.1%, 76.3%)	62.9%* (60.3%, 65.5%)
Education (18-64 only)		
Less than high school	30.9% (25.5%, 36.9%)	25.4% (22.8%, 28.2%)
High school/GED	37.7% (31.7%, 44.1%)	35.3% (32.9%, 37.7%)
Post-high school	31.4% (25.9%, 37.5%)	39.4%* (36.9%, 41.9%)

Source: National Health Interview Survey, 2019. 95% confidence intervals are shown; tests of statistical difference between columns are shown as follows: * for p-value<0.05, ** for p-value<0.01, *** for p-value<0.001. Item non-response is not included in these numbers; the highest non-response was 1.3% for urban education, all other non-response was less than 1.0%.

In this report, we describe patterns in insurance coverage and uninsured rates in rural and urban areas; review non-financial challenges in accessing care for rural residents and disparities in health outcomes between rural and urban areas; and conclude by discussing policies, programs, and resources designed to address barriers to care in rural America.

DATA AND METHODS

Our analysis uses several data sources. The American Community Survey (ACS) 1-year files from 2010 to 2019 were used to calculate uninsured and Medicaid coverage rates among non-elderly adults.⁶ The ACS is conducted by the Census Bureau and is the largest national survey of households; however, only geographic areas with at least 65,000 individuals are included in the ACS 1-year estimates. Because the ACS reports Public Use Microdata Areas (PUMA)-level data, we use crosswalks from PUMAs to core-based statistical area (CBSA) type (i.e., metropolitan, non-metropolitan), as defined by the Office of Management and Budget, to assign each PUMA to a single CBSA type, defining non-metropolitan areas as “rural.”⁷ Health insurance data by county was obtained from the Small Area Health Insurance Estimates (SAHIE) from the Census Bureau. Data on demographics and access to care among the uninsured population were obtained from the 2019 National Health Interview Survey (NHIS), a nationally representative survey of the civilian, noninstitutionalized population that covers a wide range of health-related topics. Marketplace data were obtained from the CMS Center for Consumer Information and Insurance Oversight (CCIIO) plan selection and characteristic files for the open enrollment periods for 2015-2021 coverage in [HealthCare.gov](https://www.healthcare.gov) states.[‡] Estimates of the number of uninsured adults newly eligible for Medicaid if remaining non-expansion states expanded are from ASPE’s microsimulation model – the Transfer Income Model version 3 (TRIM3) – which are based on an analysis of the Census Bureau’s Current Population Survey for calendar year 2018, using each state’s rules for Medicaid eligibility as of 2021.

Population density by county was calculated using ACS 5-year data (2014-2018). Data on health professional shortage areas (HPSAs) by county were obtained from the Health Resources and Services Administration (HRSA).

HEALTH INSURANCE COVERAGE

Uninsured Rates

The ACA expanded access to health coverage for millions of Americans, including those living in rural areas. Figure 2 demonstrates the substantial decline in the uninsured rate among non-elderly rural residents after implementation of the ACA’s coverage expansions, from 23.7 percent in 2010 to 16.0 percent in 2019, which paralleled the decline in urban uninsured rates.

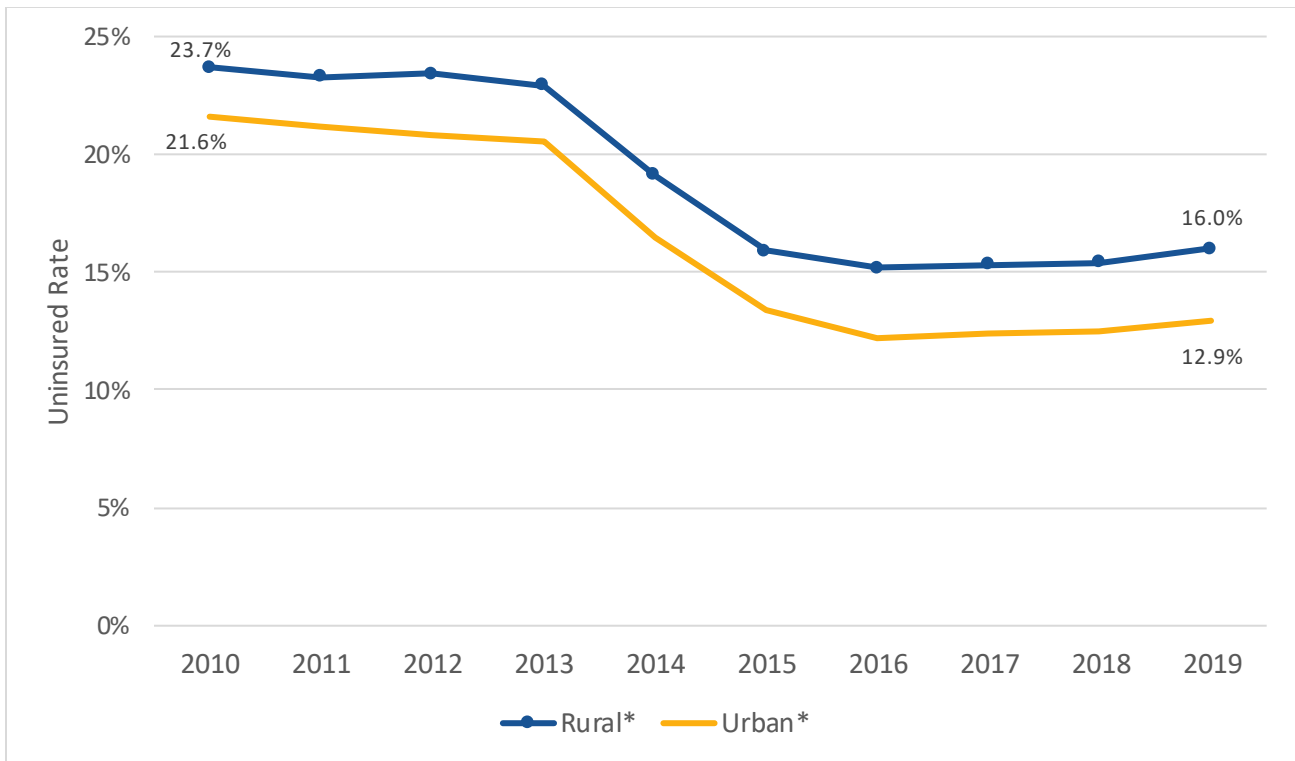
While overall uninsured rates have been declining in the United States since passage of the ACA,⁸ individuals living in rural areas still have higher overall uninsured rates than those in urban areas (16.0 vs. 12.9 percent in 2019, respectively).⁹ Rural areas have a 2-3 percentage-point higher uninsured rate compared to urban areas over the 2010-2019 period. Moreover, earlier research indicates that uninsured rates increase with degree of rurality.¹⁰ Between 2016 and 2019, the uninsured rate for both urban and rural populations increased slightly during a period of reduced funding for outreach, attempts to repeal the ACA, and other policies by the Trump administration that reduced enrollment (described at more length in a previous ASPE report).¹¹

