October 2022

RURAL POLICY RESEARCH INSTITUTE

AN INSURANCE PROFILE OF RURAL AMERICA: CHARTBOOK

ACKNOWLEDGEMENTS

This Chartbook was supported by the Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS) under cooperative agreement/grant #U1C RH20419. The information, conclusions and opinions expressed in this policy brief are those of the authors and no endorsement by FORHP, HRSA, HHS is intended or should be inferred.

The authors of this Chartbook are Timothy McBride, Abigail Barker, Emily Hernandez, Eliot Jost, Leah Kemper, and Keith Mueller.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Over the past decade, health insurance coverage has changed in major ways in rural areas with shifts towards public and publicly subsidized coverage among the nonelderly – Medicaid, Marketplace plans -- and a shift towards Medicare Advantage (MA) among those eligible for Medicare. These trends have been driven largely by policy changes but also by market changes and economic trends. This Chartbook describes these trends in detail. Some of the main findings include the following:

Uninsured Rates

- Uninsured rates were higher in non-metropolitan areas (13.3 percent) than in metropolitan areas (10.8 percent) for the population under age 65, in 2019, consistent with historical patterns;
- Between 2010 and 2019, the overall uninsured rate fell substantially in both non-metropolitan and metropolitan areas.
- The uninsured rate varied substantially across the U.S., with some states in the South and West regions generally having higher uninsured rates than those in other parts of the country.
- In both metropolitan and non-metropolitan areas, people of color (those other than non-Hispanic Whites) had higher rates of uninsurance than did non-Hispanic White persons , a gap which has persisted despite some gains in coverage for racial/ethnic minorities since the implementation of the Affordable Care Act.

Health Insurance

- Overall, workers in non-metropolitan areas were less likely than those in metropolitan areas to be offered health insurance through an employer.
- People in non-metropolitan areas were more likely than people in metropolitan areas to have Medicaid coverage or publicly subsidized Marketplace plans
- In some industries (e.g., agriculture, construction, services, health and social services (which includes education) and general services) private insurance coverage rates were significantly lower in both non-metropolitan and metropolitan areas).
- Medicaid was more likely to be the source of coverage among people living in non-metropolitan areas in the South and West than people living in metropolitan areas in those regions.

EXECUTIVE SUMMARY (CONTINUTED)

- Most people with health insurance had a usual source of care -- that is, a place where they usually go to obtain needed medical care such as a physician's office or a clinic -- but those without health insurance were much less likely to have one than those that have health insurance coverage. However, uninsured people living in rural areas were more likely to have a usual source of care, as compared to uninsured persons living in urban areas.
- Families in non-metropolitan areas were more likely to report problems paying bills than families in metropolitan areas regardless of insurance status. In addition, the percent of income spent on out-of-pocket health care expenses was greater for rural Americans, as compared to urban Americans.

Marketplace and Medicare Advantage (MA) Coverage

- The number of issuers offering Marketplace plans (offered to those under age 65) was significantly lower in rural areas as compared to urban areas: 3.0 average plans in noncore counties as compared to 4.2 plans in metropolitan counties in 2022. However, the number of marketplace plans available in rural areas has been growing in recent years with the average number of plans available in noncore areas increasing from 1.7 plans to 3.0 plans from 2018 to 2022.
- The percentage of non-metropolitan beneficiaries enrolled in an MA plan has grown significantly over time but remains lower than urban. MA plans are available to those over age 65 or disabled and eligible for Medicare.

Data, Methods and Rural Definition

The results presented in this Chartbook are drawn from multiple sources; therefore the rural definition used depends on the data source. Use of different data sources necessitates different rural and urban classifications, because when a county variable is available, more detailed rural/urban classifications can be made using Urban Influence Codes (UICs). Specifically, it is sometimes possible to subdivide non-metropolitan counties into "micropolitan" (UICs 3, 5, and 8) and "noncore" (UICs 4,6,7,9-12). In general, all data sources in this document use the terms "non-metropolitan" and "metropolitan" to classify rural and urban areas. Throughout the text when regions are cited standard Census Bureau definitions of regions are used. That is: Northeast (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, New Jersey, New York and Pennsylvania); Midwest (Illinois, Indiana, Michigan, Ohio, Wisconsin, Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota and South Dakota); South (Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia, Alabama, Kentucky, Mississippi and Tennessee, Arkansas, Louisiana, Oklahoma and Texas), and West (Arizona, Colorado, Idaho,

Montana, Nevada, New Mexico, Utah, Wyoming, Alaska, California, Hawaii, Oregon and Washington).

Data used to describe population characteristics are drawn from the individual-level data in the 2020 American Community Survey (ACS), the 2017-18 Medical Expenditure Panel Survey (MEPS), which were the most recent available data at the time of the analysis. The ACS was analyzed at the Public Use Microdata Area (PUMA) level, and individuals were categorized as metropolitan or non-metropolitan using the Office of Management and Budget (OMB) 2013 metropolitan definitions: if more than 50 percent of the PUMA's population (based on 2010 census) resided in a metropolitan county, the PUMA was considered metropolitan. In addition, federal data describing the marketplaces and Medicare Advantage (MA) plans are used as well. The pandemic had a profound impact on not only actual health insurance coverage, but the availability of data. Collecting data during the pandemic using the ACS to analyze coverage proved to be difficult due to sampling issues. As a result coverage estimates were not released for the ACS for the pandemic period as of the production of this analysis. Although expanded Medicaid rolls and increased Marketplace insurance subsidies may have had significant impacts on people's insurance coverage during the public health emergency, the full extent of the impact of these and other policy changes in response to the pandemic will not be fully known for several years as more data becomes available.

The analysis of ACA Marketplace and Medicare Advantage data is based on administrative data, compiled from aggregated data of all enrollees in these plans, and classified at the county level. This approach allows for categorization of enrollment by classification schemes designated by the US Department of Agriculture (USDA)/Economic Resource Service (ERS) from which definitions of rural people and places are derived.

In general, the data analysis presented in this Chartbook describes the insured and uninsured population; no correlation statistics or multivariate analyses were used to interpret findings. Where the entire population is described (e.g., in Marketplace or MA data), no statistical significance is noted because any observed differences are certain. All presentations of the sociodemographics (e.g., age, race/ethnicity, income, employment status, family structure, insurance type) of a population are statistically significant unless otherwise noted.

The analysis of sociodemographic characteristics of the insured and uninsured is based on the last available data from national surveys, which does not reflect the impact of the COVID-19 pandemic. The possible impact of the pandemic on these findings is discussed in the last section of the Chartbook. Full understanding of the impact of the pandemic on insurance coverage – especially the differential between rural and urban persons – will not be known until disaggregated survey data are available.

INTRODUCTION

Despite a wealth of survey data available on the topic of health insurance, few efforts have been made to comprehensively describe the health insurance landscape in rural America. Due to changes in health insurance markets, the economy and the policy landscape, insurance coverage rates have changed significantly over the last decade. Many of the differences can be attributed to changes in the types of health insurance coverage available to individuals, such as marketplace plans, MA plans and Medicaid coverage.

This Chartbook describes the trends in sources of health insurance coverage for rural and urban people, the insurance market dynamics that may differ in rural America, and the trends in out-of-pocket expenditures, while highlighting policy context and implications related to rural disparities.

Chartbook data presented includes:

- insurance coverage rates at a point in time, and over time;
- coverage rate differences by region of the county and subgroups including socioeconomic characteristics (e.g., age, race/ ethnicity, income, employment status, family structure, insurance type);
- the relationship of health status to insurance coverage;
- affordability of insurance coverage; and
- trends in Marketplace and MA coverage offerings at the county level, including entry and exit into markets, over time in rural and urban areas.

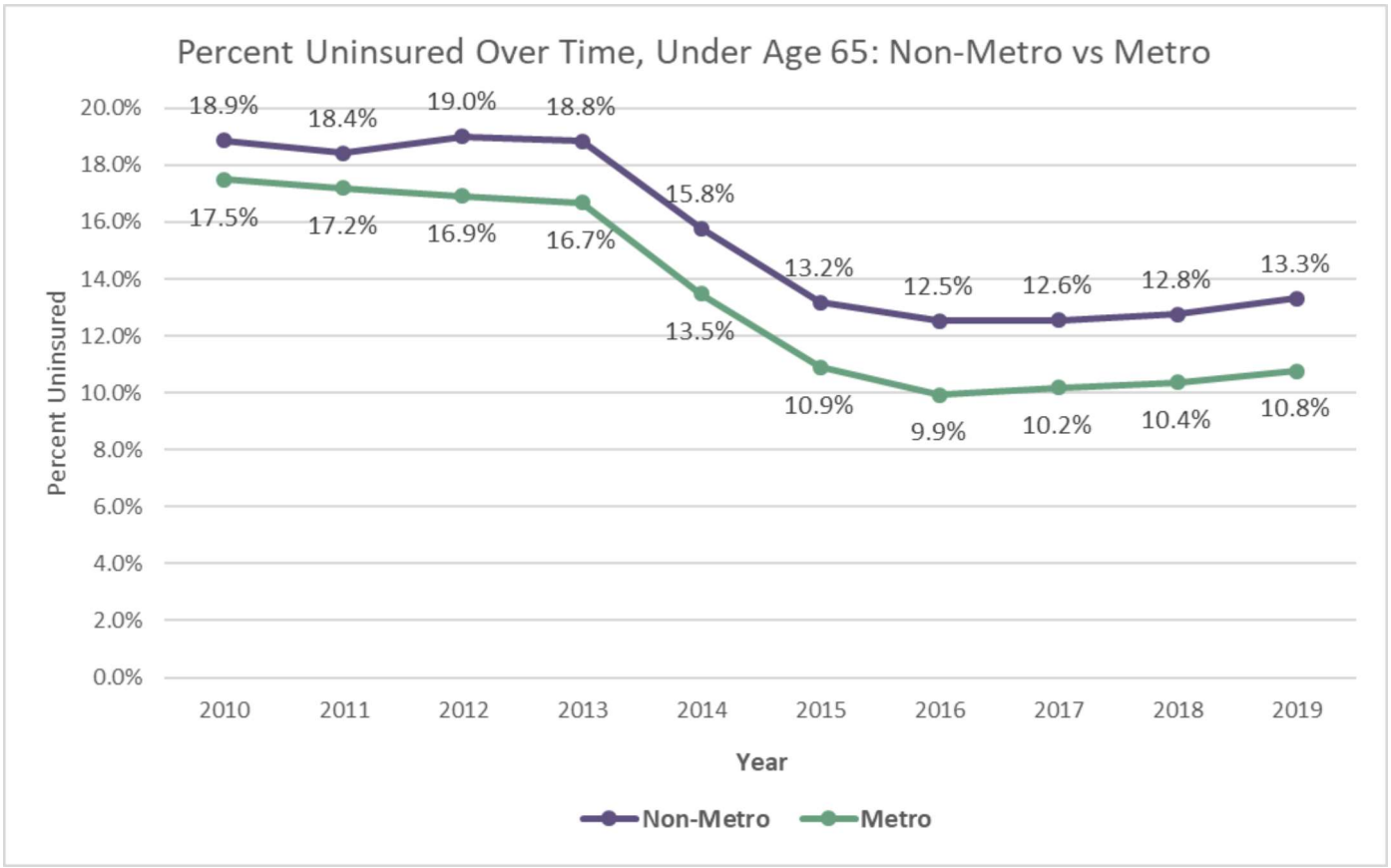
A previous RUPRI Center analysis showed that public health insurance coverage is more prevalent in rural areas while employer-sponsored insurance coverage is more prevalent in urban areas.[1] Other prior work has consistently shown that market-based health insurance programs (especially Marketplace plans, and MA plans) are less robust in rural places.[2] As the policy landscape continually changes, it is important to assess differences in coverage sources over time – as well as differences in consumers' choices and experiences – and to communicate these in an accessible manner.

Analysis provided in this Chartbook can serve as a benchmark not only for understanding recent policy and economic changes and their impact on insurance coverage, but also for how future policy changes may impact insurance coverage and the well-being of rural people, including subpopulations. A Chartbook that displays these findings in graphic and table formats provides a valuable tool to inform policymakers and other stakeholders of the current and recent historical trends in insurance coverage in rural and urban areas.

INSURANCE COVERAGE RATES SUMMARY

UNINSURED RATES OVER TIME

Historically the uninsured rate in non-metropolitan areas has been higher than in metropolitan areas. Between 2010 and 2019, the overall uninsured rate fell substantially in both urban and rural areas. The drop in uninsurance rates after 2013 reflects the impacts of the Affordable Care Act (ACA), including the expansion of Medicaid coverage in some states to include all non-elderly low-income adults (up to 138% of the federal poverty level) and the implementation of the Health Insurance Marketplaces for private health insurance.

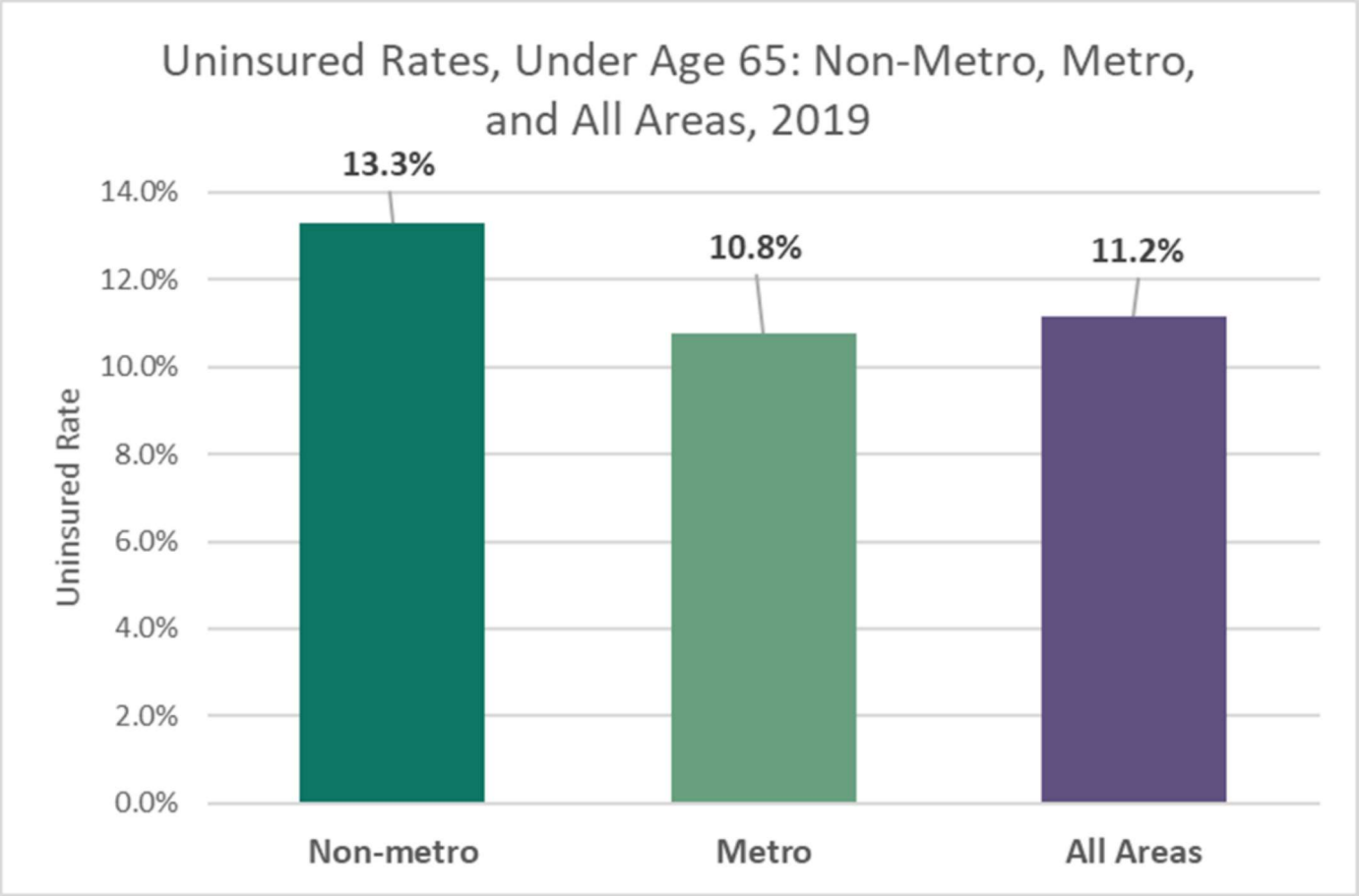


Data source: American Community Survey (ACS) 2010-2019 1-Year Estimates.

INSURANCE COVERAGE RATES SUMMARY (CONTINUED)

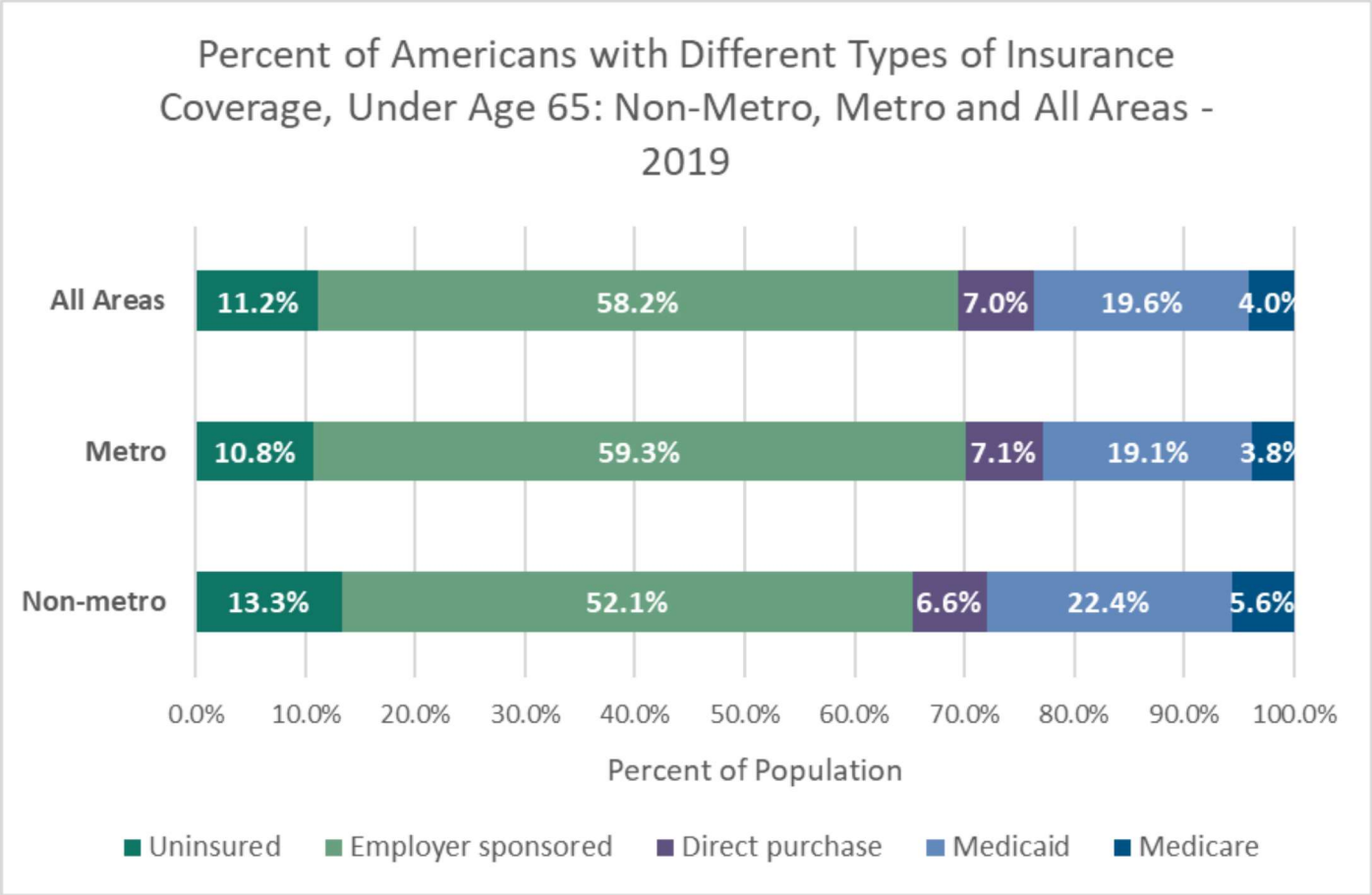
UNINSURED RATES

In 2019, uninsured rates remained higher in non-metropolitan areas 3.3 Percent) than in metropolitan areas (10.8 percent) among the population under age 65.



Data source: American Community Survey (ACS) 2019 1-Year Estimates.

