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Insight on the Issues

Health Care Coverage, Affordability, and Access Among Rural and Urban Adults Ages 50 to 64

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Key Takeaways

- ✓ **The Affordable Care Act reduced the uninsured rate among adults ages 50 to 64 in both urban and rural areas, though rural areas continue to have higher uninsured rates.**
- ✓ **Coverage gains among this age group were driven primarily by increased Medicaid enrollment in both urban and rural areas.**
- ✓ **Nongroup (i.e., individual) health insurance enrollment expanded more among older urban residents than it did among older rural residents.**
- ✓ **Household income, coverage options, and health insurance premiums likely factor into differences in rural and urban coverage rates.**
- ✓ **Rural residents ages 50 to 64 are more likely than their urban counterparts to delay or cancel care due to cost.**

Introduction

The Patient Protection and Affordable Care Act of 2010 (ACA) helped increase access to health insurance coverage by expanding Medicaid eligibility, establishing health insurance marketplaces where people can shop for and purchase individual coverage, and providing financial assistance to help enrollees afford their health care costs (see sidebar for additional details). As a result, more older Americans gained health insurance coverage and fewer reported having unmet health care needs due to cost or difficulty paying medical bills.[1]

This analysis examines rural-urban differences in health care coverage, affordability, and access over time from 2012, two years prior to implementation of the ACA, through 2019, the sixth full year of ACA Marketplace operations (see Methods in Appendix for more details).[2]

Examples of ACA Provisions Affecting Coverage Affordability

- Authorizes financial assistance (premium tax credits and cost-sharing reductions) to help people with modest incomes afford ACA Marketplace coverage
- Requires plans to cover essential benefits
- Prohibits insurers from charging higher rates or denying coverage due to preexisting conditions
- Prohibits insurers from charging older adults premiums that are more than three times what younger adults are charged ("age rating" limits)
- Provides monetary incentive to states to expand Medicaid eligibility to adults with incomes up to 138 percent of the federal poverty level (FPL).

Trends in health insurance coverage in urban and rural areas

The ACA improved health coverage among older adults in all areas, but small rural–urban differences persist.

Both rural and urban areas saw health coverage gains after ACA implementation, but older adults living in rural areas have consistently been more likely than older adults living in urban areas to be uninsured (figure 1). Uninsured rates dropped from 2013 through 2016 in both rural and urban areas, after which uninsured rates began to gradually increase due to factors such as fewer states expanding Medicaid, market uncertainty, and federal policy changes.[3]

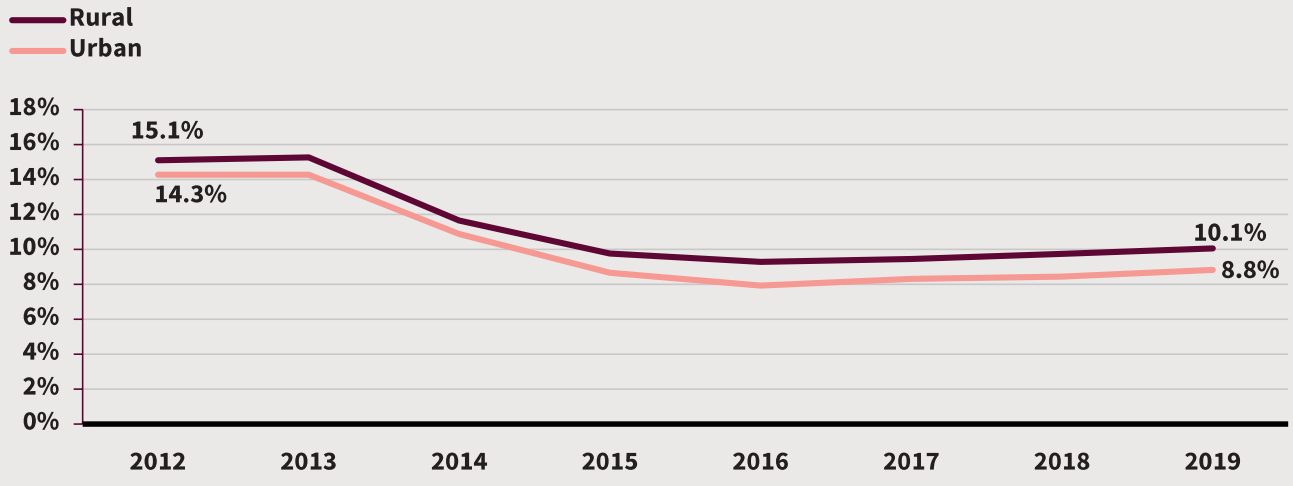
ACA-era coverage gains were driven primarily by increased Medicaid enrollment in both urban and rural areas.