1 in 5 Americans live in rural areas*
1 in 6 rural adults under 65 is enrolled in Medicaid
1 in 10 rural adults under 65 is enrolled in Marketplace
1 in 3 rural adults is enrolled in Medicare
1 in 6 rural adults ages 19-64 is uninsured

* Sources: Census Bureau, 2016; analysis of American Community Survey (ACS), 1-year estimates, 2019.

[‡] Marketplace data for states that do not use the HealthCare.gov platform are not reported as timely or with the same level of detail as HealthCare.gov states and therefore these states are not included in Marketplace estimates in this report.

Figure 2: Uninsured Rates Among Non-elderly Adults by Rural (Non-Metropolitan) Status, 2010-2019

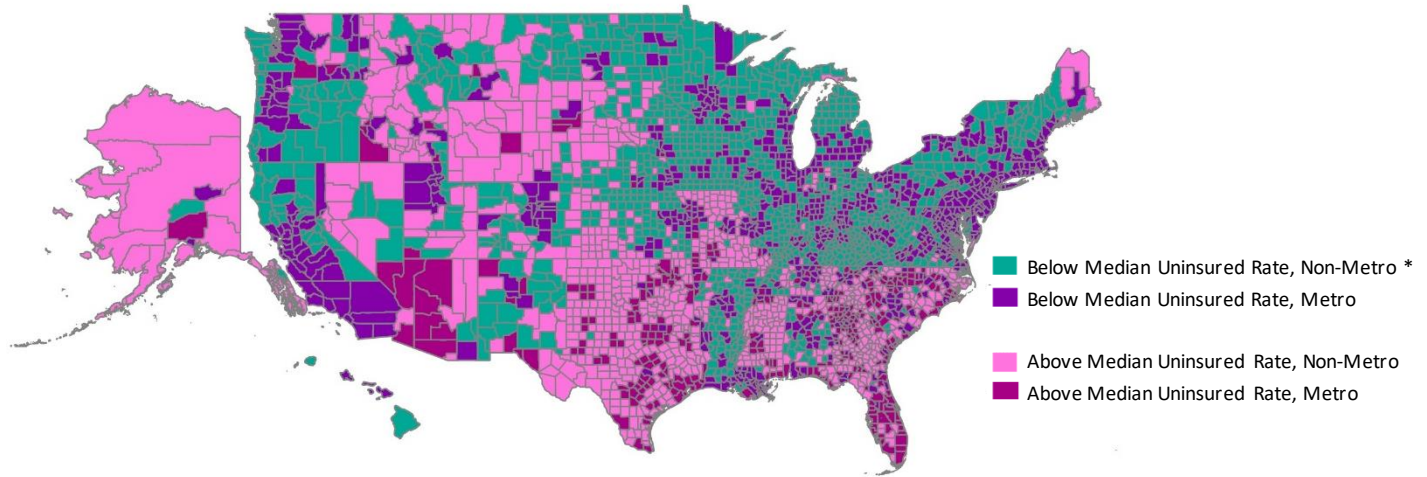


Source: American Community Survey (ACS), 1-year estimates, 2010-2019

*Definition of rural and urban based on PUMA to CBSA (where CBSA metropolitan areas are defined as “urban” and non-metropolitan areas are defined as “rural”).

Figure 3 shows counties by metropolitan/non-metropolitan status and by whether they have uninsured rates above or below the median of 11% (among the non-elderly, noninstitutionalized population) in 2019. The uninsured rate varies widely across the country. Rural counties with uninsured rates above the median (shown in pink in Figure 3) tend to be clustered in the South, Southeast, and Midwest. For example, Oklahoma had a number of rural counties with relatively high uninsured rates in 2019. However, the state implemented an expansion of its Medicaid program on July 1, 2021, which could extend coverage to nearly 200,000 individuals across the state (across both urban and rural areas).¹² Many urban counties with high uninsured rates (shown in red) are also concentrated in the South and Southeast.