INSURANCE COVERAGE RATES SUMMARY (CONTINUED)



People under the age of 65 in non-metropolitan areas were more likely than people in metropolitan areas to enroll in public sources of coverage. Medicare provides coverage for 5.6 percent of rural Americans under age 65, compared to 3.8 percent of urban Americans, while Medicaid enrolls 22.4 percent of rural Americans compared to 19.1 percent of urban Americans.* Conversely, rural Americans under age 65 are less likely to be enrolled in employer-sponsored insurance (ESI), with 52.1 percent covered, compared to 59.3 percent of urban Americans. The differences likely reflect a number of factors, including: (1) people living in non-metropolitan areas are more likely to work for smaller employers who are less likely to offer health insurance, and (2) higher poverty rates for people living in non-metropolitan areas may qualify them for Medicaid.[3]

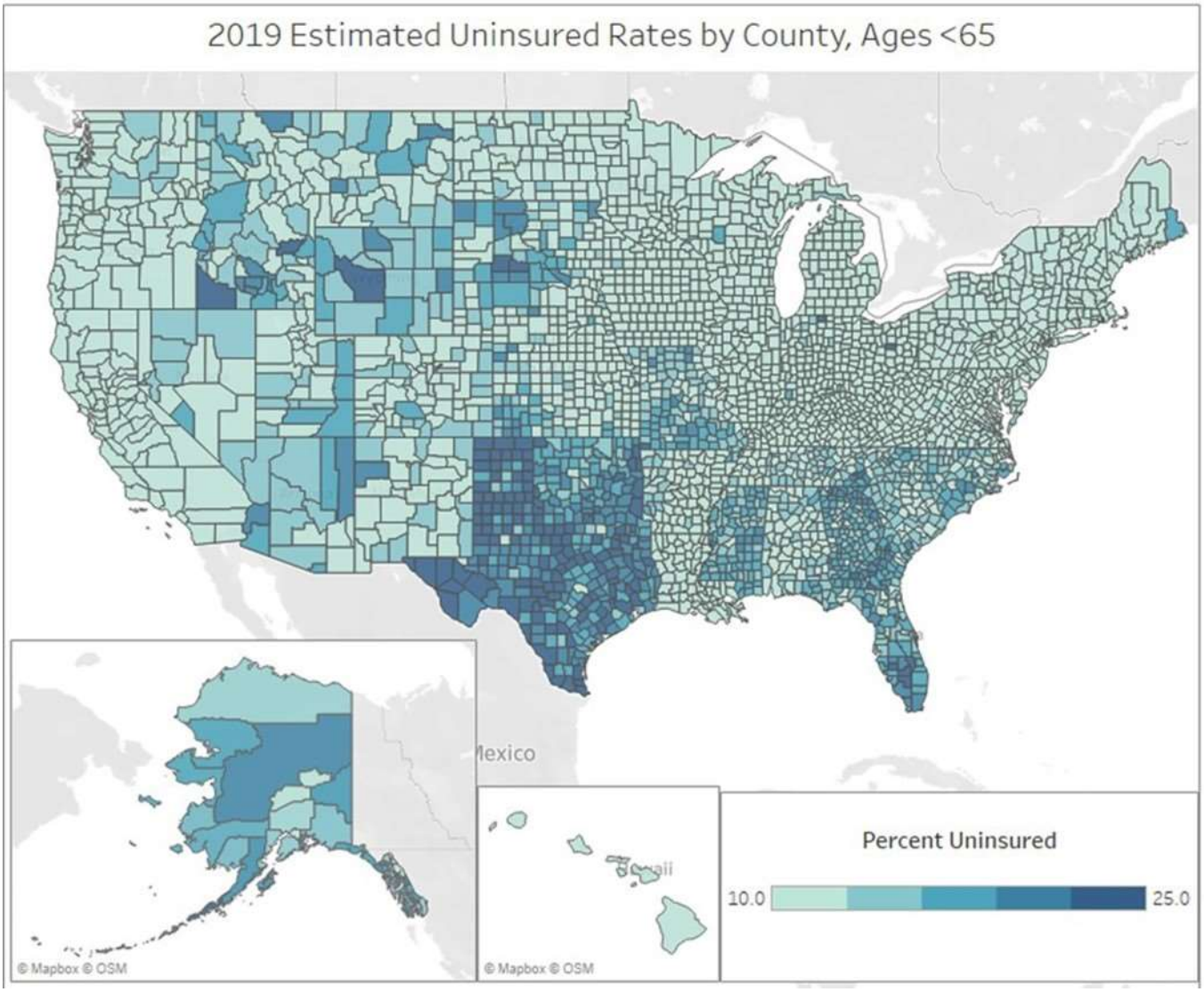
Data source: American Community Survey (ACS) 2010-2019 1-Year Estimates.

**Shown here is the primary insurance for individuals. Individuals can hold one or more individual sources at once. However, this analysis uses a "hierarchy" to assign insurance coverage to one primary source for the purposes of this analysis generally based on which source is the primary payer for medical care: Medicare, private insurance, Medicaid.*

INSURANCE COVERAGE RATES SUMMARY (CONTINUED)

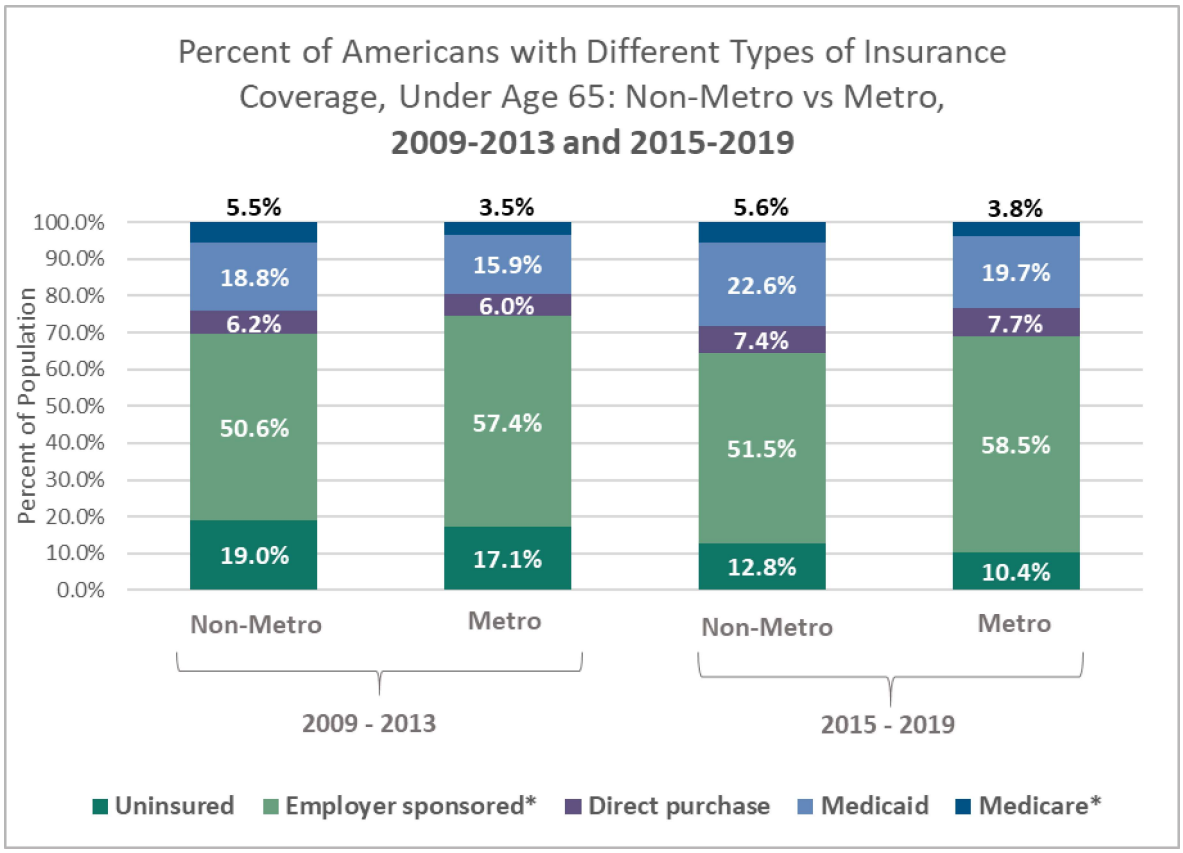
COUNTY LEVEL UNINSURED RATES

The county level uninsured rate varied substantially across the United States, with some states in the South and West regions having counties with higher uninsured rates than in other parts of the country. In part, this likely reflects the lower coverage rates for employer sponsored insurance, but the high levels in certain states are also likely related to a lack of Medicaid expansion by 2019.[4]



Data source: Small Areas Health Insurance Estimates (SAHIE 2019).

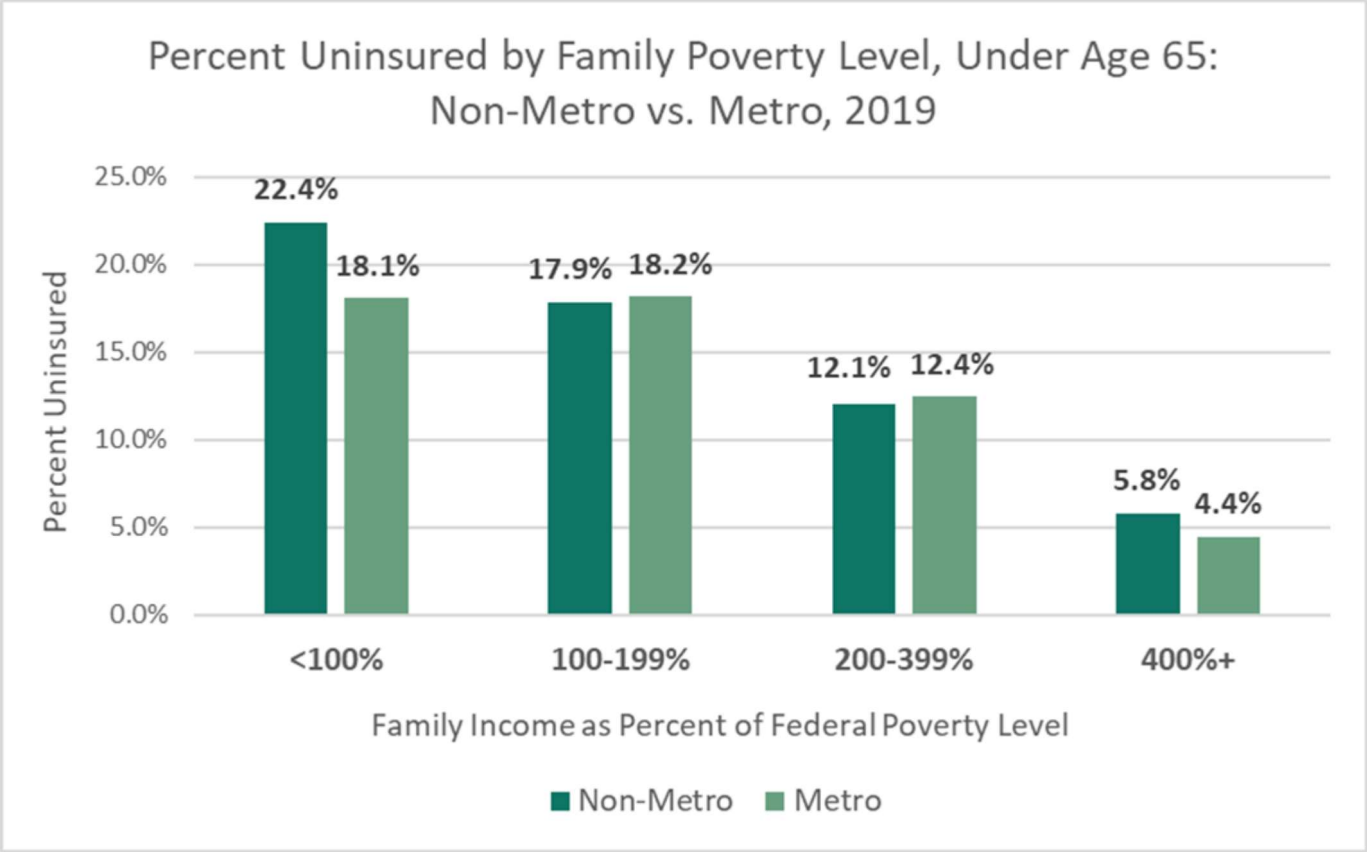
INSURANCE COVERAGE BY TYPE OVER TIME: PRE-AND POST-ACA



Non-metropolitan residents under age 65 were more likely than metropolitan area residents to be uninsured (as noted above) and more likely to be on public coverage (Medicaid or Medicare) or Marketplace plans and these general trends are consistent over time. Medicare includes coverage for the disabled and persons with end stage renal disease, and many recipients of marketplace plans receive subsidies. Comparing two recent ACS 5-year samples, uninsured rates dropped 6.2 percentage points in non-metropolitan areas from the 2009- 13 to the 2015-19 survey, while dropping 6.8 percentage points in metropolitan areas. Public coverage rates rose in both non-metropolitan and metropolitan areas, with Medicaid rates rising 3.9 and 3.7 percentage points respectively. Similarly, direct purchase coverage rates (a pre-ACA survey category which now consists primarily of Marketplace enrollees) rose 1.2 percentage points in non-metropolitan areas and 1.7 percentage points in metropolitan areas. The rise in Medicaid coverage and Marketplace rates are directly related to implementation of provisions in the ACA.[5] The increase in Medicare coverage among the nonelderly may reflect a growing disabled population. Slight increases in employer sponsored coverage rates from 2009-13 to 2015-19 in both non-metropolitan and metropolitan areas were also observed.

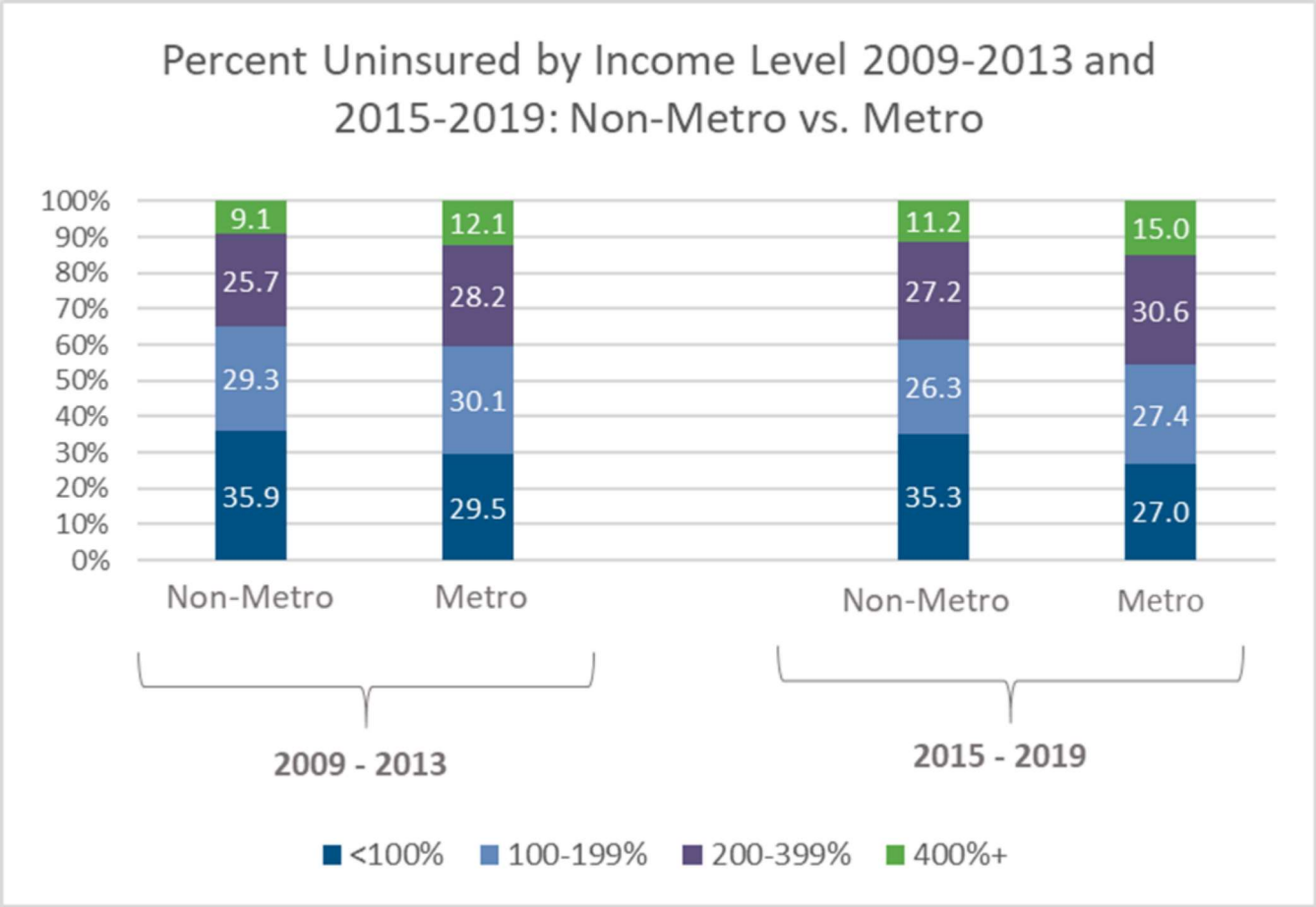
Data source: American Community Survey (ACS) 2009-2013 and 2015-2019 5-Year Estimates.

PROPORTION UNINSURED BY INCOME LEVEL AND POVERTY



Families living below 100 percent of the Federal Poverty Level (FPL) in non-metropolitan areas had the highest rates of uninsurance. In 2019, the uninsured rate for those below the FPL was higher in non-metropolitan areas (22.4 percent) than in metropolitan areas (18.1 percent). In part, this reflects the impact of Medicaid expansion during the 2014-19 period, since a higher proportion of non-metropolitan residents lived in states that had not expanded Medicaid[6]; thus, more people below the FPL remained uninsured in rural areas. A coverage gap exists in non-expansion states when some individuals earn too much to qualify for Medicaid and too little to qualify for Marketplace subsidies; more rural people below the FPL fell into the coverage gap and remained uninsured. The percent uninsured for families living between 100 and 399 percent of the poverty line was slightly higher in metropolitan areas; however, the percent uninsured for families with incomes of 400 percent or more of the FPL was higher in rural areas by 1.4 percentage points.

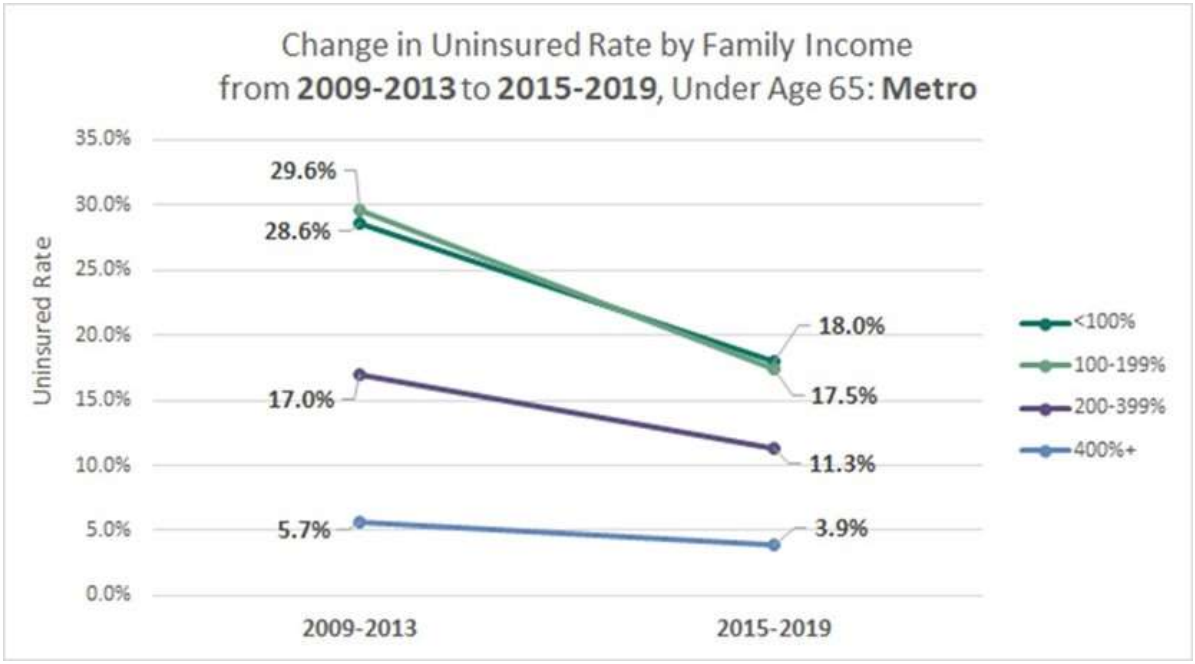
Data source: American Community Survey (ACS) 2019 1-Year Estimates.



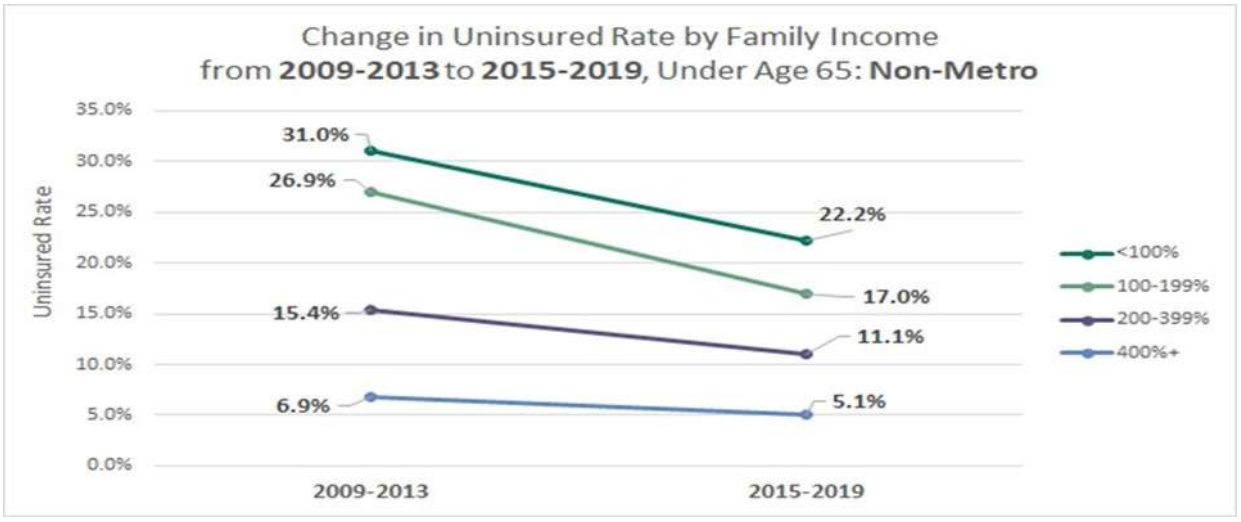
Among the uninsured, a higher share of both non-metropolitan and metropolitan people had higher incomes (200 percent of FPL or above) in the 2015 to 2019 period than in the 2009 to 2013 period, due to the ACA. During the 2015 to 2019 period, a higher proportion of the non- metropolitan uninsured had incomes below the FPL (35.3 percent) compared to the metropolitan uninsured (27.0 percent), a difference of 8.3 percentage points. Thus, while nearly half (45.6 percent) of the remaining uninsured in metropolitan areas have incomes at or above 200 percent of the FPL, only 38.4 percent of the non-metropolitan uninsured had incomes at or above 200 percent of the FPL.