One factor that could play a role in the urban-rural coverage gap is differences in access to employer coverage. Most adults ages 50 to 64 in both rural and urban areas have health coverage through their employers; however, in both 2012 and 2019, adults living in urban areas were more likely than those in rural areas to have employer coverage (figure 2). When narrowed down to only employed adults ages 50 to 64, those in urban areas were still more likely than those employed in rural areas to have employer coverage in both years (figure 3). These findings are consistent with prior research showing that urban residents are more likely to receive offers of employer-based coverage.[4]

With the ACA giving states the option to expand Medicaid, by 2019 Medicaid became the second-largest source of health coverage for adults ages 50 to 64 in both urban and rural areas, behind employer insurance. In 2012, the share of older adults enrolled in Medicaid was the same in urban and rural areas (8.3 percent; figure 2). With Medicaid expansion, Medicaid enrollment among adults ages 50 to 64 outpaced enrollment among all other forms of coverage between 2012 and 2019—and this was the case in both rural and urban areas. Medicaid enrollment rose even more among rural older adults, increasing 5.3 percentage points compared with 4.6 percentage points among urban older adults. However, older adults in rural areas continued to have higher uninsured

FIGURE 1

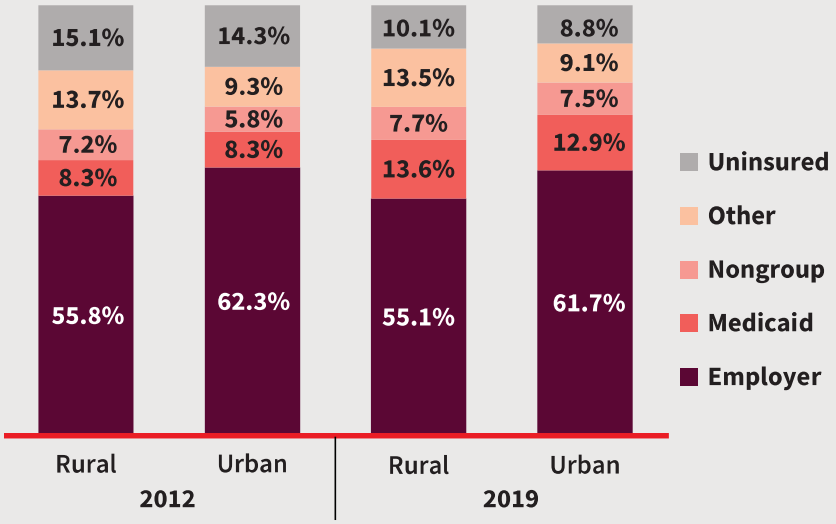
Uninsured Rate Among Adults 50 to 64 in Urban vs. Rural Areas, 2012–19