Figure 3: High and Low Uninsured Rates among the Non-Elderly Population by County Metropolitan Status, 2019



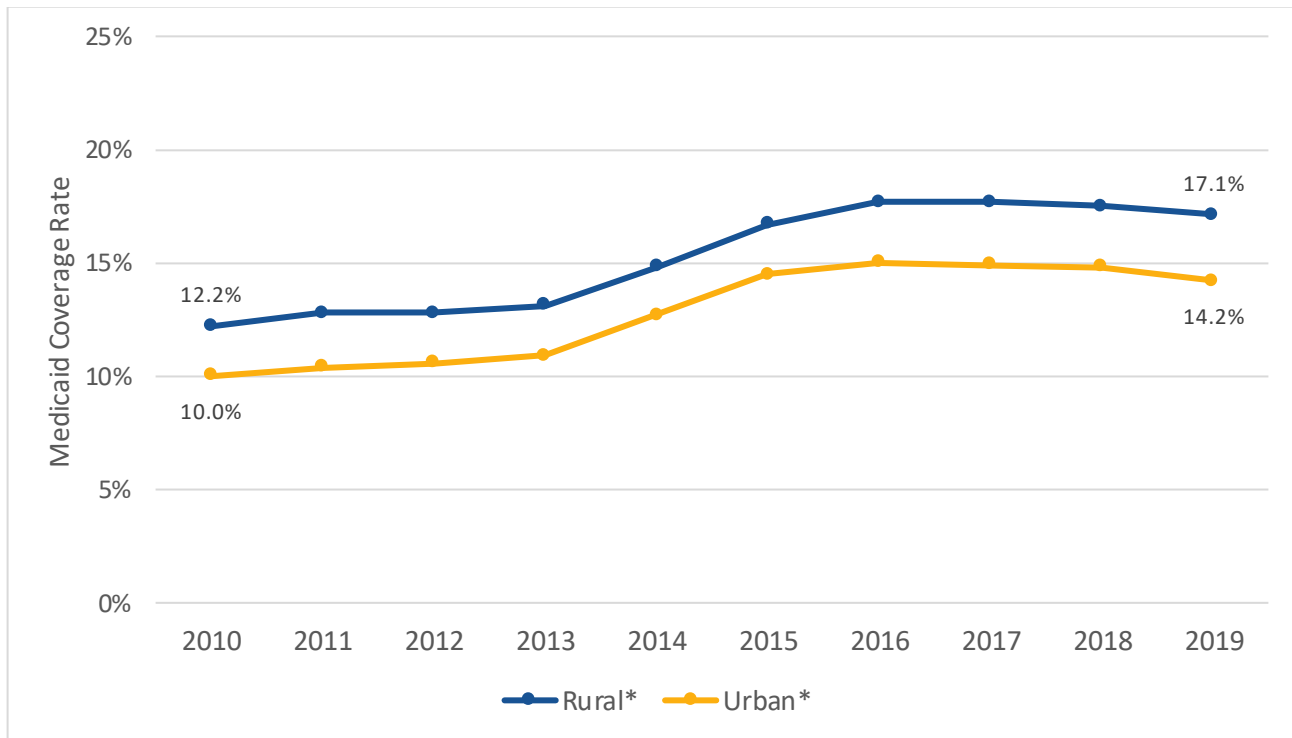
Source: 2019 Small Area Health Insurance Estimates from the U.S. Census Bureau.

* The median uninsured rate is defined as the median uninsured rate across rural and urban counties

Medicaid and CHIP Coverage

Medicaid and the Children’s Health Insurance Program (CHIP) provide an essential safety net for access to health care for millions of low-income adults, children, and families. Medicaid and CHIP are especially important sources of coverage for rural communities, with Medicaid the primary coverage for 1 in 6 individuals ages 19-64 in rural areas in 2019 (Figure 4). Additionally, 22 percent of individuals (including those 65 and older) in rural areas are dually enrolled in Medicaid and Medicare.¹³ As mentioned above, rural populations are more likely to be low-income and more likely to be unemployed or work for employers that do not offer health insurance, both factors that lead to high Medicaid coverage rates.¹⁴ Medicaid coverage rates have increased substantially since the passage of the ACA, from 12.2 percent of the rural population in 2010 to 17.1 percent in 2019 (Figure 4), with a peak in 2016 and 2017 of 17.7 percent. In multiple states including Arizona, Arkansas, California, Florida, and Hawaii, rural areas have Medicaid coverage rates that are at least ten percentage points greater than those in urban areas of the state.¹⁵

Figure 4: Medicaid Coverage Rates Among Non-elderly Adults by Rural (Non-Metropolitan) Status, 2010-2019



Source: American Community Survey (ACS), 1-year estimates, 2010-2019

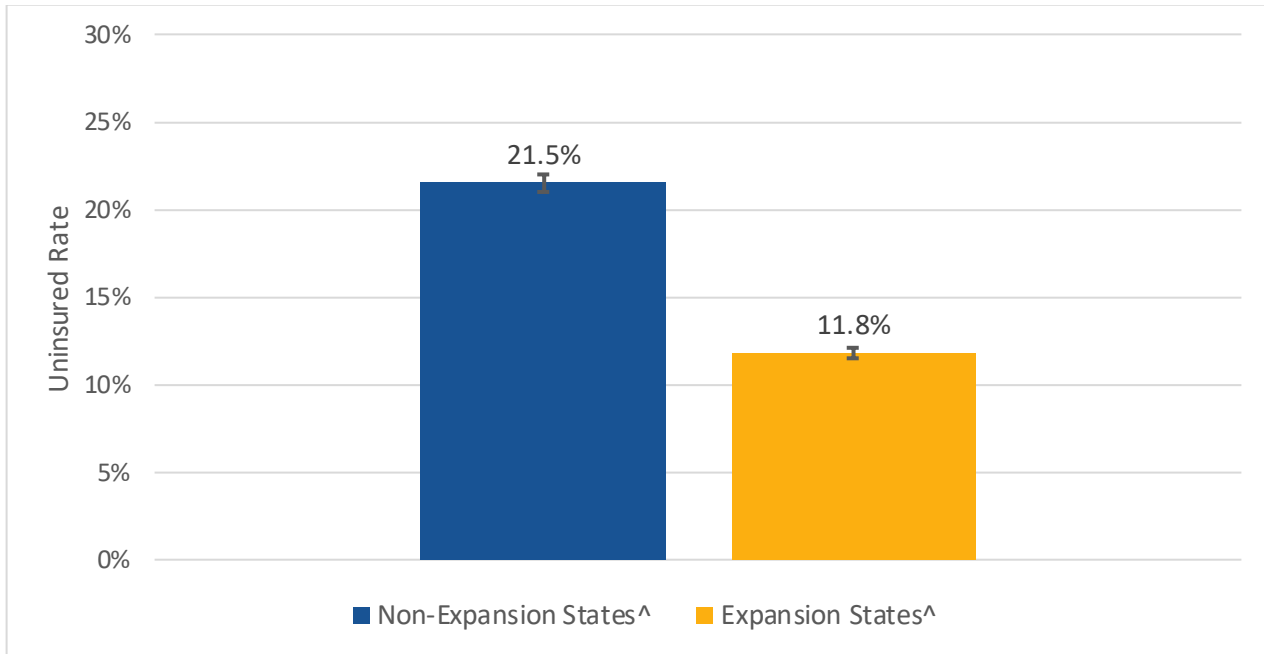
*Definition of rural and urban based on PUMA to CBSA (where CBSA metropolitan areas are defined as “urban” and non-metropolitan areas are defined as “rural”).