Data source: American Community Survey (ACS) 2009-2013 and 2015-2019 5-Year Estimates.

CHANGE IN UNINSURED RATE IN METROPOLITAN AND NON-METROPOLITAN AREAS

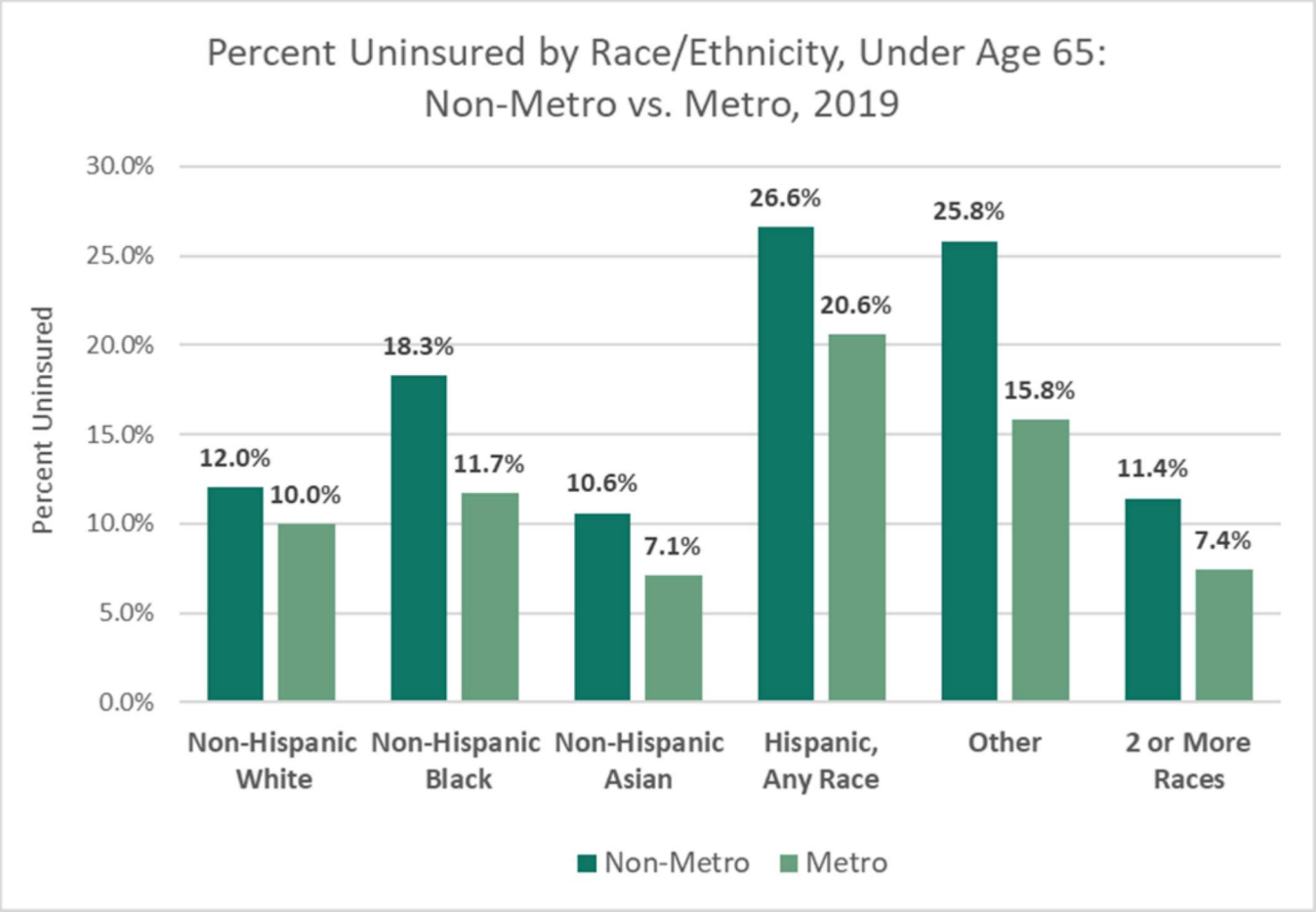


Largely because of the policy changes reflected in the implementation of the ACA, the uninsured rate declined much more rapidly for persons living below 200 percent of the FPL in both non-metropolitan and metropolitan areas between 2009-13 and 2015-19.This rapid drop in uninsurance rates for those below 200 percent of the FPL was largely driven by increased enrollment in Medicaid and increases in Marketplace enrollment, as noted above. Metropolitan areas experienced larger reductions in their uninsured rates for those with incomes under 200 percent of the FPL than did non - metropolitan areas. The uninsured rate for those with incomes under 100 percent of the FPL in metropolitan areas decreased by 10.6 percent. while the rate in non-metropolitan areas decreased by only 8.8 percent.



Data source: American Community Survey (ACS) 2009-2013 and 2015-2019 5-Year Estimates.

PROPORTION UNINSURED BY RACE / ETHNICITY

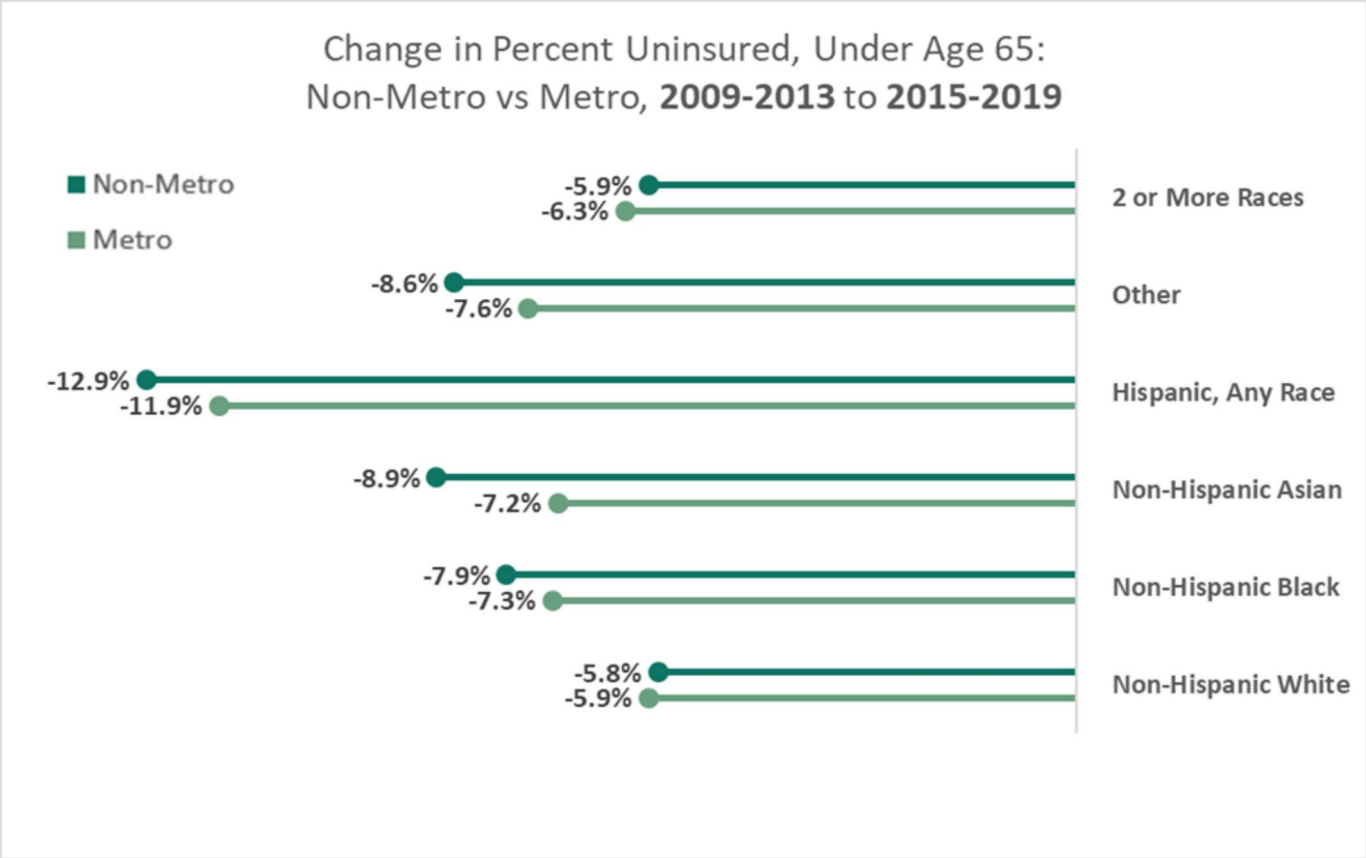


In both non-metropolitan and metropolitan areas, most racial/ethnic minority groups had higher uninsurance rates than non-Hispanic White persons excluding non-Hispanic Asian persons, a gap that has persisted despite some gains in coverage for racial/ethnic minorities since the implementation of the ACA. The uninsurance rates for minority groups in non-metropolitan areas exceeded the rates of uninsurance in metropolitan areas for all races. In 2019, 26.6 percent of Hispanic Americans of any race were uninsured, compared to 20.6 percent in metropolitan areas. At the same time, 18.3 percent of non-Hispanic Blacks in non-metropolitan areas were uninsured, compared to 11.7 percent in metropolitan areas.

Data source: American Community Survey (ACS) 2019 1-Year Estimates.

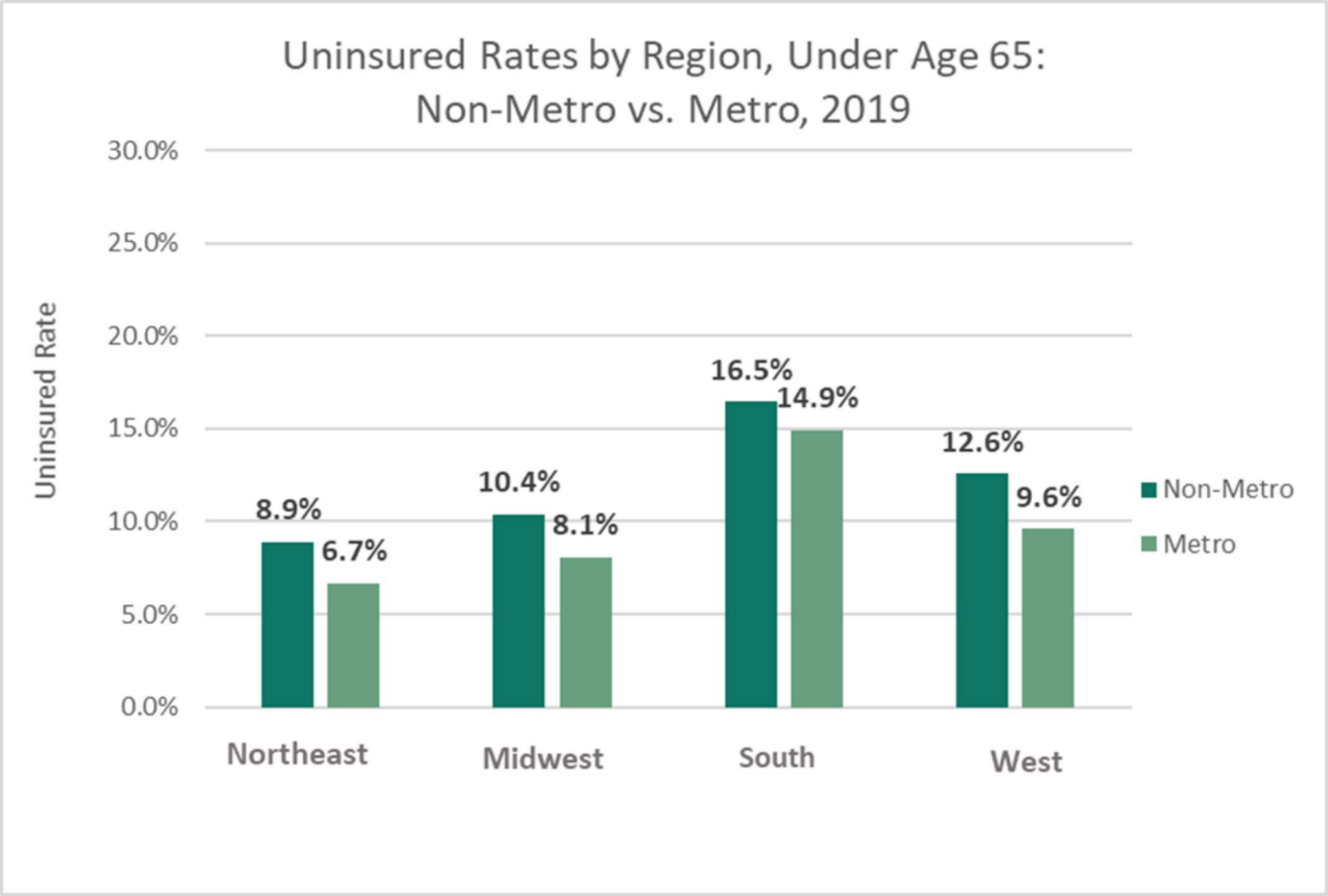
PROPORTION UNINSURED BY RACE / ETHNICITY (CONTINUED)

The chart below shows that the changes in the uninsured rate (in percentage points) were largest for those who were Hispanic, any race, in both non-metropolitan and metropolitan areas. Uninsured rates decreased by more than 10 percentage points in this group. In comparison, the average uninsured rates for non- Hispanic White dropped by less than 6 percentage points in 2015-19, as compared to 2009-13.



Data source: American Community Survey (ACS) 2009-2013 and 2015-2019 5-Year Estimates.

INSURANCE COVERAGE BY REGION

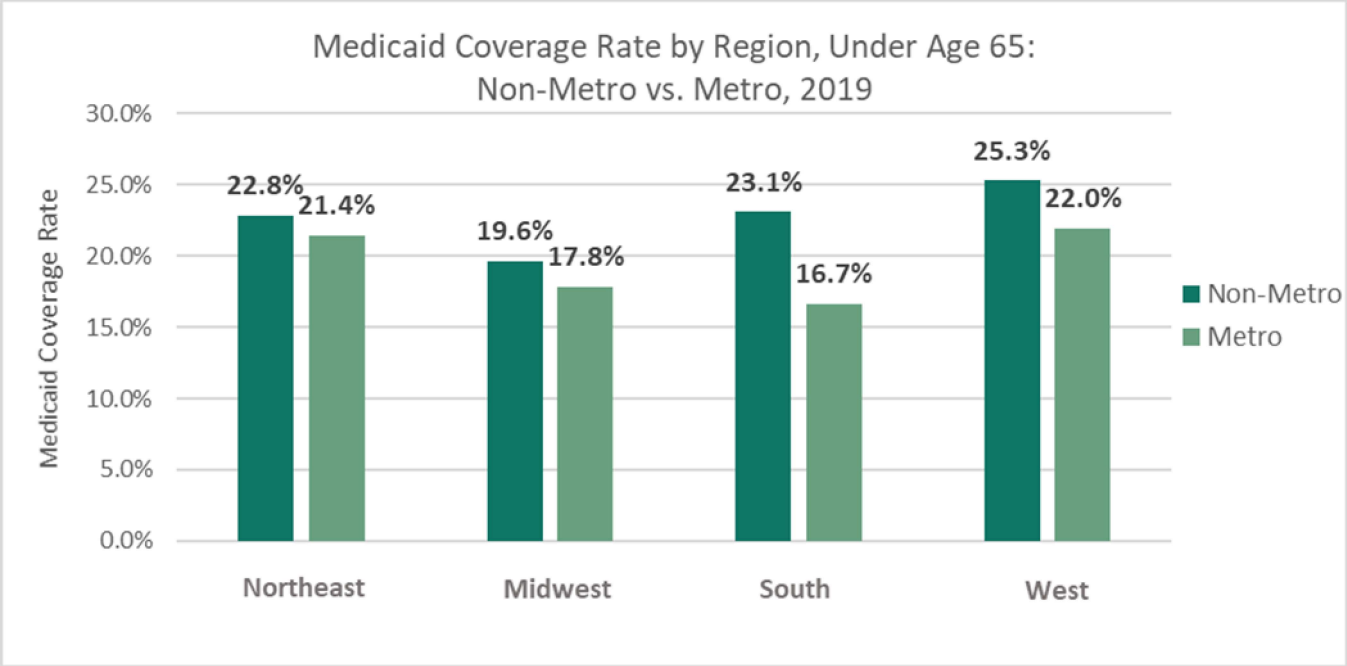


Uninsurance rates in the U.S. were highest in the South and West in 2019 in both non-metropolitan and nonmetropolitan areas, likely due largely to socioeconomic factors found more prominently in those regions (e.g., higher rates of poverty, employment factors, and racial disparities) and fewer states in the South and West that had expanded Medicaid by 2019 (12 of the 14 states that had not expanded by 2019 were in the South and West: AL, GA, SC, NC, FL, TN, TX, KS, SD and WY).[7] The uninsurance rates in non-metropolitan areas exceeded uninsurance rates in metropolitan areas in all regions. In 2019, the five states with the highest number of people without coverage were found in Texas, California, Florida, Georgia, and North Carolina. Four of these states also had very high uninsured rates, had not expanded Medicaid and are in the South; these four southern states also have high proportions of rural people.

Data source: American Community Survey (ACS) 2019 1-Year Estimates.

MEDICAID COVERAGE BY REGION

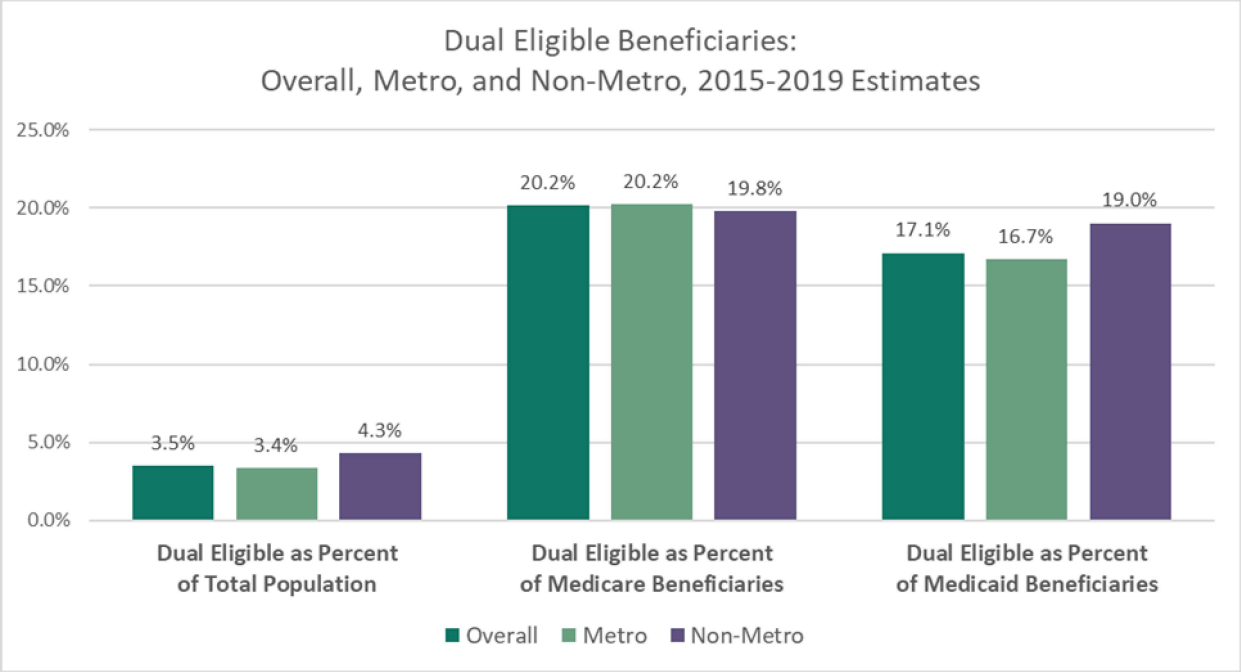
In the South and West, non-metropolitan residents relied more on Medicaid coverage than did metropolitan residents. In large part this may reflect higher poverty rates in these areas, which increases the likelihood that individuals may be on Medicaid, especially if the state has expanded Medicaid. But in some areas, such as the South, generally lower thresholds for eligibility for Medicaid mitigates this effect. In addition, a high proportion of children were on Medicaid or CHIP in non-metropolitan areas, meaning they were covered by Medicaid or CHIP, even if their parents did not have access to private coverage.



Data source: American Community Survey (ACS) 2019 1-Year Estimates.