Source: *KNG Health analysis of 2012–19 ACS Data.*

FIGURE 2

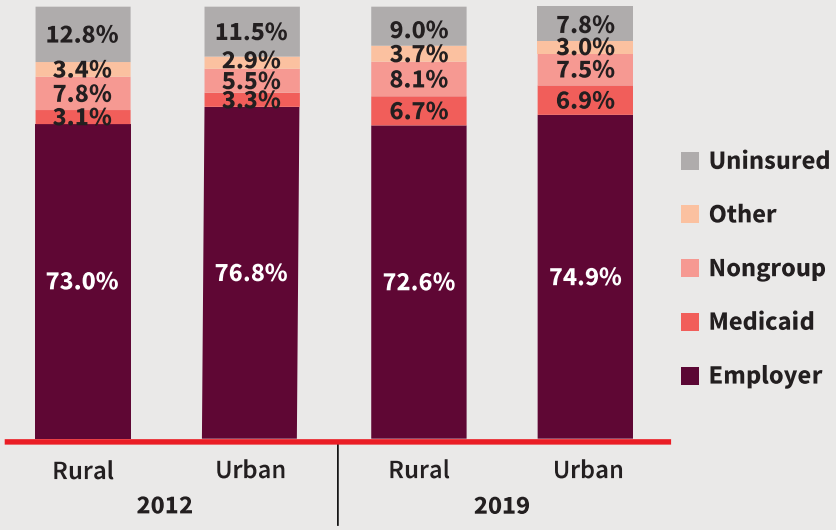
Rural vs. Urban Adults Ages 50 to 64, by Source of Coverage and Year



Source: *KNG Health analysis of 2012–19 ACS Data.*

FIGURE 3

Employed Adults Ages 50 to 64 in Rural vs. Urban Areas, by Coverage Type



Source: *KNG Health analysis of 2012–19 ACS Data.*

rates in 2019, even in Medicaid expansion states. In Medicaid expansion states, 7.6 percent of rural adults ages 50 to 64 were uninsured in 2019, compared with 6.7 percent of adults in urban areas (data not shown).

Smaller shares of older adults in both rural and urban areas had nongroup (or individual) coverage compared with other forms of coverage in 2019, though the share with nongroup coverage grew slightly between 2012 and 2019. Older adults in urban areas were more likely to enroll in nongroup coverage post-ACA, with an increase of 1.7 percentage points (from 5.8 percent to 7.5 percent) compared with 0.5 percentage points among older adults in rural areas (from 7.2 percent to 7.7 percent) between 2012 and 2019.

Possible factors driving rural–urban coverage differences

Rural older adults have lower average incomes.

Among older adults living in both rural and urban areas, uninsured rates decline as income increases (figure 4). In 2019, adults ages 50 to 64 living in rural areas had lower average incomes than those of adults living in urban areas; rural older adults were more likely to live in or near poverty and far less likely to have incomes above 600 percent of the federal poverty level (FPL; figure 5). These income differences likely played a role in differences in uninsured rates among rural and urban older adults.

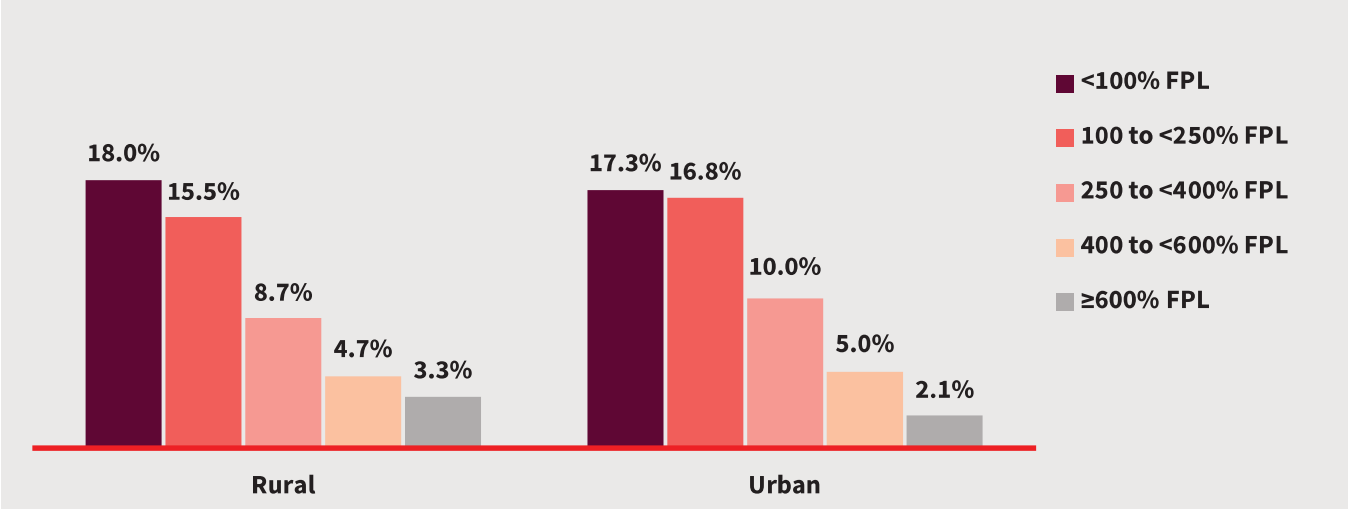
Rural older adults are less likely to be offered health insurance through their employers.