Medicaid is also a particularly important source of coverage for rural pregnant individuals, covering 50 percent of rural births in 2018, compared to 41.9 percent of urban births.¹⁶

States that have expanded Medicaid have lower rural uninsured rates. In states that have not expanded Medicaid, many individuals under 100 percent FPL may be ineligible for Medicaid and ineligible for Marketplace subsidies, leaving many with no option for affordable health insurance. This is known as the Medicaid coverage gap. In rural areas of the 13 states that have not expanded Medicaid, nearly 683,000 non-elderly adults with incomes below 100 percent FPL are uninsured, and 65.2 percent of these individuals (approximately 445,000) would be newly eligible for Medicaid if all these states were to expand Medicaid.⁵ The rural uninsured rate in states that have not expanded their Medicaid programs is 21.5 percent compared to 11.8 percent in expansion states (Figure 5). Although Medicaid expansion status is not depicted in Figure 3, many of these states are reflected in the areas shown in Figure 3 that have uninsured rates above the median.

⁵ These estimates come from ASPE’s microsimulation model – the Transfer Income Model version 3 (TRIM3) – based on analysis of the Census Bureau’s Current Population Survey, Annual Social and Economic Supplement (CPS ASEC) 1-year estimates for calendar year 2018. People are counted as uninsured if they are not classified in the survey data as having any type of insurance coverage for any part of the year; also, Medicaid enrollment that was imputed by the Census Bureau is disregarded for individuals with incomes too high to qualify based on their state and characteristics. The model assesses adult eligibility using the modified adjusted gross income (MAGI) FPL standards in place in 2021, along with other eligibility policies related to Supplemental Security Income and medically needy standards in place in 2018. Undocumented immigrants imputed to be unauthorized are still included in the total uninsured estimates; however, they are not classified as Medicaid-eligible in the analysis. Non-metropolitan areas are defined as “rural”. States included are Alabama, Florida, Georgia, Kansas, Mississippi, Missouri, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming.

Figure 5: Uninsured Rate among the Non-Elderly Population in Rural* (Non-Metropolitan) Areas, by State Medicaid Expansion Status, 2019



Source: American Community Survey (ACS), 1-year estimates, 2019 with 95% confidence intervals

*Definition of rural and urban based on PUMA to CBSA (where CBSA metropolitan areas are defined as “urban” and non-metropolitan areas are defined as “rural”).

[^]Definition of non-expansion and expansion states based on status of Medicaid expansion implementation as of 01/01/2019, obtained from KFF.¹⁷

Studies indicate that Medicaid expansion has been associated with greater reductions in the uninsured rate in rural compared to urban areas.^{18,19} Medicaid expansion has also been found to be associated with increases in visits at Community Health Centers in rural areas for nearly 20 different services, including mammograms, mental health, and substance use disorders.^{20,21} In rural areas with high baseline uninsured rates, Medicaid expansion was also associated with improved hospital financial performance and lower likelihood of hospital closure.²² However, many states with large proportions of rural residents have not expanded Medicaid.²³

Marketplace Coverage

The ACA Marketplace is another important source of health insurance coverage for lower- and middle-income individuals and families not eligible for Medicaid and without access to other affordable coverage, such as employer-sponsored insurance or Medicare. However, rural areas often have fewer insurers, including insurers participating in the federal Marketplace on the HealthCare.gov platform and State-Based Marketplaces (SBMs): on average, 2.5 insurers per county are participating in non-metro counties in 2021, compared to 3.1 insurers in metro counties, which is associated with reduced competition among insurers, higher premiums for unsubsidized individuals, and less choice for all consumers.²⁴

Table 2 shows that among HealthCare.gov enrollees (excluding those enrolled through SBMs that use their own platform), individuals in rural areas comprised approximately 15 percent of plan selections in the most recent open enrollment period (OEP) for 2021 coverage, similar to most previous OEPs. In the 2021 OEP, 1.2 million consumers living in rural counties signed up for or had their coverage automatically renewed through the HealthCare.gov platform. The share of rural versus urban plan selections remained similar in analyses conducted using 2021 plan selections as of March 1, 2021 (15% rural and 85% urban); however, it is notable that the same analysis found that rural residents make up a disproportionately larger share of the remaining uninsured non-elderly adults that may be eligible to enroll in Marketplace coverage on HealthCare.gov with financial assistance (Table 3).