MEDICAID COVERAGE BY REGION (CONTINUED)

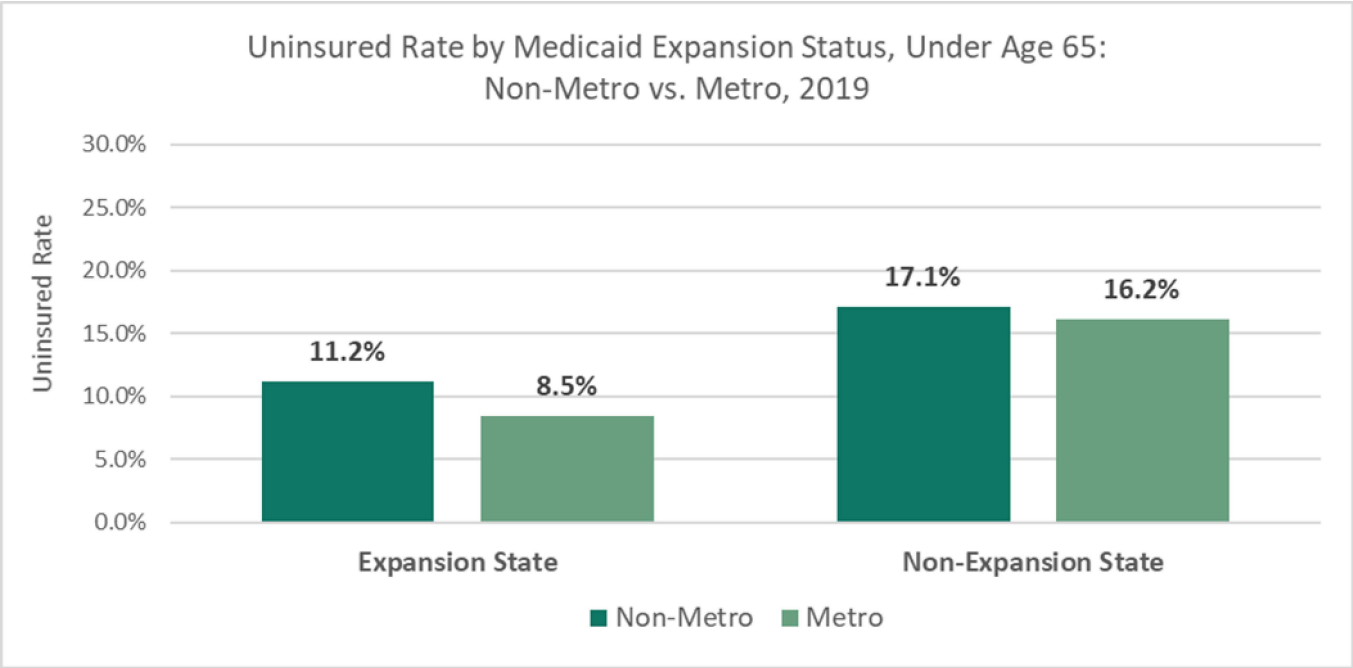
Dual eligibles are those who are enrolled in both the Medicare and Medicaid programs, and if over age 65 they are likely low income (under 85 percent of the poverty line), while if under age 65 the predominant group are recipients who are on Medicaid (so low income) but also eligible due to disability. A higher proportion of non-metropolitan persons (4.3 percent) are dual eligibles, as compared to persons living in metropolitan areas (3.4 percent), as a proportion of the total population. Looked at another way, dual eligibles are roughly 20 percent of the Medicare population in both metropolitan areas and nonmetropolitan areas. However, dual eligibles are a higher proportion of Medicaid eligibles (19 percent in non-metro areas) than they are in metro areas (16.7 percent), perhaps reflecting lower health status among non-metropolitan persons with Medicaid.



Data source: American Community Survey (ACS) 2019 1-Year Estimates.

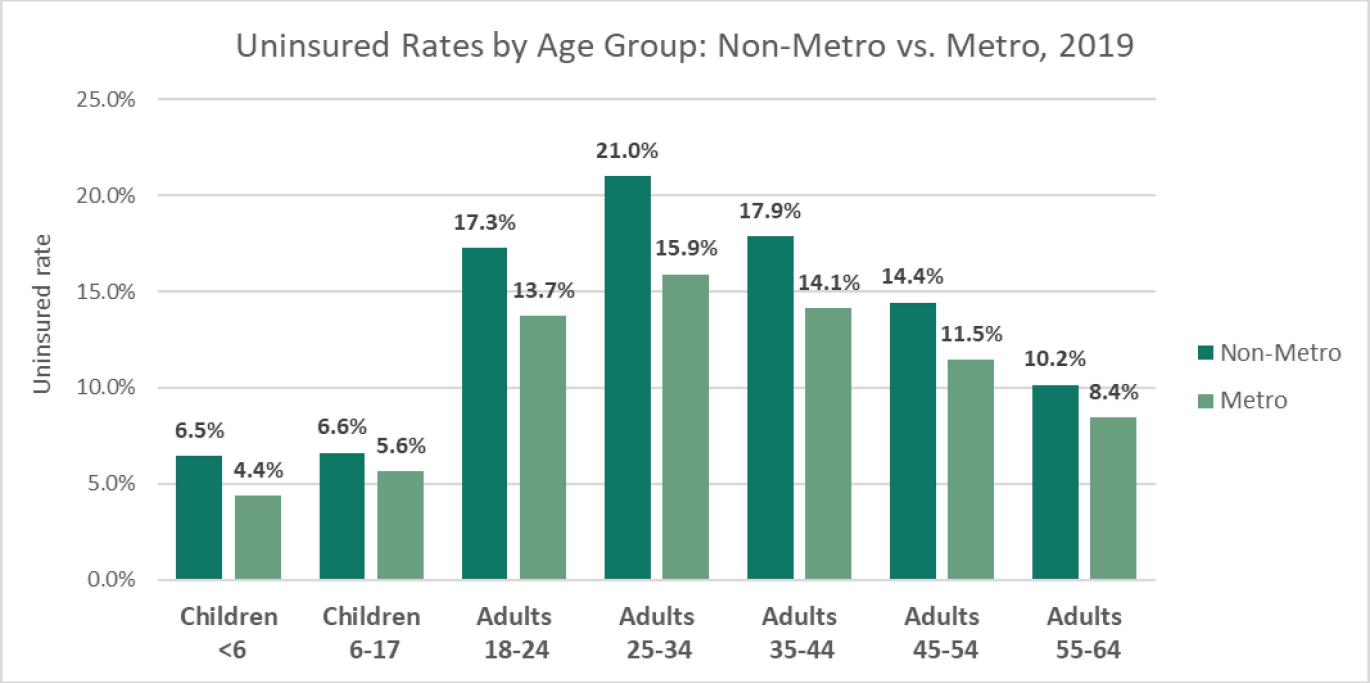
MEDICAID COVERAGE BY REGION (CONTINUED)

People living in states that had not expanded Medicaid, whether in non-metropolitan or metropolitan areas, had similar uninsured rates (17.1 percent and 16.2 percent, respectively). Overall uninsured rates were lower in states that had expanded Medicaid, with uninsured rates remaining higher in non- metropolitan areas in these states (11.2 percent) compared to rates in metropolitan areas (8.5 percent). Possible explanations for this difference include differences in take-up rates for Medicaid, a different distribution of incomes leading to different Marketplace subsidy levels, and different Marketplace plan offerings in non-metropolitan vs metropolitan areas that could affect non-metropolitan take-up rates in that program.



Data source: American Community Survey (ACS) 2019 1-Year Estimates.

UNINSURED RATES BY AGE GROUPS

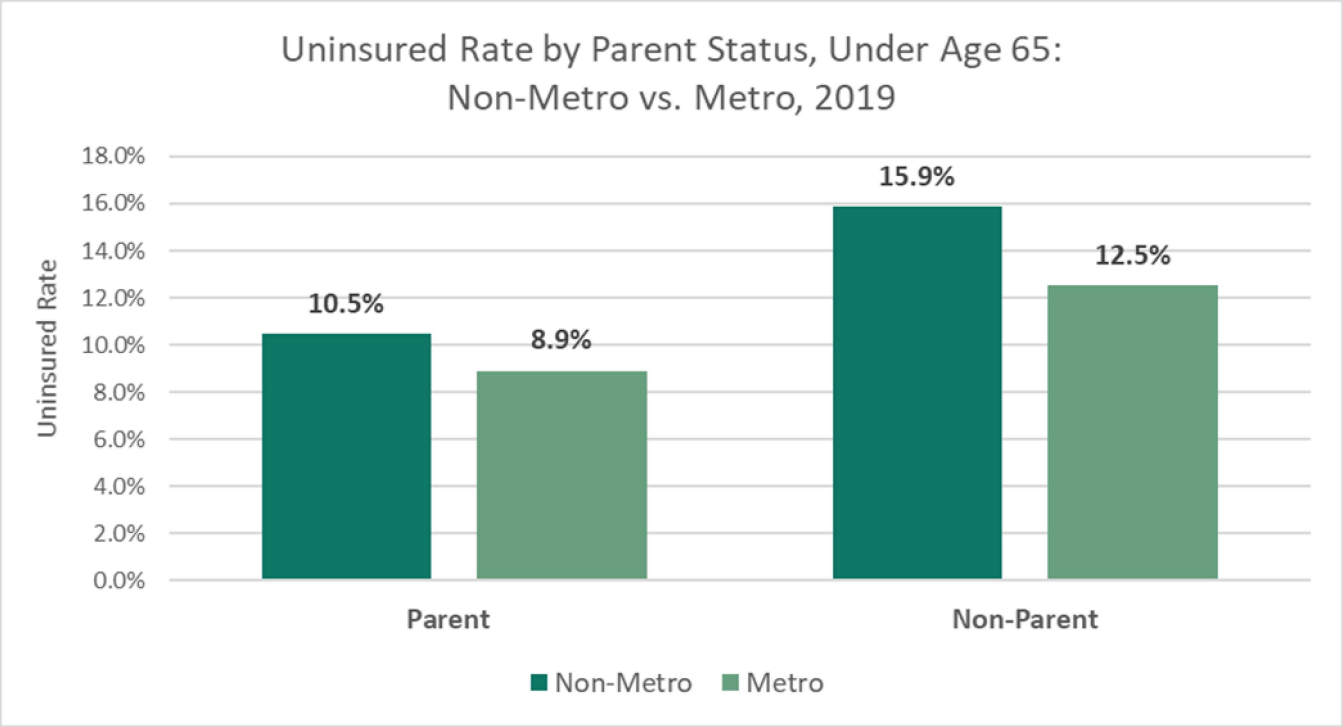


The uninsured rate varied by age group, with adults ages 25-34 having the highest uninsured rate in both metropolitan and non-metropolitan areas. Adults aged 18-24 and 35-44 also had higher uninsured rates than those aged 45 or older or younger than age 18. Children had low uninsured rates in both non-metropolitan and metropolitan areas, likely due to high Medicaid/CHIP eligibility thresholds in the U.S. for children. Overall uninsured rates were higher in non-metropolitan areas than in metropolitan areas for all age groups.

Data source: American Community Survey (ACS) 2019 1-Year Estimates.

UNINSURED RATES BY AGE GROUP (CONTINUED)

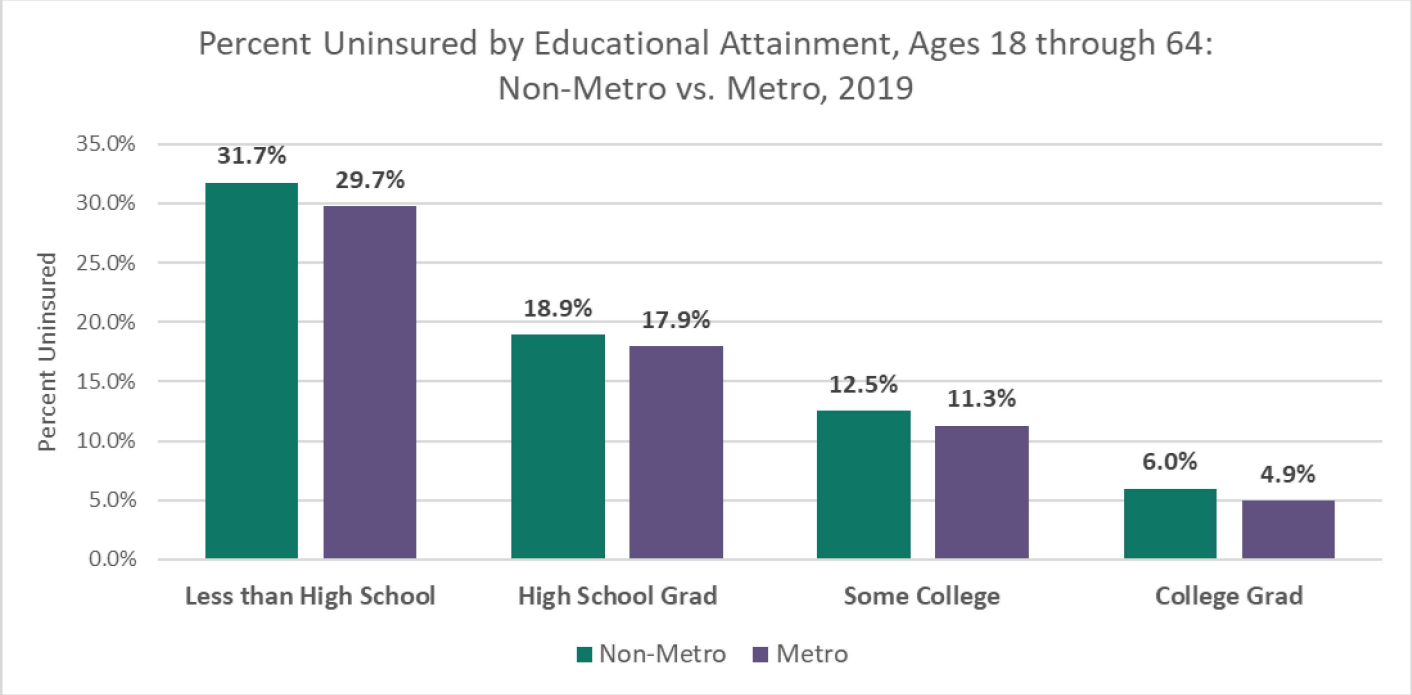
Adults who were not parents were more likely to be uninsured than those who are parents. Non-metropolitan parents were more likely than metropolitan parents to be uninsured, 10.5 percent compared to 8.9 percent, and the same was true for non-parent adults.



Data source: American Community Survey (ACS) 2019 1-Year Estimates

EDUCATIONAL ATTAINMENT

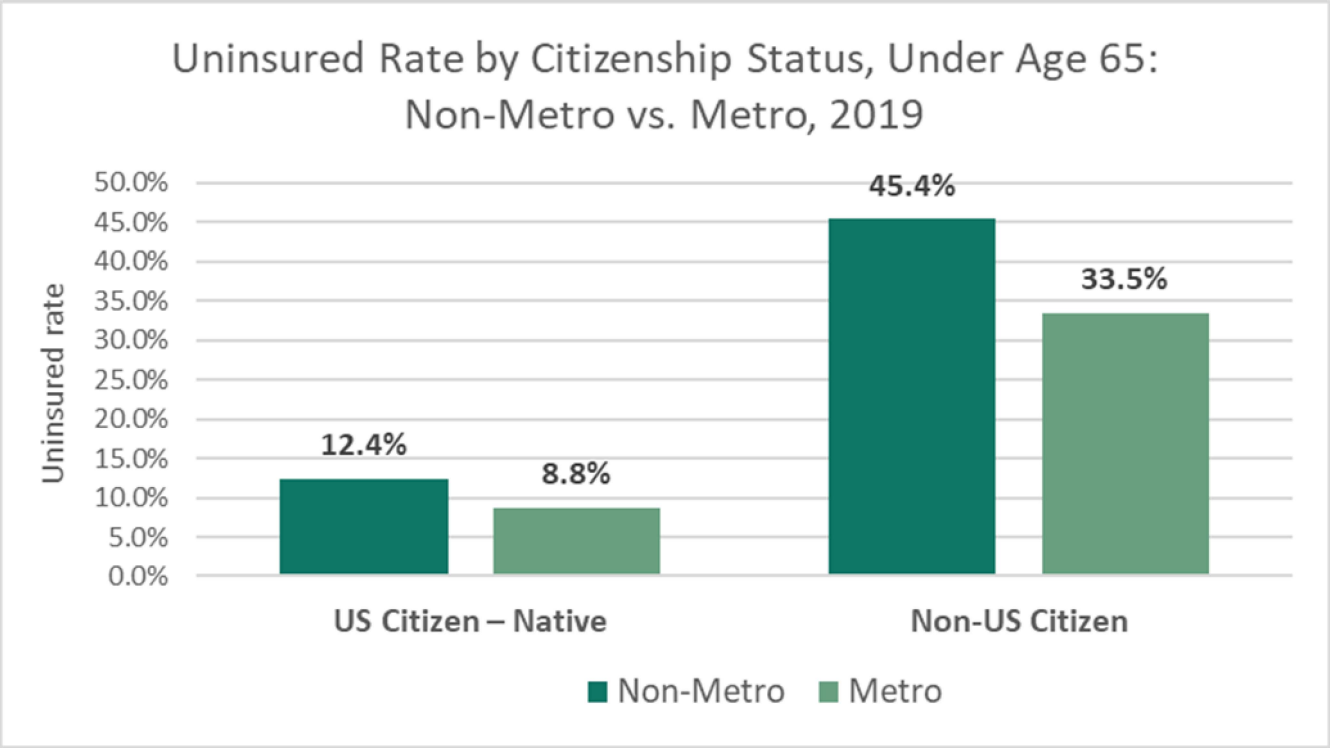
In both non-metropolitan and metropolitan areas, the uninsured rate varied significantly by educational attainment. People with college degrees— are more likely to have health insurance (6 percent in non-metro areas and 4.9 percent in metro areas), while those without a high school degree are much more likely to be uninsured (31.7 percent in non-metro areas and 29.7 percent in metro areas). Differences between uninsured rates in non-metropolitan and metropolitan areas by educational attainment were statistically significant but relatively small.



Data source: American Community Survey (ACS) 2019 1-Year Estimates

CITZENSHIP STATUS

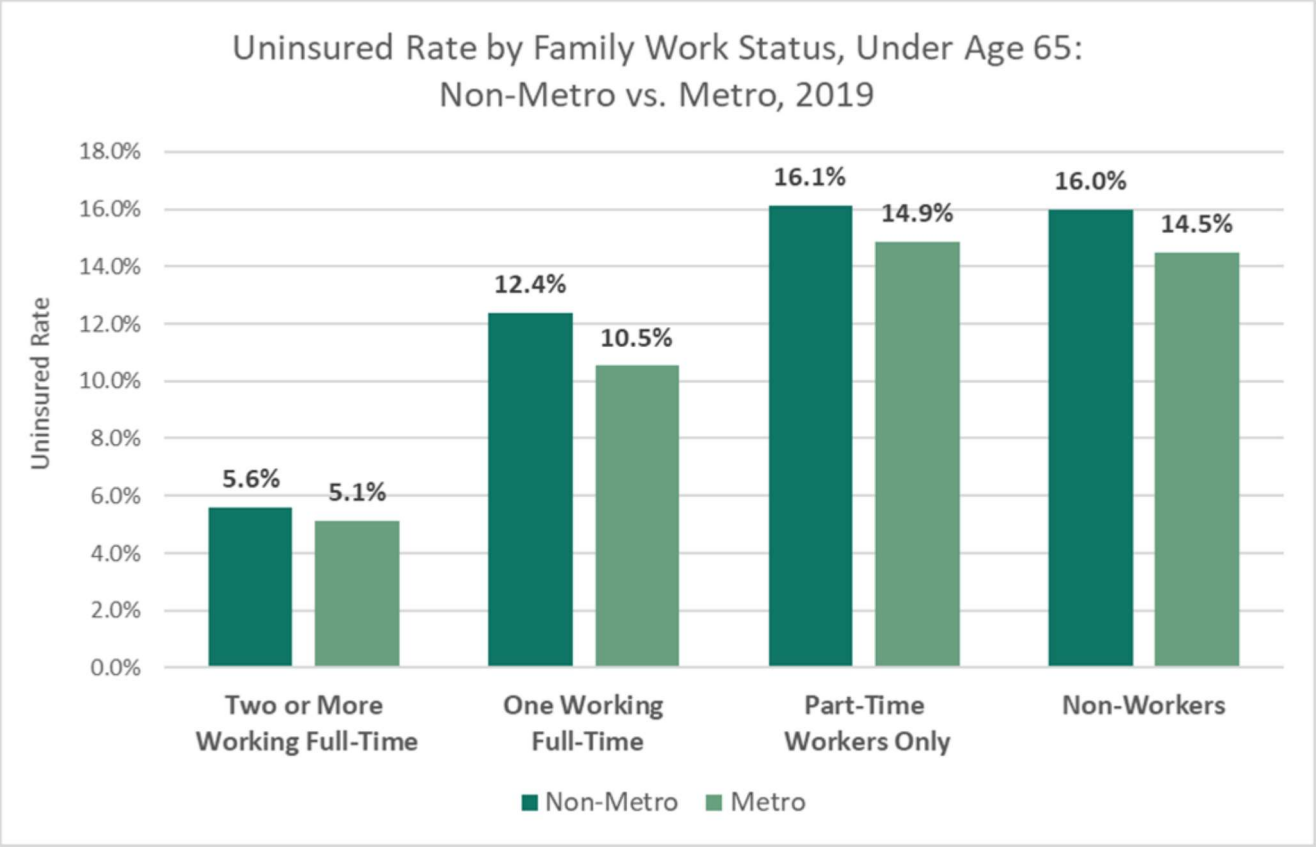
In the U.S., non-citizens are generally not eligible for public health insurance coverage (Medicaid and Medicare) and are often not offered employer sponsored health insurance. For these reasons, uninsurance rates are very high for non-citizens. As shown, uninsured rates are almost four times higher for non-citizens living in non-metropolitan areas (45.4 percent) as compared to U.S. citizens (including naturalized citizens) in the same areas (12.4 percent). Similarly, the uninsured rate is more than four times higher for non-citizens living in metropolitan areas (33.5 percent compared to 8.8 percent).