In 2019, the share of adults ages 50 to 64 who were offered health insurance through their employers was 5.8 percentage points higher in urban than in rural areas–at 77.4 percent versus 71.6 percent, respectively. This finding is consistent with prior research that found that people in urban areas are more likely to work in industries that offer employer coverage.[5]

These differences in access to employer coverage likely factored into higher rates of employer coverage among working older adults in urban areas. Employed older adults in rural areas were also more likely to be uninsured than those in urban areas, which could be partly due to differences in access to employer coverage.

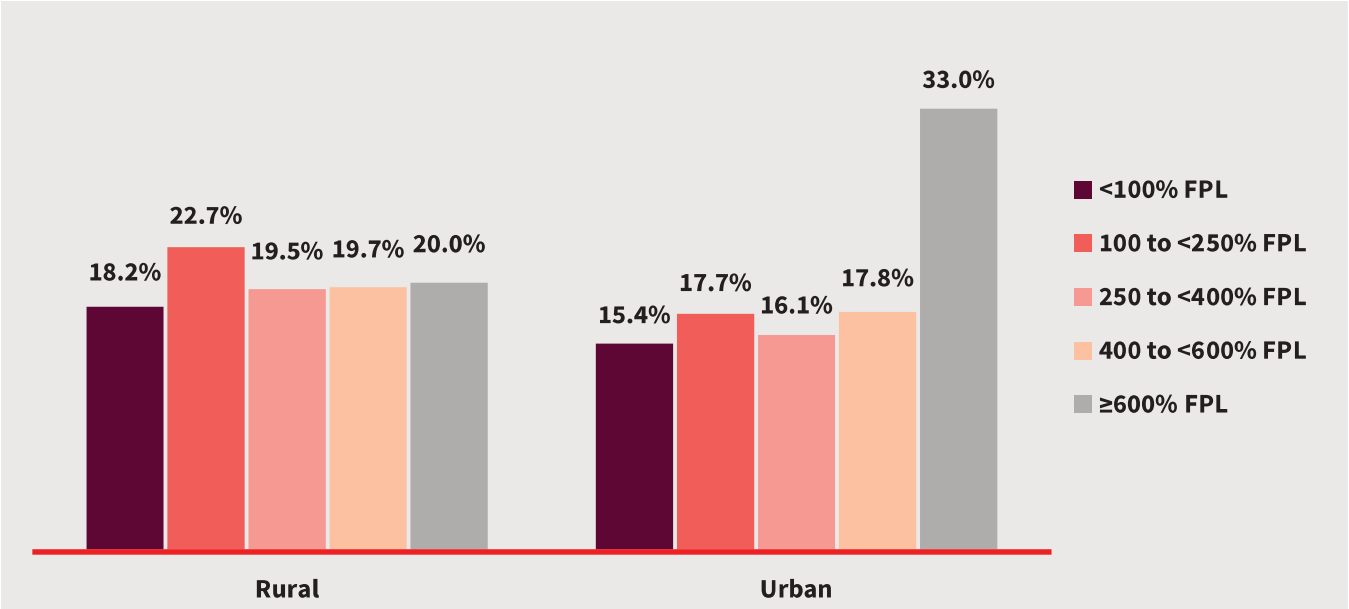
FIGURE 4

Uninsured Rate of Adults Ages 50 to 64 by Urban/Rural Location and Income, 2019



Source: *KNG Health analysis of 2019 ACS Data*

FIGURE 5
Income Distribution of Adults Ages 50 to 64 in Rural vs. Urban Areas, 2019



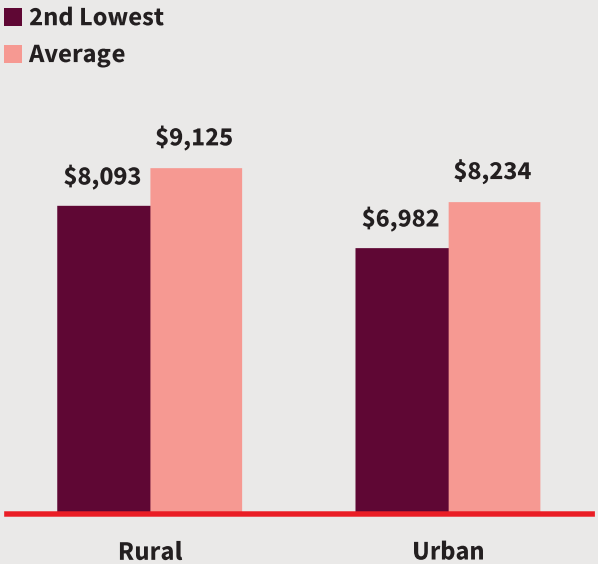
Source: *KNG Health analysis of 2019 ACS Data*

Nongroup premiums are less affordable in rural areas.