Table 2. Marketplace Plan Selections in HealthCare.gov States by Rural/Urban Status, 2015-2021, by Population Count (in Millions) and Percent*

	2015		2016		2017		2018		2019		2020		2021	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Total Plan Selections in HealthCare.gov States	8.8	100%	9.6	100%	9.2	100%	8.7	100%	8.4	100%	8.3	100%	8.3	100%
Rural[^]	1.3	14.4%	1.4	14.7%	1.4	14.7%	1.3	14.9%	1.2	14.8%	1.2	14.8%	1.2	15.0%
Urban	7.6	85.6%	8.2	85.3%	7.8	85.3%	7.4	85.1%	7.2	85.2%	7.1	85.2%	7.0	85.0%

Source: CCIIO MIDAS Open Enrollment Period Plan Selection and Characteristics Files, Coverage Year 2015-2021 Open Enrollment Periods

*HealthCare.gov plan selection counts are all as of approximately the end of the Open Enrollment Period for the coverage year

[#]HealthCare.gov plan selection counts are in millions

[^]Definition of rural and urban is based on county-level FIPS crosswalk to CBSA (where CBSA type of metropolitan areas are defined as "urban") available here: <https://www.census.gov/geographies/reference-files/time-series/demo/metro-micro/delineation-files.html>; note: this is not the same sub-county (ZIP) definition of rural and urban used in other reporting such as reports based on the HRSA Federal Office of Rural Health Policy (FORHP): <https://www.hrsa.gov/rural-health/about-us/definition/datafiles.html>. Hence, our rural estimates may differ somewhat from estimates produced elsewhere that use a different definition of rural.

Many Marketplace consumers, including those in rural areas, can now find more affordable coverage under the American Rescue Plan (ARP) premium tax credit enhancements and extensions.^{25,26,27,28} As shown in Table 3, under the ARP, zero- and low-premium health plans are now available to approximately 78.7 percent and 88.4 percent of current HealthCare.gov enrollees in rural counties, respectively, which is similar to urban counties with 78.7 percent and 86.7 percent of enrollees qualifying for such coverage, respectively. Additionally, 65.1 percent and 76.8 percent of remaining uninsured non-elderly adults in rural counties may now be able to find a zero- or low-premium health plan on HealthCare.gov, respectively, which are somewhat higher percentages than in urban areas (60.9 percent and 72.5 percent, respectively). In absolute numbers, this reflects 1.3 million people living in rural areas with access to at least one zero-premium plan.

Table 3. Zero- and Low-Premium Plan Availability for Current HealthCare.gov Enrollees and Uninsured Non-elderly Adults by Rural/Urban Status, Pre- and Post-American Rescue Plan of 2021

	Population # (%)		\$0 Available - Any Metal			\$50 or Less Per Month Available - Any Metal		
			Pre-ARP, %	Post-ARP, %	% Point Diff	Pre-ARP, %	Post-ARP, %	% Point Diff
Total Enrollees in HealthCare.gov States*	7,968,000	(100%)	65.9%	78.7%	+12.7%	78.1%	87.0%	+8.9%
Rural[^]	1,193,000	(15.0%)	65.2%	78.7%	+13.5%	78.8%	88.4%	+9.6%
Urban	6,774,000	(85.0%)	66.0%	78.7%	+12.6%	78.0%	86.7%	+8.7%
Total Uninsured in HealthCare.gov States***	11,103,000	(100%)	42.5%	61.7%	+19.2%	56.8%	73.3%	+16.5%
Rural[^]	1,921,000	(17.3%)	46.7%	65.1%	+18.4%	60.6%	76.8%	+16.2%
Urban	9,182,000	(82.7%)	41.6%	60.9%	+19.4%	56.0%	72.5%	+16.5%

Source: HHS Office of the Assistant Secretary for Planning and Evaluation: Zero- and Low-Premium Brief Series, 2021 (available [here](#))

*HealthCare.gov plan selections as of 3/1/2021

**Remaining uninsured as of 2019 from the American Community Survey. The uninsured examined in this analysis are non-elderly adults (ages 18-64) in HealthCare.gov states who are likely eligible for Marketplace plans and APTCs based on their incomes being above 138 percent FPL in Medicaid expansion states, and above or equal to 100 percent FPL in non-expansion states. We do not examine those with incomes below 100 percent FPL in the uninsured part of the analysis, though some individuals in this income range may be QHP-eligible.

[^]Definition of rural and urban is based on county-level FIPS crosswalk to CBSA (where CBSA type of metropolitan areas are defined as "urban") available here: <https://www.census.gov/geographies/reference-files/time-series/demo/metro-micro/delineation-files.html>; note: this is not the same sub-county (ZIP) definition of rural and urban used in other reporting such as reports based on the HRSA Federal Office of Rural Health Policy (FORHP): <https://www.hrsa.gov/rural-health/about-us/definition/datafiles.html>. Hence, our rural estimates may differ somewhat from estimates produced elsewhere that use a different definition of rural.