Data source: American Community Survey (ACS) 2019 1-Year Estimates

WORK STATUS

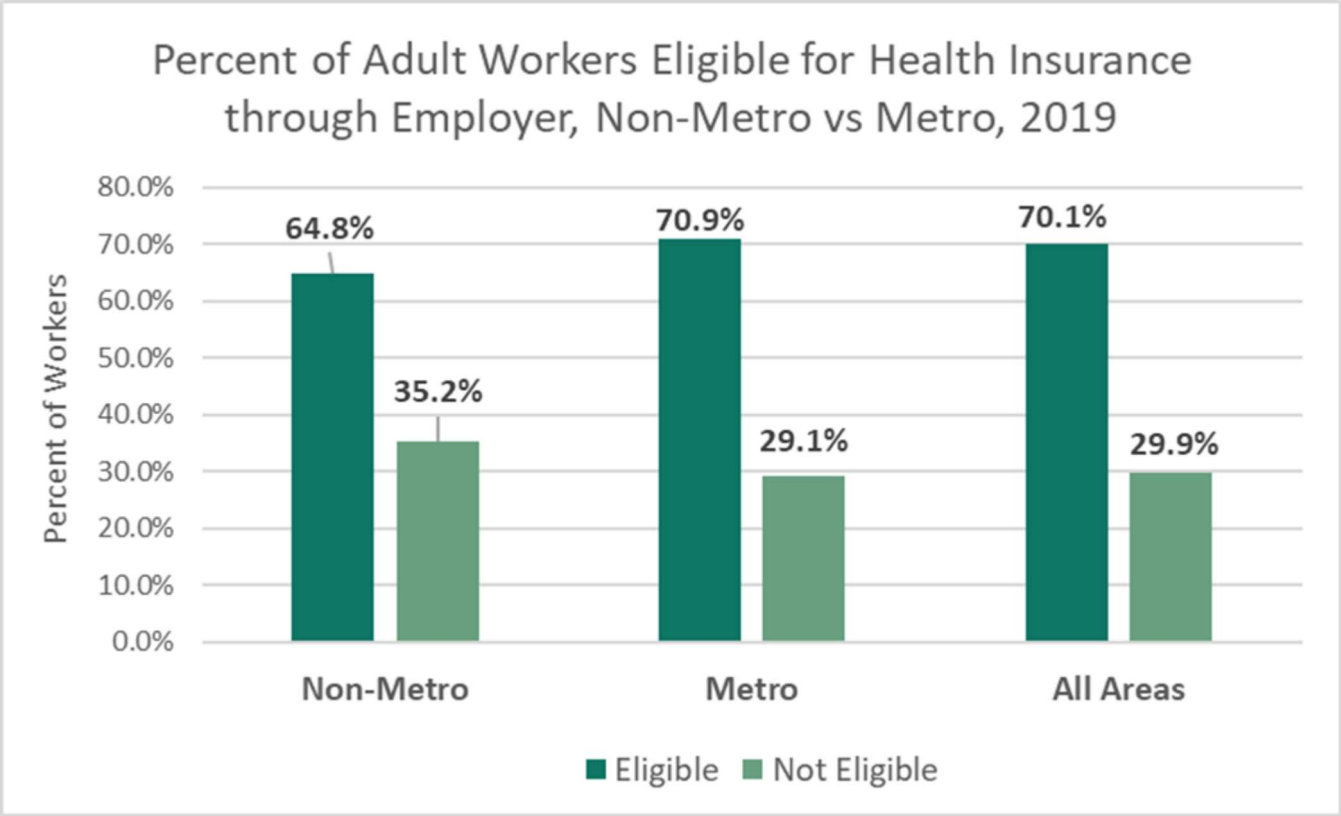
People who worked full-time were more likely to have access to employer-sponsored insurance, and thus less likely to be uninsured, whether living in non-metropolitan or metropolitan areas. In general, families with at least one full-time worker had much lower uninsured rates than families with less workforce participation. However, access to health insurance appears to be more likely for families with a full-time worker, as compared to families with a part time worker, since the uninsured rate for families with part time workers does not differ markedly from those with no workers. In addition, only 5.6 percent of those in families from non-metropolitan areas where two or more people were working full time were uninsured in 2019.



Data source: American Community Survey (ACS) 2019 1-Year Estimates

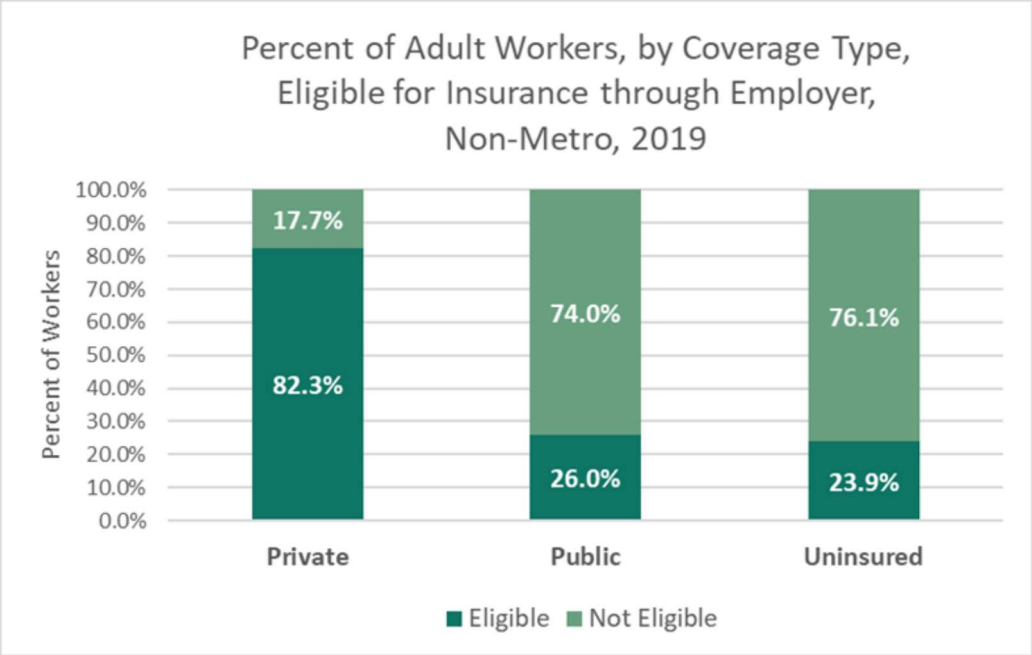
WORKERS OFFERED EMPLOYER SPONSORED HEALTH INSURANCE

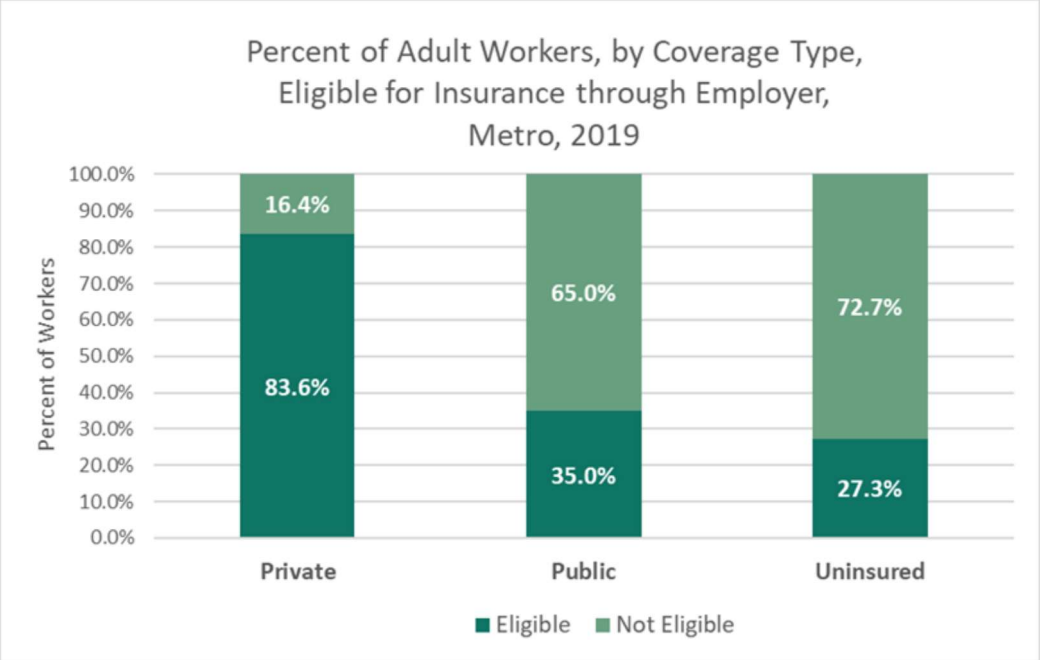
A sizeable share of uninsured people (23.9 percent) — and some who have public coverage (26.0 percent) — were eligible for some type of health insurance through their employer (see figure on page 27). This finding suggests that other issues beyond simple access (e.g., unaffordable premiums), may be creating barriers to participating in employer-sponsored healthcare programs. Overall, workers in non-metropolitan areas were less likely than metropolitan-area workers to be offered health insurance through an employer (64.8 percent compared to 70.9 percent).



Data source: Medical Expenditure Panel Survey (MEPS) 2017-2018 Full-Year Consolidated Files

Non-metropolitan residents who were enrolled in public coverage were less likely (26 percent) to be eligible for health insurance coverage through their employer than metropolitan residents (35 percent). Uninsured non-metropolitan residents were also less likely (23.9 percent) than their metropolitan area to be uninsured, and a portion (17.7 percent0 of those living in nonmetro areas were not eligible for employer coverage but purchased marketplace coverage.





Data source: Medical Expenditure Panel Survey (MEPS) 2017-2018 Full-Year Consolidated Files

INSURANCE STATUS, BY OCCUPATION

As noted above, workers in non-metropolitan areas were less likely than those in metropolitan areas to be eligible for private health insurance through an employer. This difference is one reason why uninsurance rates for workers are higher in non-metropolitan areas. In particular, private coverage rates in certain industries are significantly lower for both non-metropolitan and metropolitan residents. For example, uninsured rates are lower in agriculture, construction, services, and health and social services. Non-metropolitan residents are more likely to be employed in these industries, while metropolitan workers are more likely to work in industries with higher private coverage rates (e.g., finance/insurance/real estate, public administration).

Insurance Status Among Occupations in Various Industries, percent of 2019 nonelderly adult workers	Non-Metro			Metro		
	Private	Public	Uninsured	Private	Public	Uninsured
Professionals and Managers						
Agriculture	*73.1	11.5	15.4	*72.9	12.2	14.9
Construction	73.4	9.3	17.3	80.4	7.4	12.3
Finance/Insurance/Real Estate	85.8	7.4	6.8	91.4	4.6	4.1
Health and Social Services	85.1	8.8	6.1	87.8	7.3	4.9
Information/Communications/Education	88.2	6.9	4.8	89.4	6.6	4.0
Mining/Manufacturing	88.9	5.8	5.3	92.5	4.0	3.5
Professionals	82.6	8.9	8.6	89.3	5.5	5.3
Public Administration	88.2	8.3	3.5	88.9	8.7	2.4
Services	74.1	14.5	11.4	82.8	9.4	7.8
Utilities & Transportation	84.9	7.1	8.1	89.1	5.7	5.2
Wholesale and Retail Trade	84.5	7.2	8.3	87.8	6.2	6.0
Non-Managers						
Agriculture	53.0	15.9	31.1	45.8	22.9	31.3
Construction	56.8	15.3	27.9	56.2	13.5	30.3
Finance/Insurance/Real Estate	77.1	12.3	10.6	81.4	9.5	9.2
Health and Social Services	66.2	21.1	12.7	69.8	19.4	10.9
Information/Communications/Education	77.2	14.2	8.6	80.3	11.9	7.8
Mining/Manufacturing	74.7	11.5	13.8	74.5	12.7	12.8
Professionals	54.7	22.0	23.2	61.2	18.4	20.3
Public Administration	79.8	13.3	6.9	83.6	11.9	4.5
Services	57.2	20.0	22.9	59.7	19.5	20.8
Utilities & Transportation	71.7	13.8	14.6	69.3	16.4	14.4
Wholesale and Retail Trade	62.8	19.9	17.3	68.3	17.6	14.1

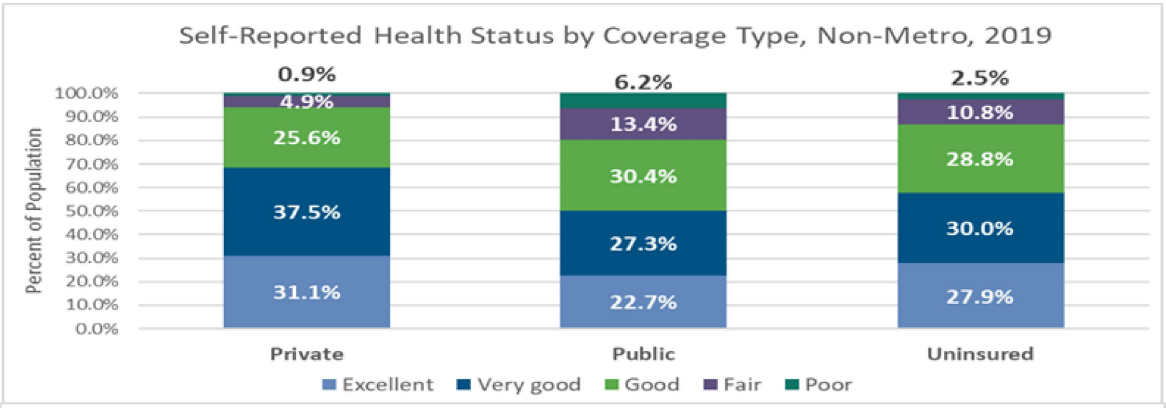
Data source: American Community Survey (ACS) 2019 1-Year Estimates
**Differences in private coverage rates between non-metropolitan and metropolitan managers in the agricultural industry were not significant*

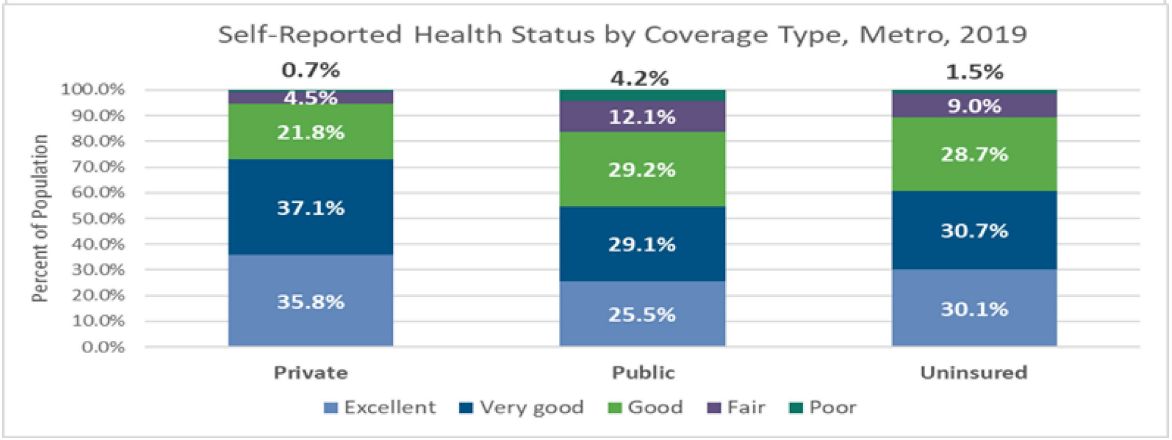
HEALTH STATUS BY INSURANCE STATUS

The health status of people living in non-metropolitan areas varies somewhat from that of people living in metropolitan areas. In addition, health insurance coverage varies in non-metropolitan and metropolitan areas. Descriptive results will demonstrate some key findings on the associations among health status, geographic location and health insurance status.

SELF-REPORTED HEALTH STATUS

Non-metropolitan residents were slightly more likely than metropolitan residents to self-report fair or poor health status, regardless of health insurance status. Those without health insurance were also more likely to report fair or poor health status than those with private health insurance among non-metropolitan residents (13.3 percent compared to 5.8 percent) and among metropolitan residents (10.5 percent compared to 5.2 percent). The highest concentrations of fair or poor health status occurred among those with public coverage (19.6 and 16.3 percent of non-metropolitan and metropolitan residents, respectively). This may reflect that those who report poor health are more likely to be on public programs such as Medicaid and Medicare, on the basis of disability. Also, access issues and social determinants of health may contribute to these differences.

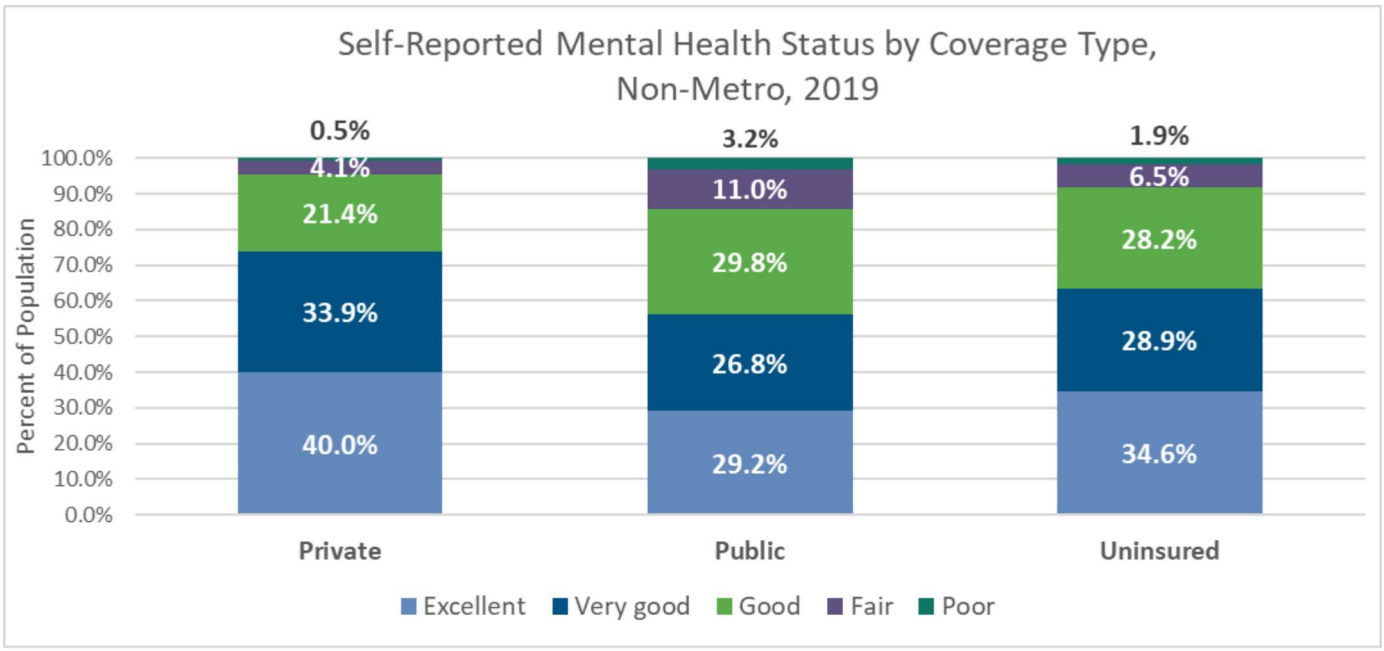


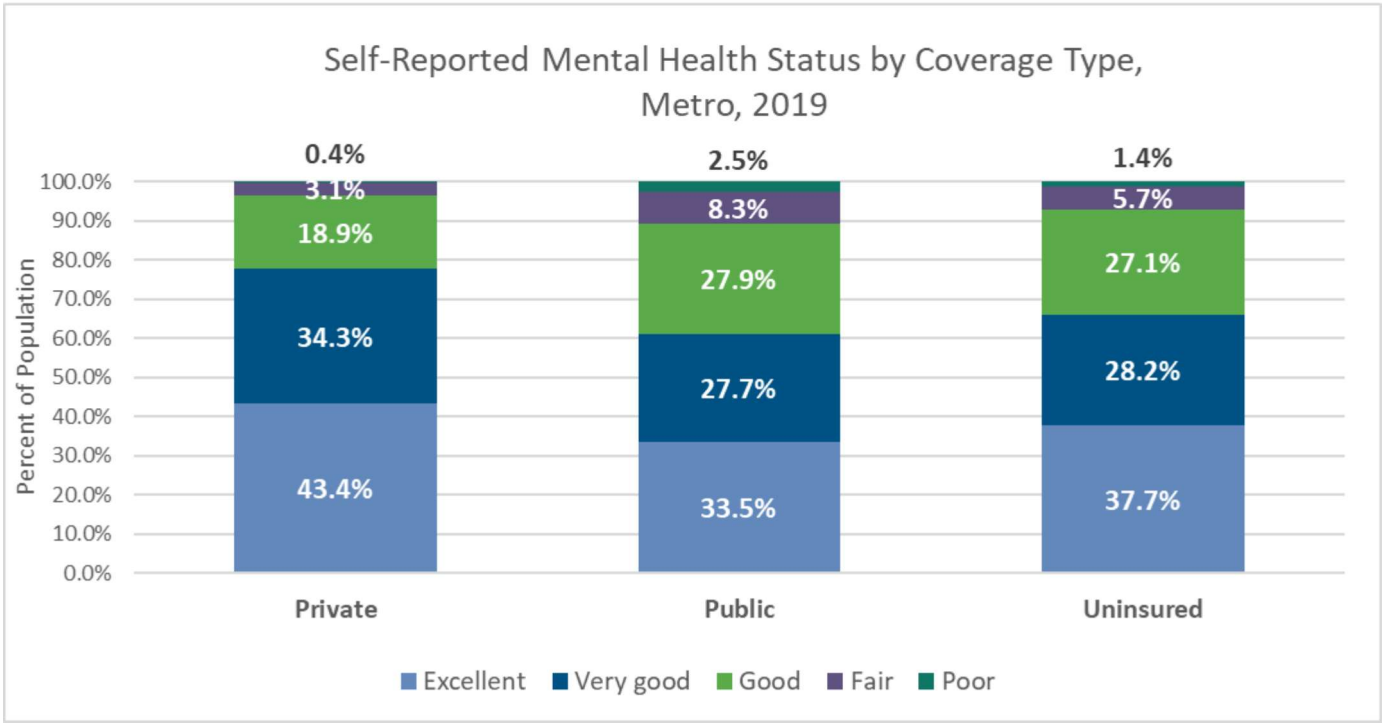


Data source: Medical Expenditure Panel Survey (MEPS) 2017-2018 Full-Year Consolidated Files

SELF REPORTED MENTAL HEALTH STATUS

Non-metropolitan residents were slightly more likely than metropolitan residents to self-report fair or poor mental health status, regardless of health insurance status. Similar to patterns with self-reported health status, privately insured individuals are much less likely to report fair or poor mental health (4.6 percent of non-metropolitan residents and 3.5 percent of metropolitan residents), compared to the publicly insured and uninsured groups.