Rural working adults ages 50 to 64 face higher unsubsidized premiums in the nongroup health insurance market, which could factor into some rural residents' decisions to forgo coverage. In 2019, annual premiums for second-lowest-cost silver ACA Marketplace plans (used to calculate premium tax credits) were $1,111 lower in urban areas than in rural areas, while average silver plan premiums were $891 lower (figure 6).[6] Bronze and gold plans were also more affordable in urban areas.

Less insurer competition due to lower population density likely drives higher premiums in rural areas.[7] In fact, urban areas tended to have 1.4 times the number of plans offered in rural areas.

FIGURE 6
Second-lowest Cost and Average Marketplace Plan Premium for Silver Plans, 2019



Source: *KNG Health analysis of 2019 HIX Compare data*

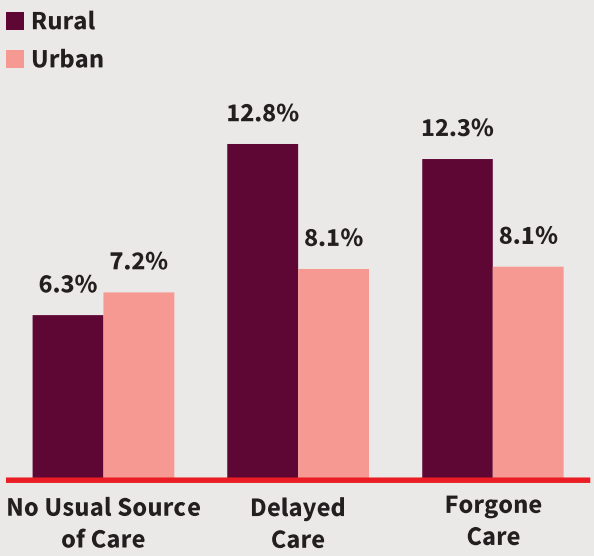
Access to care among rural and urban older adults

Older adults living in rural areas were more likely than their urban counterparts to report delaying or canceling care due to care cost, but they were more likely to report having a usual source of care.