NON-FINANCIAL BARRIERS TO CARE

Despite gains in insurance coverage that have occurred in rural areas, individuals living in rural areas often face other challenges in accessing care. One of the most important barriers to accessing care in many rural communities is provider availability. Table 4 below shows the ratio of a selection of provider types per 10,000 persons in metropolitan and non-metropolitan areas. It illustrates the discrepancy in per capita providers, particularly for physicians. Many rural areas experience persistent provider shortages, particularly for certain types of specialists and for primary care providers.²⁹ Certain rural areas have also been significantly impacted by the overdose crisis and, when combined with a shortage of behavioral health specialists in many rural areas,³⁰ residents in these areas may face significant barriers to receiving treatment for substance use disorder.³¹

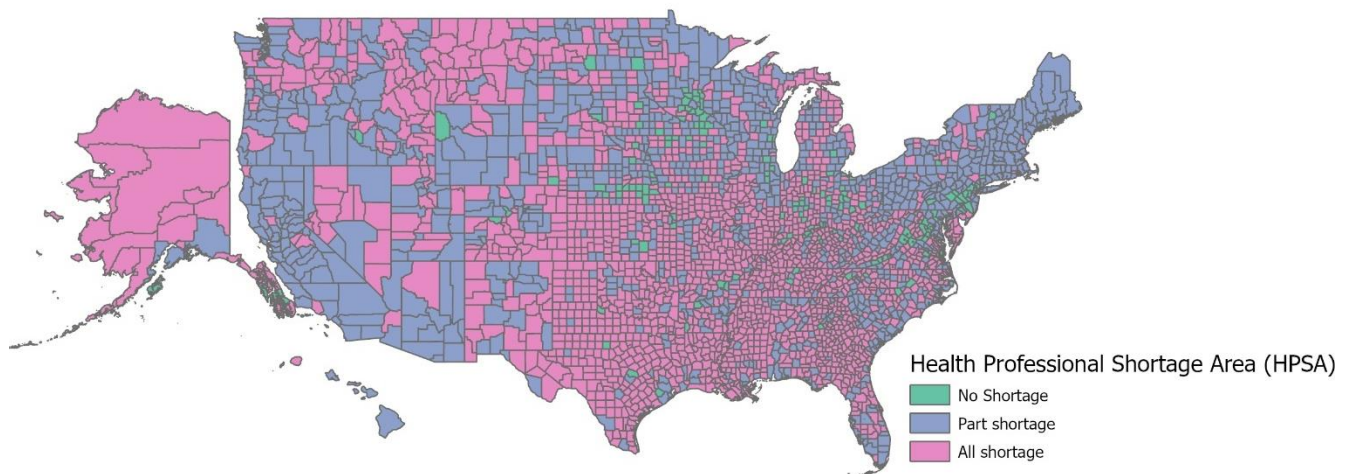
Table 4: Providers per 10,000 Persons for Metropolitan and Non-Metropolitan Areas

	Non-Metropolitan	Metropolitan
Physicians	13	33
Nurse Practitioners	7	9
Dentists	3	5

Source: HRSA Area Health Resources Files, 2018 and 2019

To help address these problems of geographic maldistribution of providers, HHS identifies areas of the country that have shortages of critical health professionals and facilities for the purposes of directing program resources to address provider shortages. One designation is a health professional shortage area (HPSA) for primary, dental, or mental health care providers, which is used, for instance, in directing resources for the National Health Service Corps and the Nurse Loan Repayment Program (described in greater detail below). For all three of these types of providers, the vast majority of HPSAs are located in rural areas.³² Figure 6 below shows the distribution of primary care HPSAs by county and by whether the county is partially or entirely a shortage area. It demonstrates that these HPSAs are distributed across the country, with significant overlap with rural and southern counties (as in Figure 1). As discussed in greater detail below, Community Health Centers receiving federal grants must be located in medically-underserved areas or serve medically-underserved population groups, which are separate designations used to identify areas where there are shortages of providers.

Figure 6: Primary care health professional shortage area designations by county



Source: HRSA data as of April 2021, accessed via ruralhealthinfo.org.

A related issue is the decline in the number of rural hospitals and concerns about maintaining hospital services in rural areas. Rural hospitals can face particular challenges to financial viability, such as small populations and low patient volumes and serving older and sicker patients as well as patients who are more likely to be low-income, more likely to be covered by public insurance rather than private insurance, and more likely to be uninsured.^{33,34,35,36} Rural hospital closures are also more likely to occur in communities with larger Black and Hispanic populations and in areas with higher unemployment, which can further contribute to disparities in outcomes.³⁷ Rural pregnant individuals face limited access to obstetric services, with nearly half of all rural counties lacking hospital obstetric services and 179 rural counties experiencing closures of hospital obstetric services between 2004 and 2014.³⁸ Payment policies such as Critical Access Hospital designation have helped retain some basic hospital services in many rural areas, but rural hospitals are less likely to provide all the services that urban hospitals provide, such as intensive care units,³⁹ psychiatric units,⁴⁰ and obstetric care.⁴¹ There has also been a fairly steady rate of rural hospital closures since 2010.^{42,**} In addition, individuals in rural areas can be geographically isolated and therefore often tend to live farther from care⁴³ and lack public reliable public transit, which can make care harder to access and contribute to worse health outcomes (particularly in emergencies).

The COVID-19 pandemic put additional stress on health care systems and particularly on some hospitals during earlier phases of the public health emergency when overall utilization rates declined. The COVID-19 Provider Relief Fund allocated \$11.09 billion to rural areas in particular, which went to 8,858 facilities (including rural acute general hospitals, Critical Access Hospitals, Rural Health Clinics, and Community Health Centers located in rural areas). To help support rural providers during the pandemic, HRSA also has provided \$100 million to encourage vaccine confidence and outreach in rural communities, as well as funding the Small Hospital Improvement Program (SHIP) to support COVID-19 activities, including a planned additional \$398 million to SHIP grantees to work with 1,730 small rural hospitals for COVID-19 testing and mitigation. Nonetheless, there were 19 rural hospital closures in 2020.^{44,45}

** In this context, hospital closure means cessation of short-term acute inpatient care. The closure can be a complete closure, in which no health care services are available at the former hospital site; but other closures are converted closures, meaning that a facility continues to provide services other than inpatient care (e.g., outpatient, emergency, urgent care, SNF, rehab, etc.).