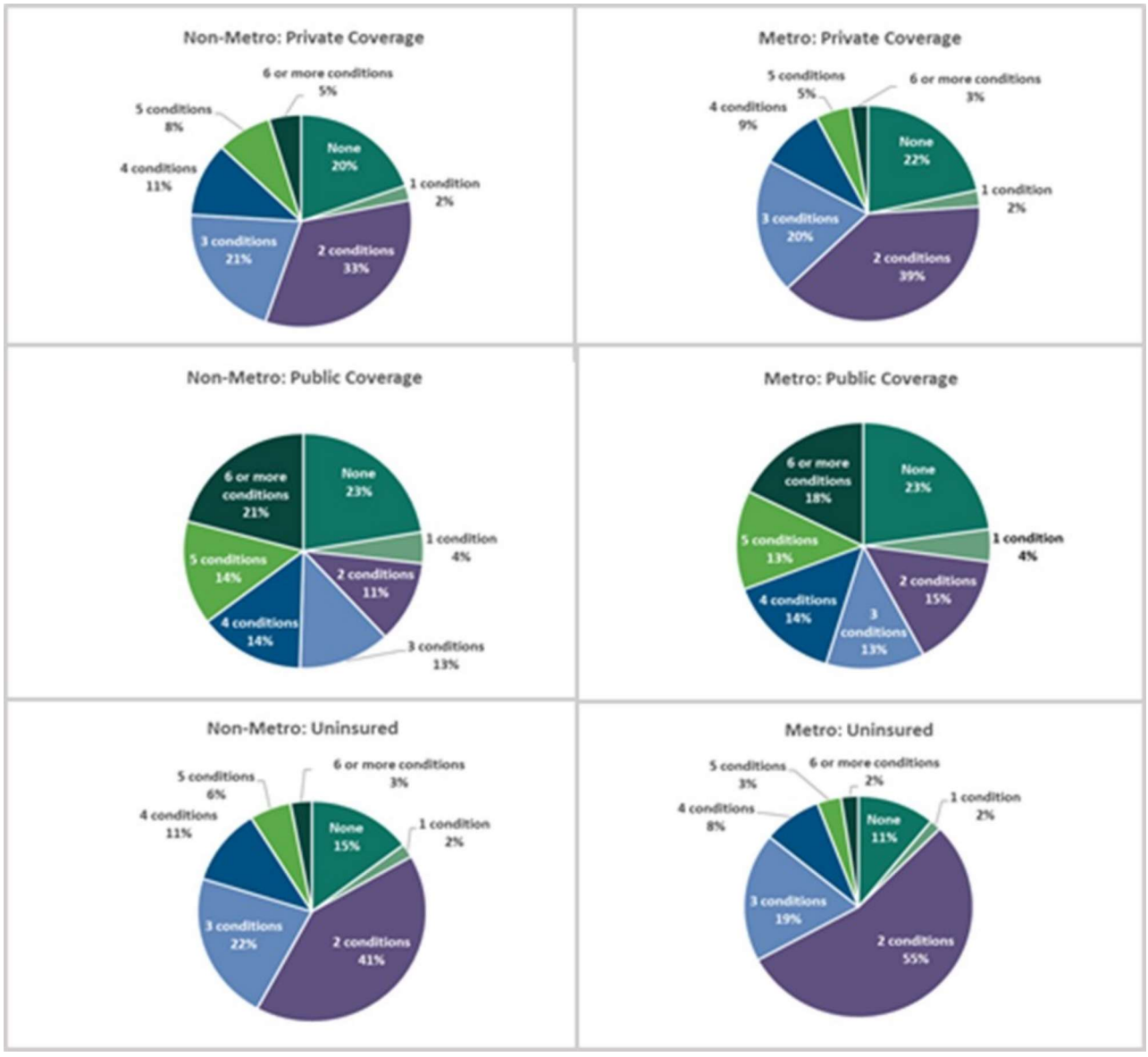




Data source: Medical Expenditure Panel Survey (MEPS) 2017-2018 Full-Year Consolidated Files.

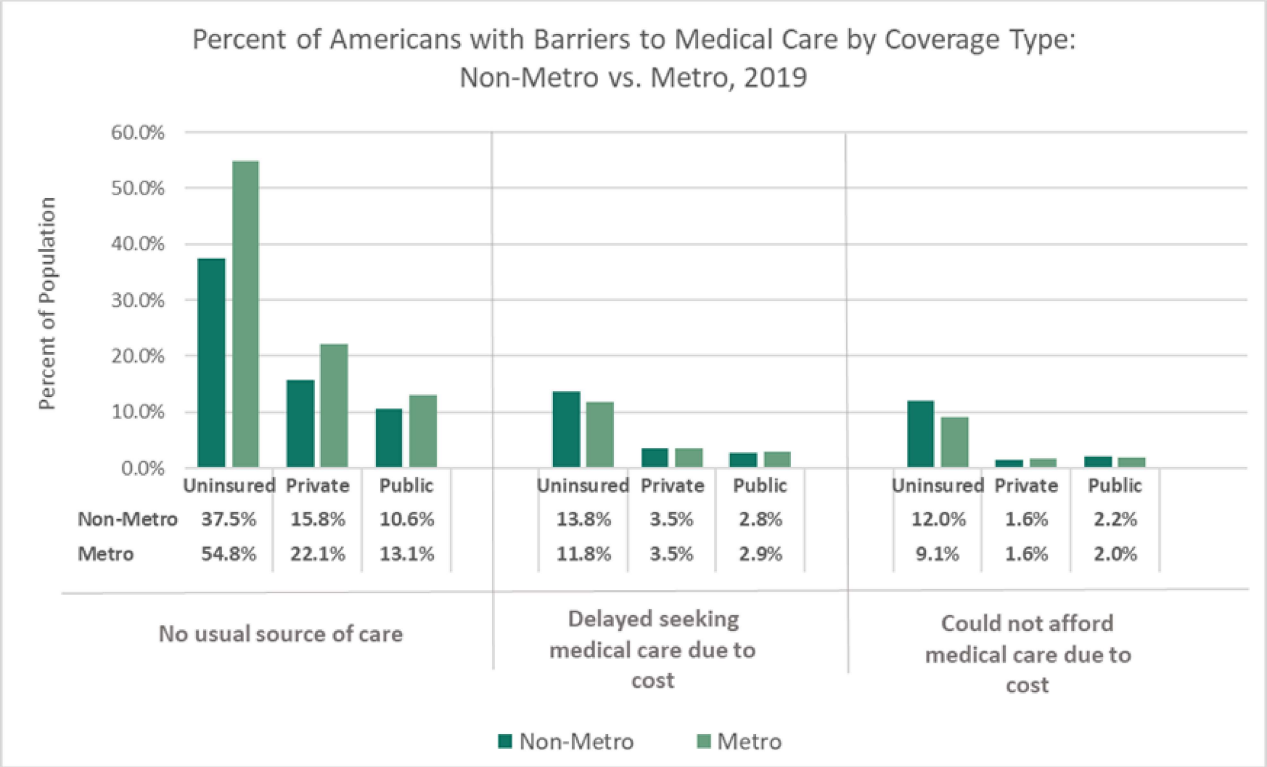
CHRONIC HEALTH CONDITIONS BY HEALTH INSURANCE STATUS

Poor health is often related to poorly managed chronic conditions; thus, individuals with multiple chronic conditions are generally at greater risk. The charts below show that individuals in non-metropolitan areas were more likely than those living in metropolitan areas to have three or more chronic conditions regardless of insurance (drawn from a list of chronic conditions that includes: arthritis, asthma, cancer, chronic bronchitis, coronary heart disease, diabetes, emphysema/lung conditions, high cholesterol, stroke). Among non-metropolitan residents, 45 percent of privately covered, 62 percent of publicly covered, and 42 percent of uninsured individuals had 3 or more chronic conditions; among metropolitan residents the corresponding values were 37 percent, 58 percent, and 32 percent.



Data source: American Community Survey (ACS) 2010-2019 1-Year Estimates.

ACCESS TO HEALTH CARE



One common measure of access to care available in the MEPS asks whether people have "a usual source of care;" that is, a place where they usually go to obtain needed medical care such as a physician's office or a clinic. Many uninsured people report no usual source of care: 37.5 percent of uninsured non-metropolitan residents and 54.8 percent of uninsured metropolitan residents report no usual source of care. This trend also held for metropolitan and non-metropolitan residents with private and public health insurance coverage, as non-metropolitan residents were always more likely to have a usual source of care than metropolitan residents.

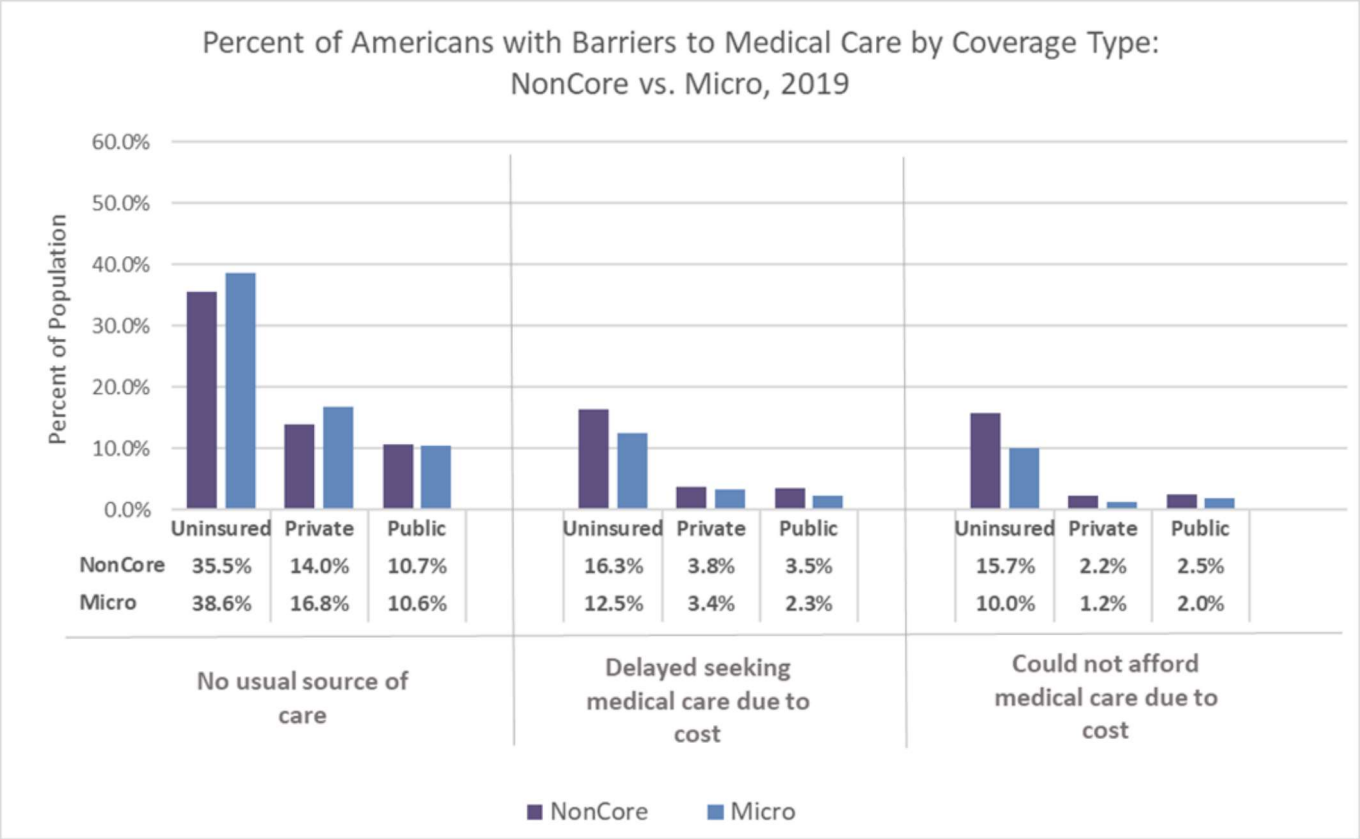
Further comparison of non-metropolitan responses by insurance status shows that only 15.8 percent of those with private coverage and only 10.6 percent of those on public coverage had no usual source of care, relative to the 37.5 percent mentioned above.

Other MEPS measures of access ask whether people delayed seeking care or could not afford medical care due to the costs. On these measures, 13.8 percent of non-metropolitan uninsured residents reported delaying medical care due to the cost, and 12.0 percent of the non-metropolitan uninsured could not afford medical care due to the cost. In each case, these rates were significantly higher than what people living in metropolitan areas experienced.

Data source: Medical Expenditure Panel Survey (MEPS) 2017-2018 Full-Year Consolidated Files

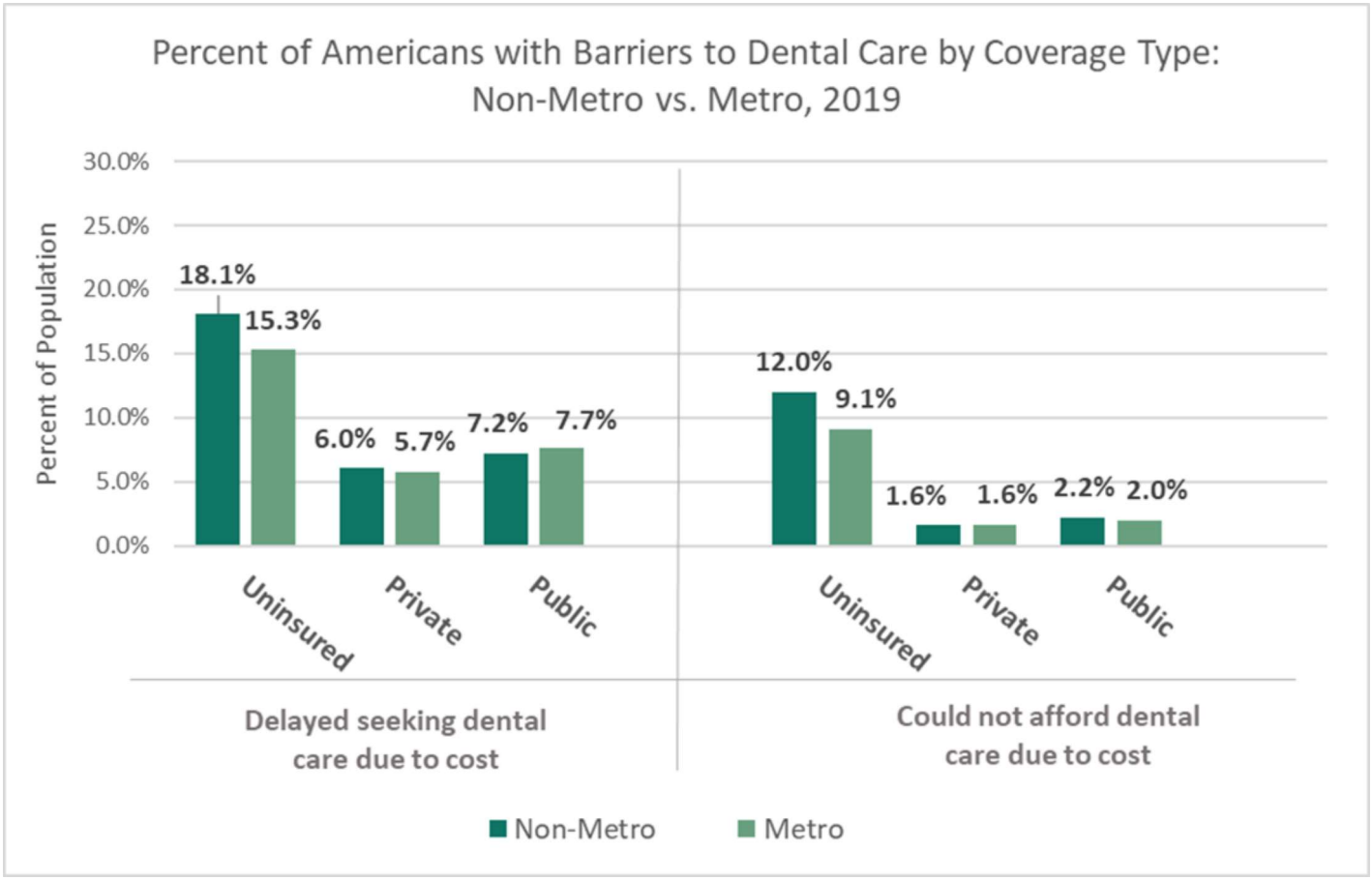
ACCESS TO HEALTH CARE (CONTINUED)

Among non-metropolitan residents, small differences in access to care between those living in noncore and micropolitan areas exist. Micropolitan (micro) areas are defined as non-metropolitan labor-market areas centered on urban clusters of 10,000-49,999 people.[8] Noncore areas are the remaining counties that are not part of "core-based" metropolitan or micro areas. Over 35 percent of uninsured individuals living in noncore areas report having no usual source of care, compared to 38.6 percent of those living in micropolitan areas. However, the uninsured living in noncore areas were more likely to delay seeking medical care due to cost and more frequently stated an inability to afford medical care due to cost than the uninsured living in micropolitan areas.



Data source: Medical Expenditure Panel Survey (MEPS) 2017-2018 Full-Year Consolidated Files

ACCESS TO HEALTH CARE (CONTINUED)

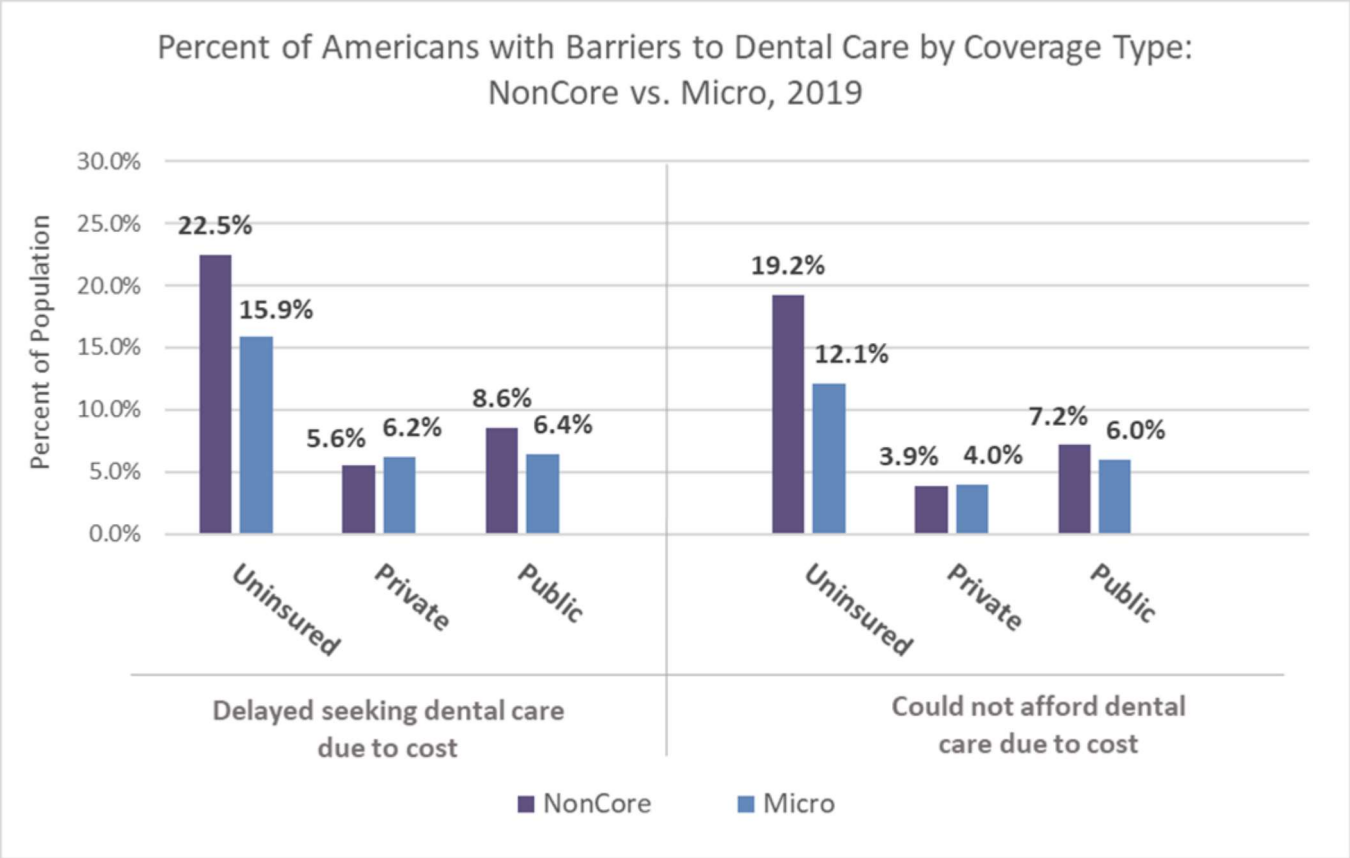


Another important measure of access to care is whether rural residents delay dental care due to the cost or cannot afford dental care due to the cost. A higher proportion of non-metropolitan uninsured residents (18.1 percent compared to 15.3 percent) delayed dental care due to the costs and could not afford dental in non-metropolitan areas (12.0 percent compared to 9.1 percent) compared to metropolitan residents.