Rural residents face unique barriers to accessing health care, including limited access to providers and having to travel long distances for care.[8] Consistent with previous research, we found that older adults living in rural areas reported delaying care due to cost and canceling care due to cost more often than their urban counterparts did in 2019 (figure 7). However, rural older adults were slightly less likely than their urban counterparts to report having no usual source of care. These patterns were mostly consistent across insurance coverage types.

Cost-related access issues among rural residents could be driven by lower average incomes compared with those in urban areas, as well as issues related to distance to and availability of health providers.

FIGURE 7
Access to Health Care Among Adults Ages 50 to 64



Note: *Rural refers to nonmetropolitan. Urban refers to large central metropolitan (most urban) but does not include large fringe metropolitan or medium and small metropolitan.*

Source: *KNG Health analysis of 2019 NHIS data*

Looking ahead: policy implications for the rural–urban coverage gap

Health insurance is important for healthy aging, and improving access to equitable, affordable, comprehensive coverage and care can help reduce rural-urban health disparities. The ACA improved coverage rates among adults ages 50 to 64 in both rural and urban areas, but our analysis found that small coverage differences and larger gaps in access to care remain. Older adults living in rural areas also continue to face disproportionate barriers to health care and coverage—including higher premiums and fewer coverage options and providers—that can result in forgoing or delaying care and lead to worse health outcomes.[9,10,11] These factors also play a role in higher rates of chronic disease and mortality among older adults living in rural areas.[12]

Policymakers may consider a wide range of proposals to improve access to coverage and affordable health care among older adults, especially those living in rural areas. Examples include the following:

- **Protect ACA health coverage provisions**: Rural older adults gained access to more affordable health care coverage due to ACA provisions such as Medicaid expansion and the prohibition of insurer discrimination based on preexisting conditions. Policymakers should defend against efforts to erode the law and reject proposals to expand certain plans (e.g., short-term plans) that do not comply with ACA consumer protections.
- **Expand Medicaid**: States that have not expanded Medicaid can still do so, and expansion would help improve access to health coverage for older adults in rural areas. Research shows that Medicaid expansion is associated with better financial performance of hospitals and lower

likelihood of hospital closures, especially in rural areas.[13]

- **Improve affordability of individual health coverage**: States could implement reinsurance programs, which lower risk for insurers and have been shown to reduce premiums and maintain insurer participation in state marketplaces.[14,15] This could buffer some of the challenges associated with providing coverage in rural areas. States could also explore policies to redesign or combine rating areas to expand health-insurance risk pools in rural areas.
- **Increase outreach and enrollment efforts**: Medicaid and state marketplaces could target older adults living in rural areas with outreach and enrollment efforts. Such efforts should be culturally and linguistically appropriate and be able to reach those adults who may be socially isolated or not well connected to community services. Enrolling more rural older adults in marketplace plans could also help stabilize markets and bring down premium costs in rural areas.
- **Improve access to health care services and providers**: Policymakers could invest in training, recruiting, and retaining the rural health workforce and explore innovative ways to address provider shortages in rural areas, including improving access to telehealth and ensuring licensed health care practitioners are able to practice at the top of their license. The Center for Medicare and Medicaid Innovation (CMMI) should continue to test alternative payment and delivery models in rural areas, including models that could improve the financial viability of hospitals and other health care facilities in rural areas. Policymakers could ensure adequate funding for safety-net providers in rural areas to meet the needs of uninsured adults and create sustainable transportation models for older adults and those with disabilities to access health care in rural communities.
- **Enhance understanding of rural health needs**: Policymakers could invest in research to better understand the experiences, needs, and preferences of older rural populations and differences within rural populations around access to and affordability of health coverage and care. This could include community-based participatory research and other methods to ensure older residents of rural areas are active participants in research and policy discussions.

These kinds of straightforward solutions can help tackle the rural-urban coverage and access gaps, and they have the potential to improve rural health equity.