INTERVENTIONS THAT ADDRESS ACCESS TO CARE FOR RURAL POPULATIONS

Telehealth

Given the distances to care and shortages of provider availability that exist in many rural communities, telehealth has presented a potential opportunity to improve access to care. Before the COVID-19 pandemic, payment policies for telehealth for Medicare fee-for-service (FFS) was limited, even in the context of care provided to rural patients, while more of the expansion in coverage of telehealth had taken place in the commercial insurance marketplace. Overall, telehealth utilization was low as a percent of all health care utilization. For instance, fewer than 1% of Medicare FFS primary care visits were provided via telehealth in February 2020, before the public health emergency began.^{46,47} However, in response to the COVID-19 public health emergency, during which in-person visits fell precipitously in the early months of the pandemic, significant waivers to Medicare (FFS) reimbursement policies and many states' Medicaid reimbursement policies were issued. For instance, the Centers for Medicare & Medicaid Services (CMS) expanded the Medicare FFS services that were eligible for telehealth, allowed audio-only visits (as opposed to requiring video), expanded the type of practitioners eligible to provide telehealth, removed geographic restrictions (previously, with a few exceptions, only rural patients were eligible to receive telehealth services), and loosened site of service requirements to allow patients to receive telehealth wherever they're located (including their home).⁴⁸ Many states also broadened the use of telehealth to deliver services in Medicaid during the pandemic.

Overall utilization of telehealth increased dramatically during the pandemic, particularly during early months. For example, compared to the same time period during 2019, in April 2020 there was a 350-fold increase in primary care telehealth visits among Medicare FFS beneficiaries.⁴⁹ An analysis of data from four large telehealth providers showed a 154 percent increase in telehealth visits during the last week of March 2020, compared to the same period of 2019.⁵⁰ Most of the changes to payment policy that led to these increases in telehealth utilization are set to expire at the end of the public health emergency, unless steps are taken to make them permanent.

One constraining factor to utilization of telehealth services – particularly telehealth with video – in rural areas is availability and affordability of broadband internet access. An analysis by of data from the U.S. Census Bureau's 2019 American Community Survey estimated that 60.9 percent of persons in non-metropolitan areas reported having access to broadband internet service while 13.4 percent had no internet access at all, compared to 76.7 percent and 7.4 percent, respectively of persons in metropolitan areas.⁵¹ In areas where broadband is available, available service options might still not be considered affordable. Broadband internet access is generally required to utilize video telehealth services.

Workforce Programs

HHS and the federal government more broadly support several programs designed to bolster the healthcare workforce, particularly for underserved populations and communities, of which many have a focus on rural areas. These programs aim to help alleviate the issues of provider shortages and to improve quality of care in these communities. One such program is the National Health Service Corps (NHSC), which offers scholarships and loan repayment for students who commit to serve in a Health Professional Shortage Area (which are, as mentioned above, often located in rural areas). As a result, approximately 1 in 3 providers participating in the NHSC works in a rural area.⁵² Another similar example is the Nurse Corps Loan Repayment Program, which provides loan repayment to registered nurses in exchange for a commitment to either work at facilities with a shortage of nurses or to serve as a nurse faculty in an eligible facility. Some examples of eligible facilities

include Federally Qualified Health Centers, Community Mental Health Centers, American Indian Health Facilities, Small Rural Hospitals, and Rural Health Clinics, among others.⁵³ Currently, there are approximately 1,700 Nurse Corps clinicians and 135 Nurse Corps faculty participating in the program, and since 2020, 411 of them have served at rural sites and schools.

HRSA funds the Area Health Education Center grant program, which provides funding to grantees who provide community-based training and develop strategic partnerships in their communities. The goal of the program is to expand the distribution of the health care workforce and increase quality of care, particularly in rural and underserved communities. Between 2014 and 2019, 42 percent of the individuals who had completed one of these training programs were from rural backgrounds and 40 percent or more of the experiential training sites were in rural areas.⁵⁴

Another example is HRSA's Behavioral Health Workforce Education and Training (BHWET) Program, which funds a variety of initiatives with the goal of enhancing the quality of education and clinical training of the behavioral health workforce. An additional goal is to increase the number of individuals working as behavioral health providers and paraprofessionals. The program has a particular focus on providing training for serving in underserved and rural communities. Of the graduates who responded to a follow-up survey after the program, 46 percent reported working in either medically underserved or rural communities.⁵⁵

HRSA's Rural Residency Planning Grant program and the Teaching Health Center program can also play a role in expanding the pipeline of rural physicians through their emphasis on community-based training. Many rural areas also rely on the State Conrad 30 J-1 Visa waiver program that allows states to place foreign-trained physicians in underserved areas.^{56,57,58}

Health Care Clinics and Centers

In addition to the Department's workforce programs, HHS provides funding through grants to help support certain types of primary care facilities, which may be located in rural areas. For instance, HRSA provides funding for Community Health Centers, which provide community-based, culturally competent primary and specialty care. These facilities serve vulnerable populations (and provide services regardless of a patient's ability to pay and on a sliding fee scale) and are located in areas that are underserved and where there may be barriers to access to care.