Data source: American Community Survey (ACS) 2010-2019 1-Year Estimates

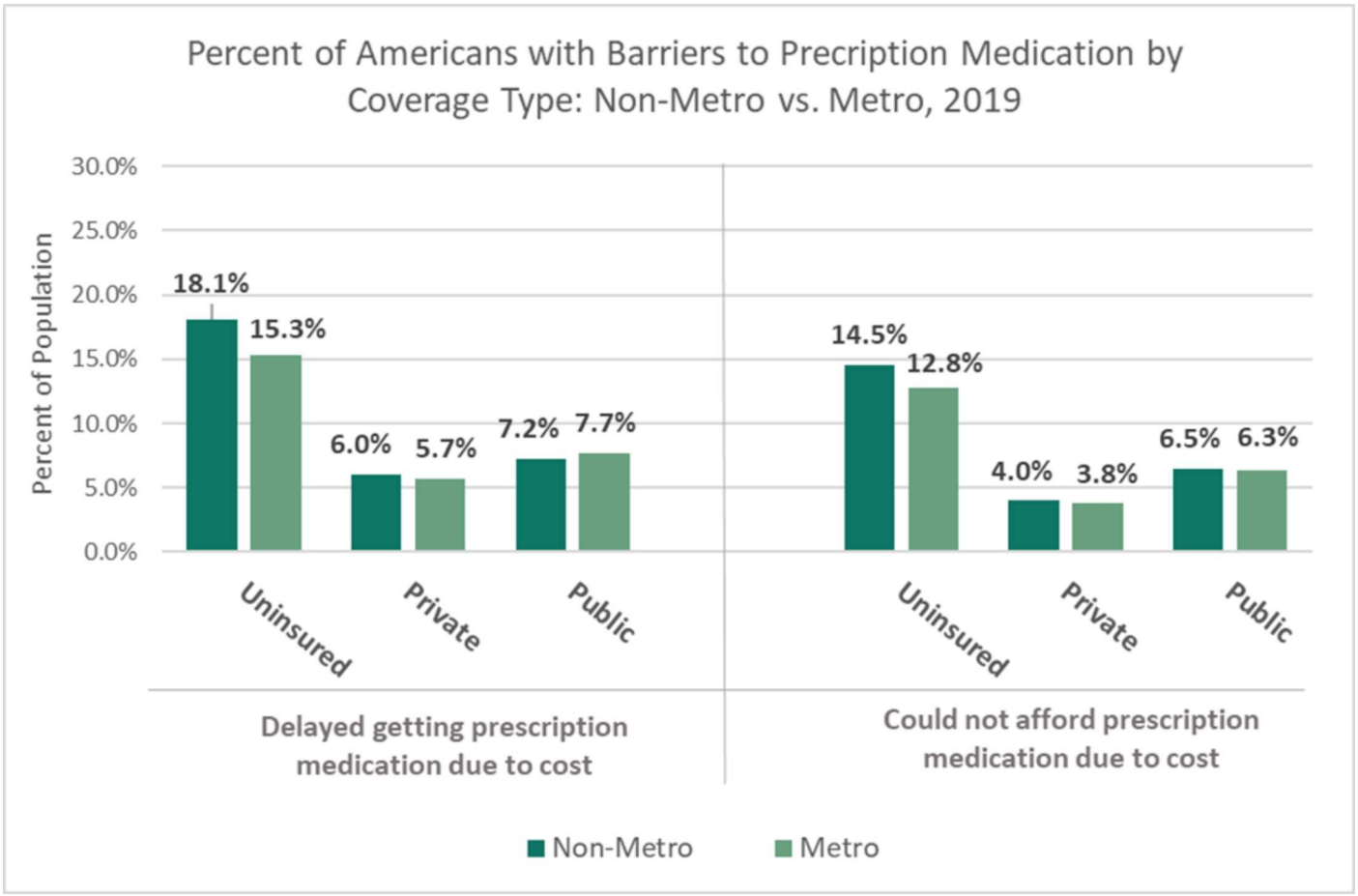
ACCESS TO HEALTH CARE (CONTINUED)

Further analyzing dental care in non-metropolitan areas, the uninsured in noncore areas were more likely (22.5 percent) to delay seeking dental care due to cost than those in micropolitan areas (15.9 percent). In addition, 19.2 percent of residents in noncore areas could not afford dental care due to cost, compared to 12.1 percent of individuals in micropolitan areas. Individuals with public and private insurance coverage in noncore and micropolitan areas were less likely than those who were uninsured to delay dental care or be unable to afford dental care.



Data source: Medical Expenditure Panel Survey (MEPS) 2017-2018 Full-Year Consolidated Files

ACCESS TO HEALTH CARE (CONTINUED)

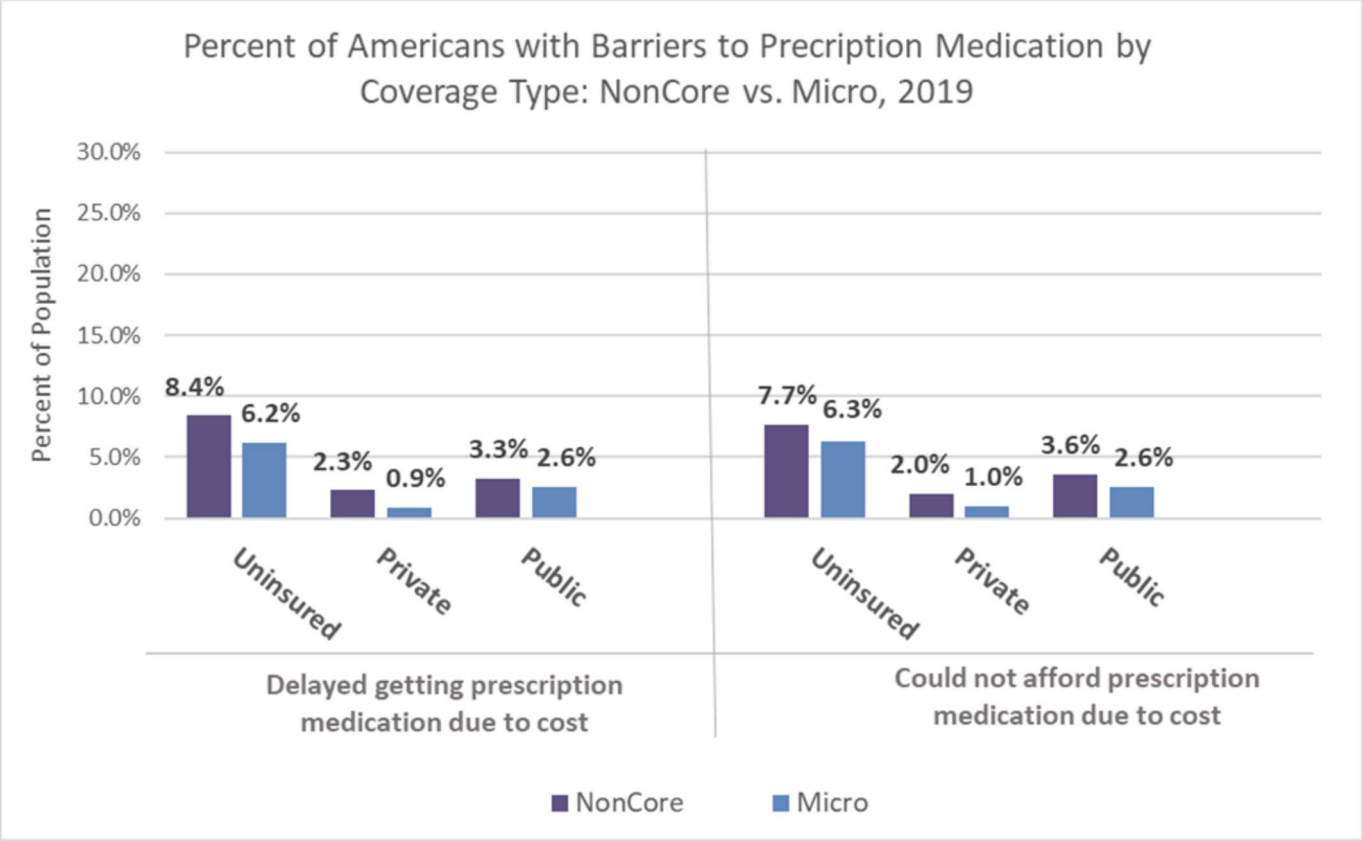


Prescription drugs — which can be very expensive — are accessible and affordable through most health insurance plans, which varies by metropolitan and non-metropolitan status (as shown above). As shown above, 18.1 percent of non-metropolitan uninsured residents delayed getting prescription medication due to cost, and 14.5 percent of non-metropolitan uninsured residents could not afford prescription medication due to cost, compared to 15.3 percent and 12.8 percent respectively among the metropolitan uninsured.

Data source: Medical Expenditure Panel Survey (MEPS) 2017-2018 Full-Year Consolidated Files

ACCESS TO HEALTH CARE (CONTINUED)

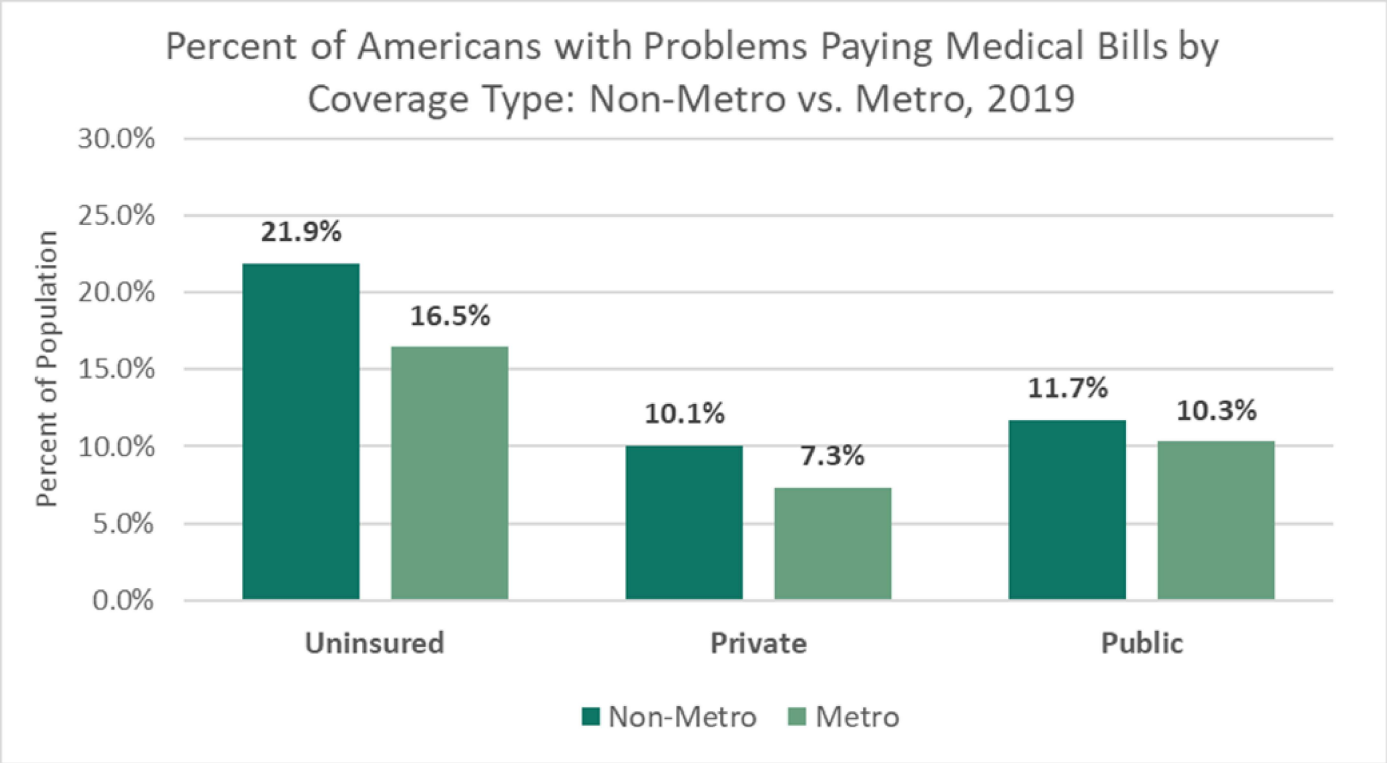
Uninsured residents living in non-metropolitan, noncore areas were more likely to delay getting prescription medication due to cost and were more likely to be unable to afford their prescription medication due to cost than the non-metropolitan uninsured residents in micro areas (8.4 percent compared to 6.2 percent). This trend was also true for those living in non-metropolitan areas with public and private health insurance coverage.



Data source: Medical Expenditure Panel Survey (MEPS) 2017-2018 Full-Year Consolidated Files

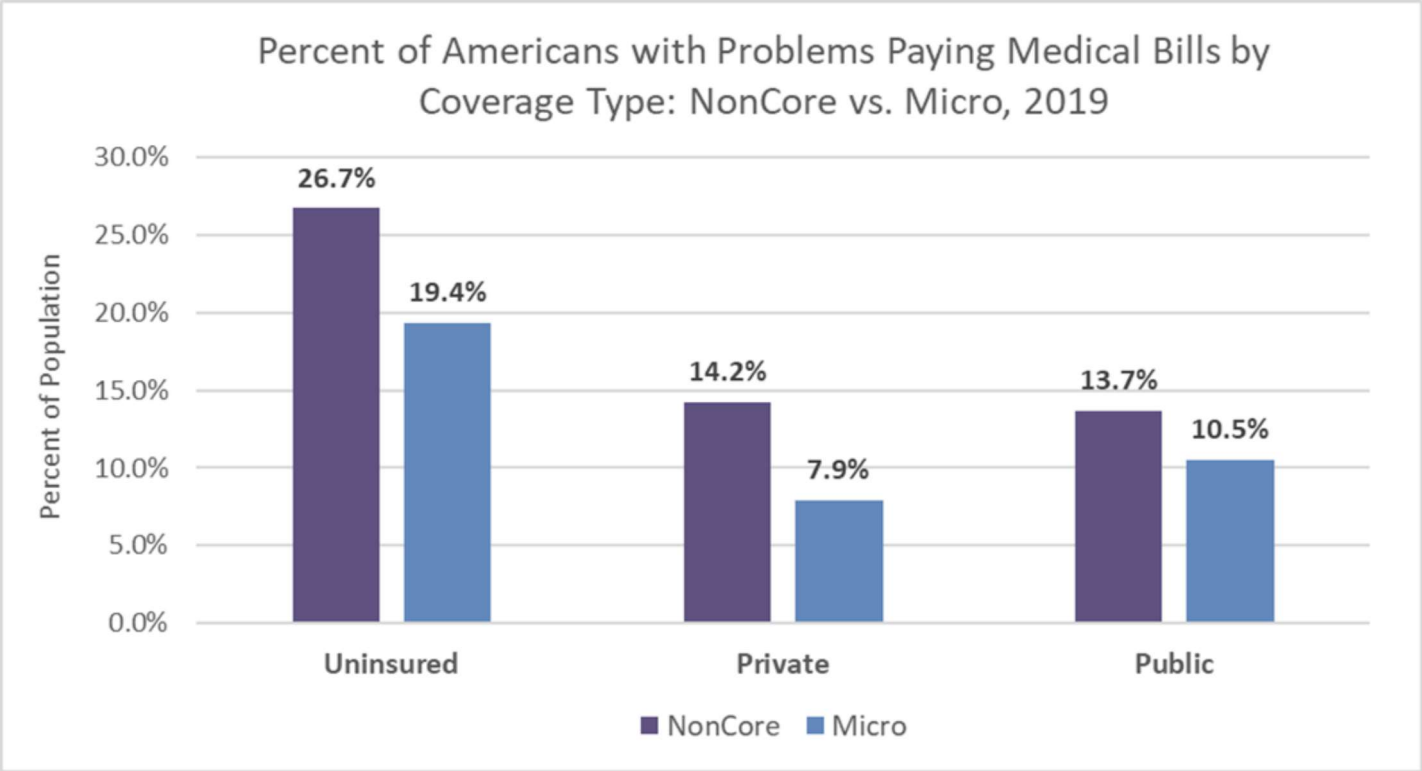
COST BURDEN

Across all insurance types and age groups, families in non-metropolitan areas were more likely to report problems paying medical bills than families in metropolitan areas. The gap is particularly pronounced among uninsured households, as about 22 percent of uninsured nonmetropolitan residents reported problems paying medical bills, compared to 16.5 percent of metropolitan residents. The gap is less pronounced for those with private coverage (10.1 percent compared to 7.3 percent) or public coverage (11.7 percent compared to 10.3 percent). The fact that those with public coverage report more problems than those with private coverage is likely related to certain Medicaid and Medicare services not being covered, which could result in medical bills among individuals with low ability to pay.



Data source: Medical Expenditure Panel Survey (MEPS) 2017-2018 Full-Year Consolidated Files

COST BURDEN (CONTINUED)

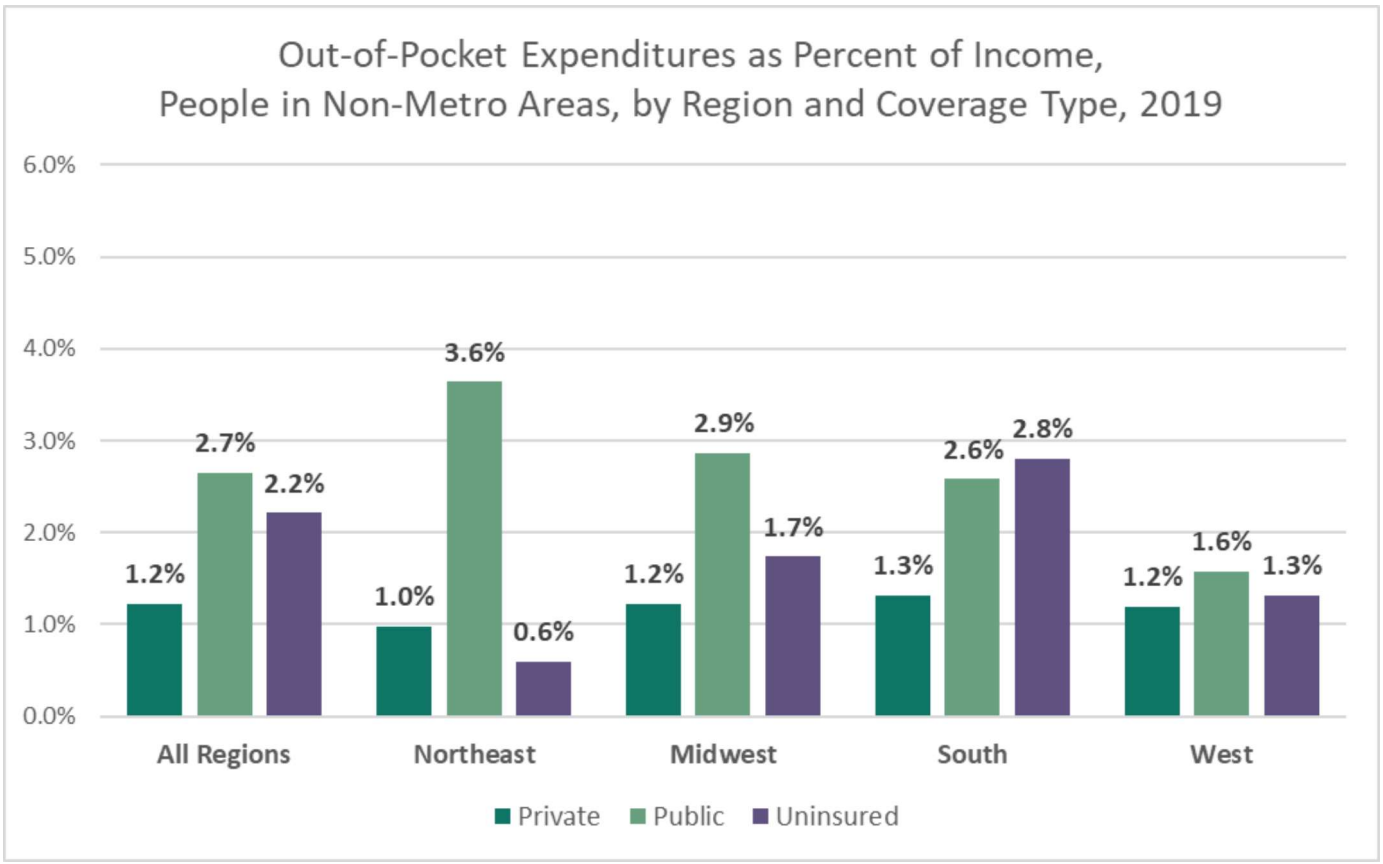


People living in noncore areas are more likely to report problems paying their medical bills than are people living in micropolitan rural areas. For example, among the uninsured 26.7 percent of non-core residents reported problems paying medical bills compared to 19.4 percent of those in micro areas.