Appendix: Methods

KNG Health used the American Community Survey (ACS), National Health Interview Survey (NHIS), Current Population Survey (CPS), Medical Expenditure Panel Survey (MEPS), and HIX Compare (HIX) survey data to study the impact of geographic location on health insurance coverage and access. Analysts employed different methods to categorize levels of rurality due to differences in the data.

The ACS statistics on coverage, employment status, offer rates, premiums, and health plans use a rurality classification derived from public use microdata areas (PUMAs). KNG Health used the percentage of each PUMA's population living in a metropolitan area to classify respondents according to the percentage living in metropolitan areas: 0%, 1-49%, 50-99%, and 100%. Our analyses exclude the "mostly rural" and "mostly urban" categories in order to make comparisons between respondents living in fully rural and fully rural areas. Importantly, nearly 80 percent of ACS respondents live in a 100% urban area ("urban" in this analysis), while only 8 percent live in a 100% rural area ("rural").

The NHIS geography information is limited to 2019 and describes geography using a county-based classification system: "large

ACS

Level of Rurality	% of Respondent's PUMA Living in Metro Area	2019 % of Age 50–64 Population
Rural	0	8.4
Mostly rural	1–49	6.2
Mostly urban	50–99	6.0
Urban	100	79.4

NHIS

Respondent's County Classification	2019 % of Age 50–64 Population
Nonmetropolitan	15.3
Medium and small metro	29.6
Large fringe metro	26.3
Large central metro	28.7

central metro," "large fringe metro," "medium and small metro," and "nonmetropolitan" (distribution of respondents below). Our analysis focused only on nonmetropolitan adults ages 50 to 64 (15 percent of older respondents) and large central metro (29 percent of older respondents), which we define as "rural" and "urban," respectively.

KNG Health cleaned the ACS survey data to match external benchmarks for nongroup and Medicaid coverage, as there were notable differences in health coverage enrollment data when comparing the ACS data with the CMS data.

- To address the undercount in Medicaid enrollment, KNG Health reassigned people to Medicaid with qualifying incomes and then scaled this population to match state-level monthly Medicaid enrollment data.
- The nongroup population was scaled down to meet state-level nongroup benchmarks from the medical loss ratio.
- After scaling to state-level data, national nongroup and Medicaid enrollment counts were scaled to Congressional Budget Office (CBO) national coverage benchmarks.
- KNG Health also scaled NHIS respondent weights to match those in the adjusted ACS by health care coverage types and age ranges (18–49 vs. 50–64) to have comparable aggregate populations between surveys.

To determine employer premium contributions by level of rurality, KNG Health cross-walked MEPS statistics to ACS respondents, by state and industry, across those who reported being employed. Similarly, they cross-walked MEPS offer rates to CPS respondents, by state and employer firm size, across those who reported being employed.

To determine premiums by metal level, numbers of plans, and number of carriers by rurality, KNG Health obtained county-level plan information from HIX and then converted county-level data to PUMA-level data using 2010 county-PUMA population cross-walked from the Missouri Census Data Center Geocorr 2018. This enabled KNG Health to develop PUMA statistics reflecting a blend of those observed in their respective counties. The PUMA-level plan information was then mapped to ACS respondents to determine plan information by rurality.

1 Jane Sung and Olivia Dean, "How Has the Affordable Care Act Affected Americans Ages 50–64?," AARP Public Policy Institute, January 2016, https://blog.aarp.org/thinking-policy/how-has-the-affordable-care-act-impacted-americans-ages-50-64.

2 This paper includes data up through 2019 and does not include COVID-19–related impacts. Subsequent policy actions also likely affected the availability and affordability of coverage, including the expansion of financial assistance for marketplace coverage enacted under the American Rescue Plan Act (ARPA) of 2021.