Community Health Center services always include primary medical care and often include pharmacy, mental health, substance abuse, and oral health services coupled with enabling services, such as case management, outreach and enrollment support, transportation, interpretation and health education, to help ensure that clients are able to access the health care they need. Approximately one in five rural residents, one in three individuals living in poverty, and one in four uninsured individuals get care from a HRSA-funded Community Health Center each year.⁵⁹ In 2019, more than 40 percent of HRSA-funded Community Health Center organizations were located in rural areas.⁶⁰

Another example is the Rural Health Clinic Program, in which healthcare facilities that meet certain requirements are reimbursed at enhanced rates by Medicare and Medicaid. They must be located in rural underserved areas and meet certain other requirements such as using a team approach to delivering care with physicians working with non-physician providers such as nurse practitioners and physician assistants. They are also required to provide outpatient primary care and basic laboratory services, but unlike Community Health Centers, they are not required to provide care regardless of insurance status or ability to pay of patients.⁶¹ There are currently nearly 4,500 Rural Health Clinics distributed across 47 states and serving over 7 million individuals.⁶²

DISPARITIES IN HEALTH OUTCOMES

Despite the ACA and ARP's major expansion of coverage in rural areas and HHS's programs to enhance access to care, disparities in health outcomes and mortality between rural and urban areas have persisted for many years on a wide range of measures. For instance, rural populations have higher mortality rates overall,⁶³ higher rates of premature death (defined as years lost before age 75),⁶⁴ and a higher percent of potentially excess deaths from the five leading causes (heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke).⁶⁵ On average, rural areas also have higher rates of maternal and infant mortality as well as maternal morbidity.^{66,67,68,69} Rural communities have worse rates on several measures relating to mental and behavioral health, such as higher rates of suicide,^{70,71} higher rates of age-adjusted overdose deaths,⁷² as well as higher rates of any diagnosed mental illness and serious mental illness.⁷³ Those living in rural areas also tend to have higher rates of many chronic conditions such as hypertension and obesity, which may reflect, in part, the relatively older age distribution of residents in many rural communities.⁷⁴ In addition, rural residents also have higher rates of cigarette smoking, lower levels of physical activity, and lower rates of seatbelt use.^{75,76,77}

People of color living in rural areas frequently have worse health outcomes and higher mortality compared to rural non-Hispanic White residents as well as to urban residents of the same race. They are also more likely to live in economically depressed rural areas compared to their White counterparts.^{78,79} Research has shown the important contribution of socioeconomic factors and other social determinants of health to health outcomes.^{80,81,82,83,84}

In the context of the COVID-19 pandemic, urban areas were impacted most during the early months of the pandemic, which began to spread to many rural areas during the summer of 2020.⁸⁵ Cumulative per capita case rates were higher in metropolitan areas until the end of October 2020, when case rates in non-metropolitan areas surpassed those in metropolitan areas. This trend continued until April 2021, when the rates were approximately the same.⁸⁶ Many of the demographic, socioeconomic, and health factors that disadvantage rural populations would have also contributed to rural residents being more vulnerable to COVID-19 infection. HRSA has been providing support to rural areas in multiple ways during the pandemic, through programs such as Telehealth Resource Centers, Community Health Centers, and rural Tribal communities. HRSA is also providing a direct allocation of COVID-19 vaccines to Rural Health Clinics, independent of any state/jurisdiction allocation, ensuring that individuals who have not been reached by other means are able to get vaccinated from local, trusted providers. HHS provided additional support through larger programs such as the Provider Relief Fund, the Paycheck Protection Program, and increased funding to the Teaching Health Center Graduate Medical Education (THCGME) Program.⁸⁷ While this report focuses on healthcare access and coverage for rural residents in particular, the above findings taken together also speak to the importance of addressing other factors that can affect health outcomes in rural areas such as social determinants of health and availability of healthcare providers.

CONCLUSION

Disparities in health outcomes and mortality between rural and urban communities have persisted for many years, and these disparities are worse for more vulnerable populations such as Black, American Indian/Alaska Native, and people of color, as well as people with low incomes. Although rural areas are diverse and vary widely across the country across multiple dimensions such as population size, racial/ethnic composition, and socioeconomic status, many rural communities share geographic and demographic challenges such as distance to care, infrastructure limitations, provider shortages, lack of broadband access, and aging populations that contribute to persistent health disparities.

Expanding coverage is one way to increase access to care, and uninsured rates in rural areas have fallen substantially since the passage of the ACA, although overall uninsured rates in rural areas continue to be higher than in urban areas. Medicaid is an important source of coverage in rural areas, and the percent of individuals living in rural areas who are covered by Medicaid is higher than in urban areas and has increased substantially since implementation of the ACA. States that have not expanded their Medicaid programs have significantly higher uninsured rates in rural areas than states that have expanded Medicaid. More than a million Marketplace enrollees are in rural areas, and more than 3 of 4 individuals who remain uninsured in rural areas of states that use the HealthCare.gov platform may be able to find zero- or low-premium plans (after premium tax credits) under the ARP.

There are a number of other services and programs financed or supported by HHS, including telehealth, health workforce programs, and Rural Health Clinics and Community Health Centers, that make important contributions to reducing barriers to access to care in rural communities. These policies and ongoing coverage expansion are key tools in HHS's effort to improve outcomes and health equity in rural America where nearly 1 in 5 Americans reside.

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ABOUT THE AUTHORS

Gina Turrini is a Social Science Analyst in the Office of Health Policy in the Office of the Assistant Secretary for Planning and Evaluation.

D. Keith Branham is a Senior Research Analyst for the Office of Health Policy in the Office of the Assistant Secretary for Planning and Evaluation.

Lucy Chen is an intern in the Office of Health Policy in the Office of the Assistant Secretary for Planning and Evaluation.

Ann B. Conmy is a Social Science Analyst in the Office of Health Policy in the Office of the Assistant Secretary for Planning and Evaluation.

Andre R. Chappel is the Director of the Division of Public Health Services in the Office of Health Policy in the Office of the Assistant Secretary for Planning and Evaluation.

Nancy De Lew is the Associate Deputy Assistant Secretary for Health Policy in the Office of the Assistant Secretary for Planning and Evaluation.

Benjamin D. Sommers is the Deputy Assistant Secretary for the Office of Health Policy in the Office of the Assistant Secretary for Planning and Evaluation.

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