3 Factors likely contributing to rising uninsured rates after 2016 were the expiration of the ACA's federal transitional reinsurance program, market instability caused by the public debate around repeal of the ACA and the individual mandate penalty, significant reductions in federal funding for marketplace enrollment outreach and advertising, and other federal policy changes like those related to immigration and the public charge rule that may have discouraged enrollment in subsidized health coverage.

4 Sharon L. Larson and Steven C. Hill, "Rural–Urban Differences in Employment-related Health Insurance," *Journal of Rural Health* 21, no. 1 (January 2005):21–30, https://doi.org/10.1111/j.1748-0361.2005.tb00058.x.

5 Vann Newkirk and Anthony Damico, "The Affordable Care Act and Insurance Coverage in Rural Areas," Kaiser Family Foundation, May 29, 2014, https://www.kff.org/uninsured/issue-brief/the-affordable-care-act-and-insurance-coverage-in-rural-areas/.

6 Insurance plans available on the ACA health insurance marketplaces come in four health plan categories, or "metal levels": bronze, silver, gold, and platinum. Bronze plans have the lowest premiums and highest out-of-pocket costs, silver plans have moderate premiums and moderate out-of-pocket costs, gold plans have high premiums and low out-of-pocket costs, and platinum plans have the highest premiums and lowest out-of-pocket costs.

7 E. Wengle, "Are Marketplace Premiums Higher in Rural Than in Urban Areas?" Urban Institute, November 15, 2018, https://www.rwjf.org/en/library/research/2018/11/are-marketplace-premiums-higher-in-rural-than-in-urban-areas.html.

8 "Healthcare Access in Rural Communities," Rural Health Information Hub, Accessed November 3 2022, https://www.ruralhealthinfo.org/topics/healthcare-access.

9 Adam W. Gaffney, Laura Hawks, Alexander C. White, Steffie Woolhandler, David Himmelstein, David C. Christiani, and Danny McCormick, "Health Care Disparities Across the Urban–Rural Divide: A National Study of Individuals with COPD," *Journal of Rural Health* 38, no. 1 (January 2022): 207–16, https://doi.org/10.1111/jrh.12525.

10 Shiwani Mahajan, César Caraballo, Yuan Lu, et al., "Trends in Differences in Health Status and Health Care Access and Affordability by Race and Ethnicity in the United States, 1999–2018," *JAMA* 326, no. 7, (2021):637–48, https://jamanetwork.com/journals/jama/fullarticle/2783069.

David M. Levine, Bruce E. Landon, and Jeffrey A. Linder, "Quality and Experience of Outpatient Care in the United States for Adults With or Without Primary Care," *JAMA Internal Medicine* 179, no. 3 (2019):363–72, https://doi.org/10.1001/jamainternmed.2018.6716.

11 Ibid.

12 Gordon Gong, Scott G. Phillips, Catherine Hudson, Debra Curti, and Billy U. Philips, "Higher US Rural Mortality Rates Linked to Socioeconomic Status, Physician Shortages, and Lack of Health Insurance," *Health Affairs (Millwood)* 38, no. 12 (December 2019): 2003–10, https://doi.org/10.1377/hlthaff.2019.00722.

13 Richard C. Lindrooth, Marcelo C. Perraillon, Rose Y. Hardy, and Gregory J. Tung, "Understanding the Relationship Between Medicaid Expansions And Hospital Closures," *Health Affairs* 37, no. 1 (January 2018): 111–20, https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0976.

14 Chris Sloan and Neil Rosacker, "State-Run Reinsurance Programs Reduce ACA Premiums by 16.9% on Average," Avalere, October 29, 2019, https://avalere.com/press-releases/state-run-reinsurance-programs-reduce-aca-premiums-by-16-9-on-average.

15 Rachel Schwab, Emily Curran, and Sabrina Corlette, "New Georgetown Report: Assessing the Effectiveness of State-Based Reinsurance," Center on Health Insurance Reforms, CHIRblog, November 27, 2018, http://chirblog.org/new-georgetown-report-assessing-effectiveness-state-based-reinsurance/.

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