Data source: Medical Expenditure Panel Survey (MEPS) 2017-2018 Full-Year Consolidated Files

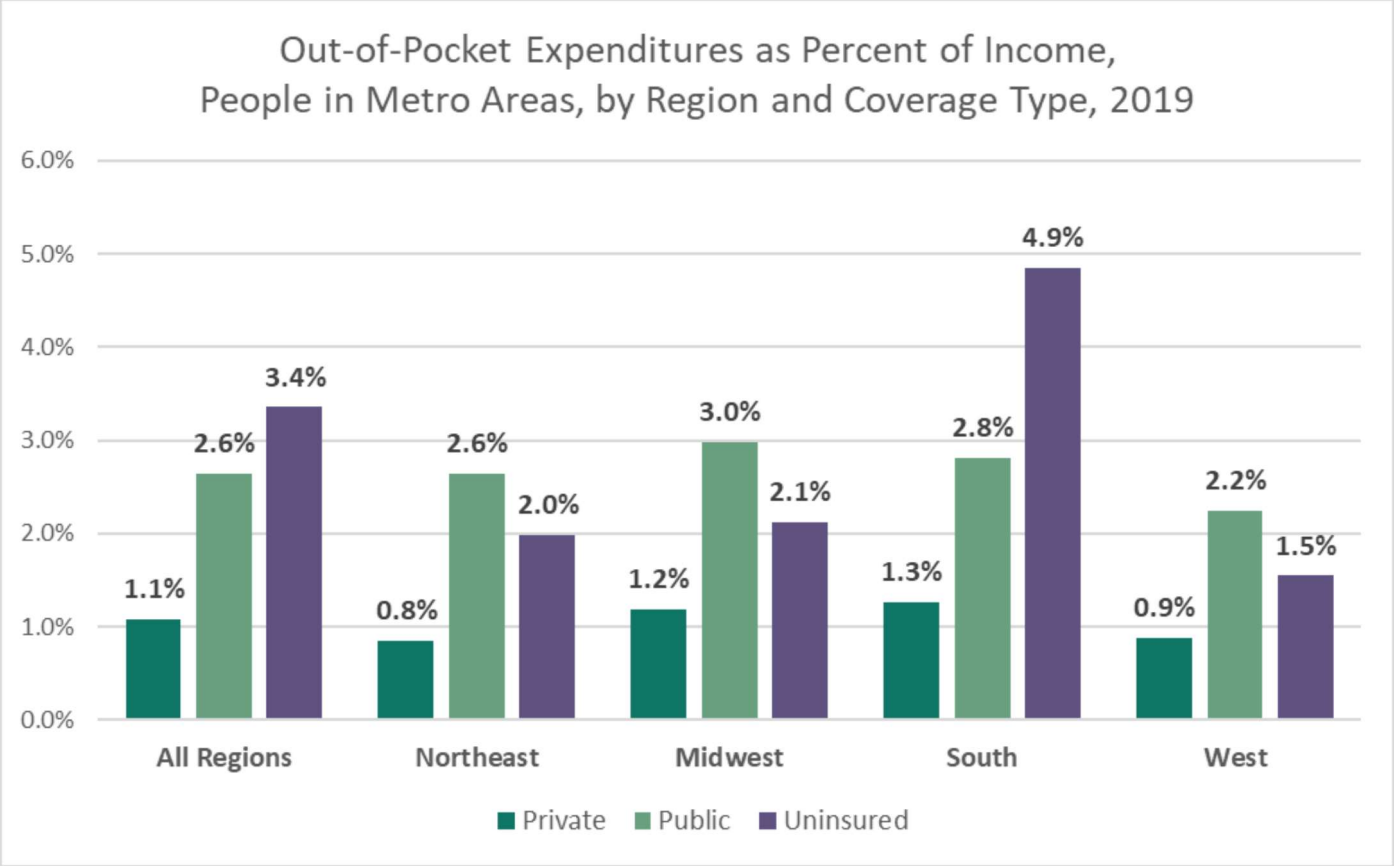
CHILDREN'S HEALTH INSURANCE

Out-of-pocket (OOP) expenditures relative to income is another measure of cost burden. MEPS reports how all utilization is paid, including amounts paid by individuals for their own care (not including health insurance premiums). OOP expenditures for rural Americans of all ages are highest for those on public insurance in the Northeast, Midwest, and West, suggesting that even though many services are covered without copayments, especially in Medicaid, there are significant gaps in coverage that result in greater financial burden for people with public coverage. The greatest disparity by coverage type, but also the lowest OOP expenditures relative to income for uninsured persons, occurred in the Northeast. The South had the highest OOP exposure across insurance types, and the uninsured had the highest OOP costs in the South.



Data source: Medical Expenditure Panel Survey (MEPS) 2017-2018 Full-Year Consolidated Files

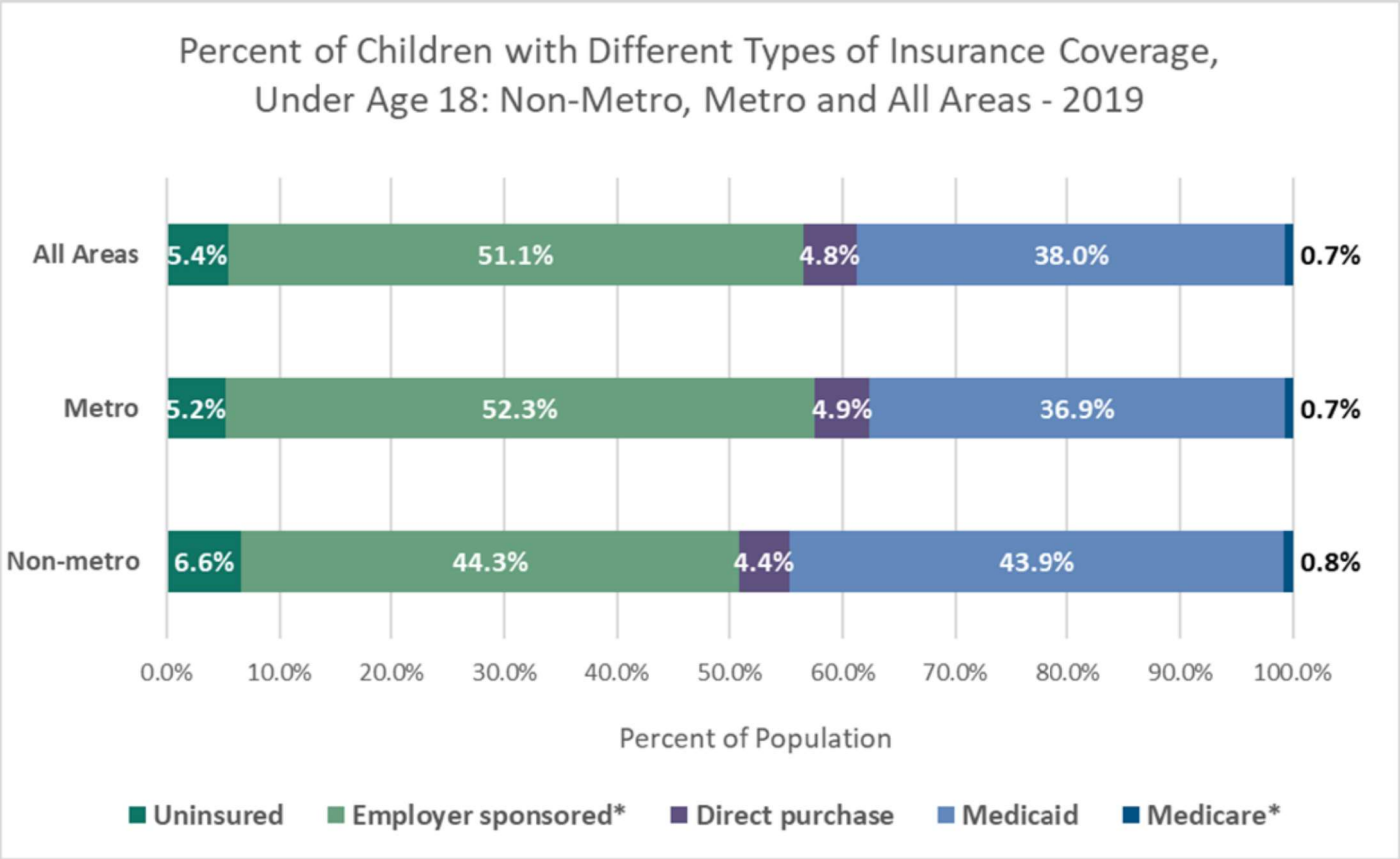
CHILDREN'S HEALTH INSURANCE (CONTINUED)



Out of pocket exposure is calculated by dividing the total health expenditures paid by an individual by their family income.

Data source: Medical Expenditure Panel Survey (MEPS) 2017-2018 Full-Year Consolidated Files

CHILDREN'S HEALTH INSURANCE (CONTINUED)



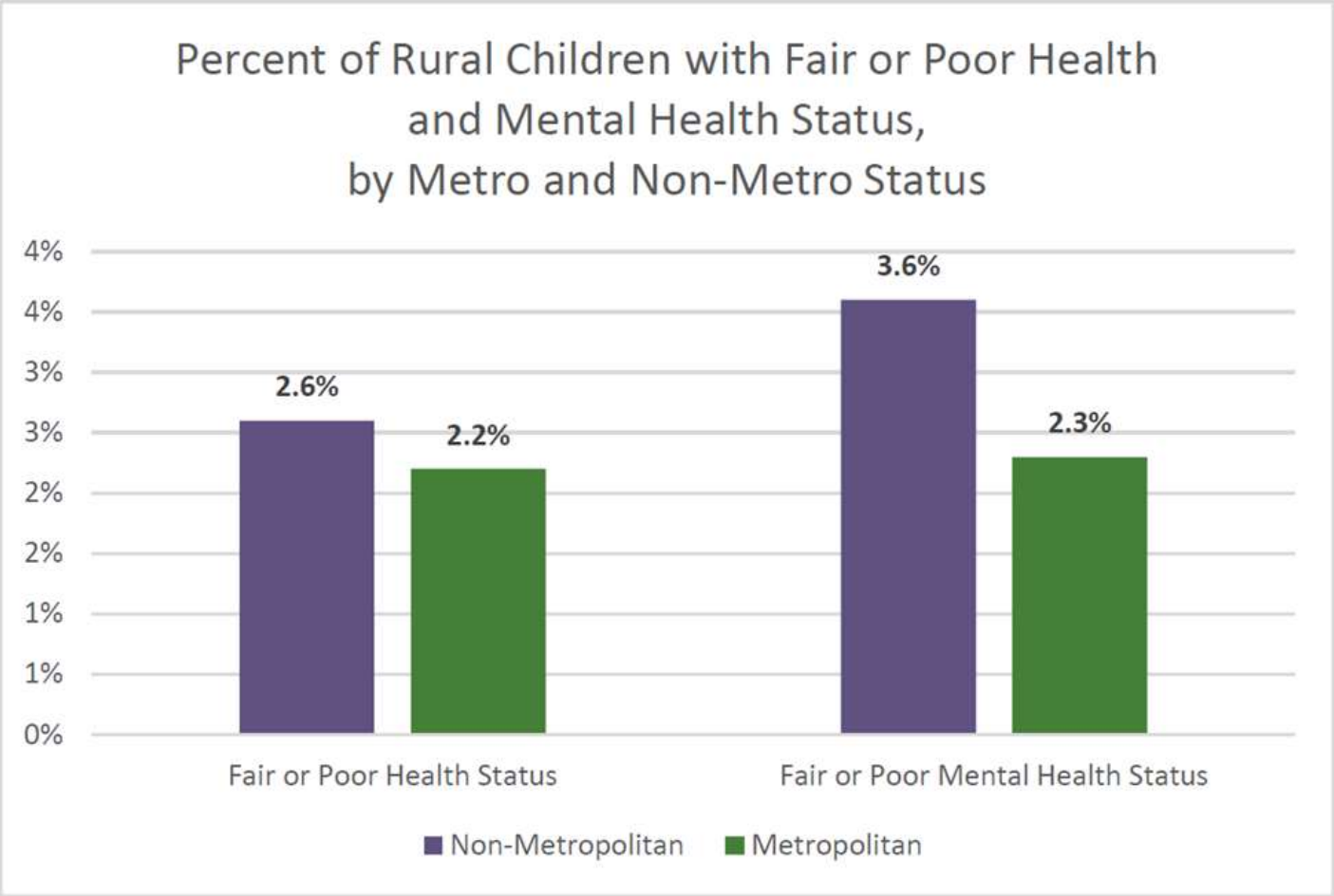
Children in non-metropolitan areas were much less likely to be covered by an employer plan than those in metropolitan areas. Instead, non-metropolitan children were more likely to be covered by Medicaid/CHIP or to be uninsured compared to those in metropolitan areas.

Data sources: American Community Survey (ACS) 2019 1-Year Estimates; Medical Expenditure Panel Survey (MEPS) 2017-2018 Full-Year Consolidated Files

HEALTH STATUS OF CHILDREN

The health status of non-metropolitan children, as reported by their parents, is slightly worse (2.6 percent reporting fair or poor health status) as compared to their metropolitan counterparts (2.2 percent). Further analysis of the non-metropolitan population showed that 2.8 percent of children living in micropolitan areas and 2.2 percent of children living in non-core areas had fair or poor health status.

A higher proportion of non-metropolitan children had fair or poor mental health status (3.6 percent), compared to metropolitan children (2.3 percent). Further analysis of the non-metropolitan population showed that 4.1 percent of children in micropolitan areas and 2.5 percent of children in noncore areas experienced fair or poor health status.

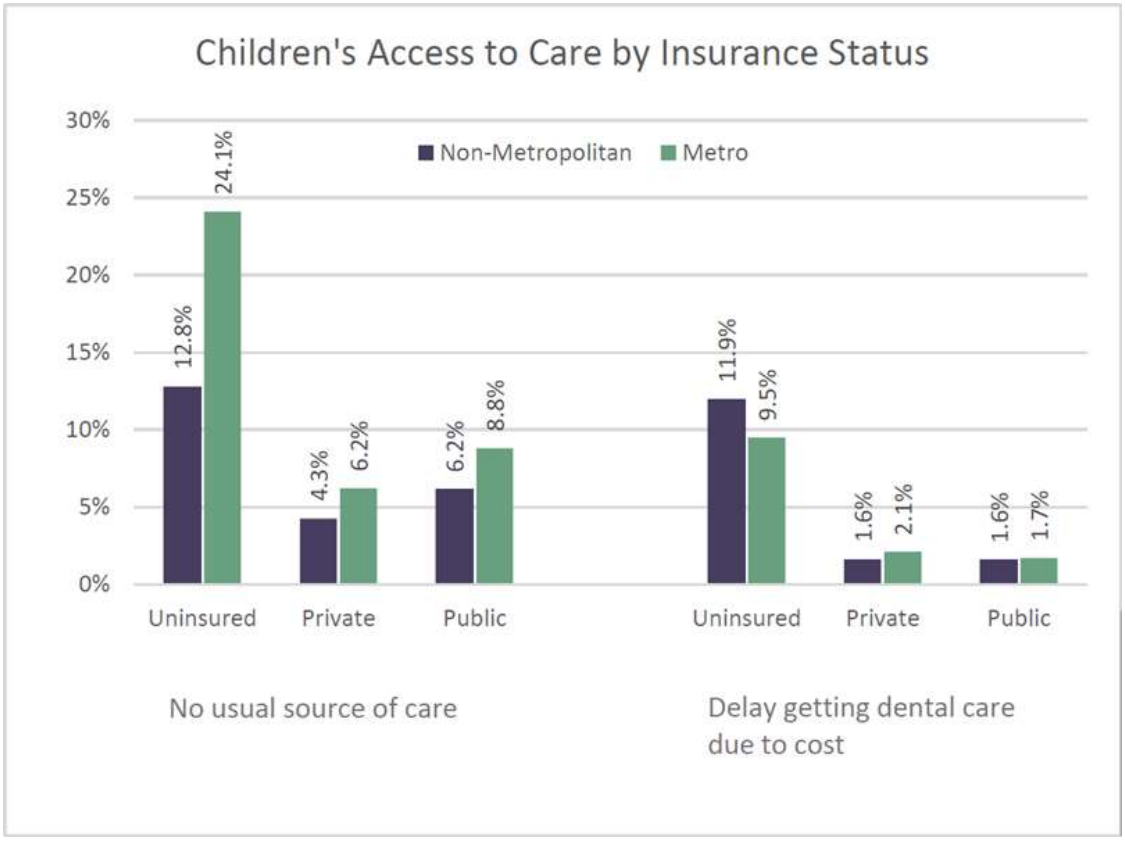


Data sources: American Community Survey (ACS) 2019 1-Year Estimates; Medical Expenditure Panel Survey (MEPS) 2017-2018 Full-Year Consolidated Files

ACCESS TO CARE FOR CHILDREN, BY HEALTH INSURANCE STATUS

Children's access to care is analyzed similarly to the analysis of adult access, using a MEPS question which asks whether people have a "usual source of care;" that is, a place where they usually go to obtain needed medical care such as a physician's office or a clinic. Most people report that their children have a usual source of care, though those without health insurance are much less likely to have one. Among uninsured children in non-metropolitan areas, 12.8 percent had no usual source of care, whereas only 4.3 percent of children with private coverage and 6.2 percent of children with public coverage had no usual source of care. For comparison, the values for children in metropolitan areas were much higher: 24.1 percent, 6.2 percent, and 8.8 percent respectively.

Given the importance of dental care to children, an important measure of access to care is whether children's parents delay their dental care due to the cost. While only 1.6 percent of children on private coverage and 1.6 percent of children on public coverage in non-metropolitan areas experience delays dental care due to costs, 11.9 percent of uninsured children do so. In contrast, in metropolitan areas, delays in accessing dental care occur for 2.1 percent of children with private coverage, 1.7 percent of children with public coverage, and 9.5 percent among uninsured children.



Data source: Medical Expenditure Panel Survey (MEPS) 2017-2018 Full-Year Consolidated Files

AVAILABILITY OF MARKETPLACE PLANS

The numbers of issuers offering Marketplace plans in counties across the country has varied considerably since implementation in 2014. Of particular note is the drop in the average number of plans from 2015 to 2018, followed by an increase in plans in the 2018-2022 period in all areas. While there is significant variation in issuer participation across the country, some regional and state-level patterns can be observed. Of note is the dramatic drop in average plans offered in rural areas in the Northeast from 2015 to 2018, with a subsequent recovery in the number of plans in the 2018-2022 period; increase in the average number of issuers in rural (and urban) areas in the South in the 2018-2022 period.

Average Number of Issuers Per County	Year							
	2014	2015	2016	2017	2018	2019	2020	2021
Overall	3.0	3.9	3.6	2.3	1.9	2.1	2.4	2.9
Urban	3.4	4.5	4.2	2.7	2.2	2.5	2.9	3.4
Rural	2.8	3.5	3.3	2.0	1.7	1.9	2.1	2.6

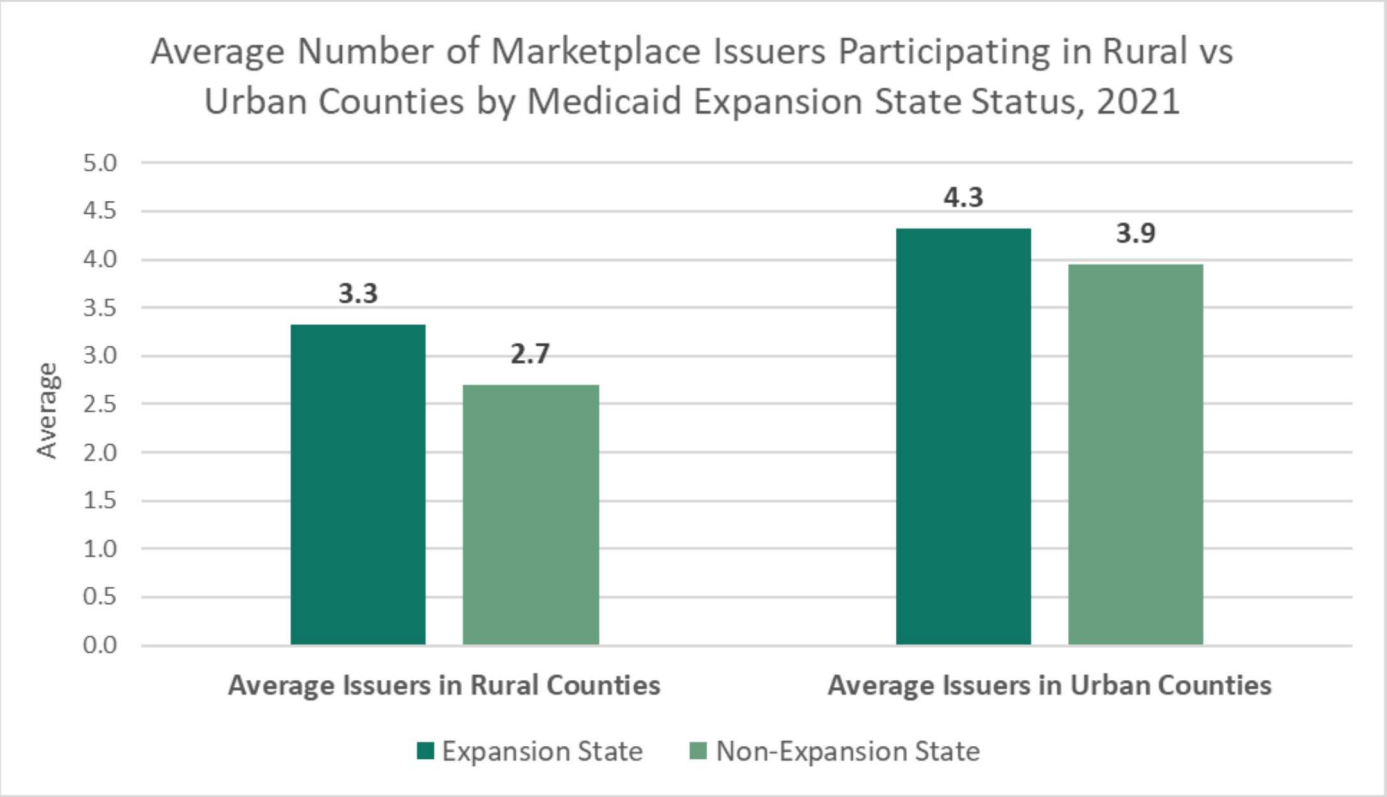
Average Number of Issuers Per County by Region	Year							
	2014	2015	2016	2017	2018	2019	2020	2021
Northeast								
Urban	4.8	6.0	5.5	4.0	3.4	4.2	4.4	4.6
Rural	4.0	4.9	4.4	3.1	2.6	3.6	3.4	3.7
Midwest								
Urban	3.5	4.9	4.8	2.9	2.2	2.5	2.9	3.3
Rural	2.9	3.7	3.6	2.2	1.7	2.0	2.3	2.6
South								
Urban	2.7	3.8	3.6	2.2	1.7	2.0	2.4	3.0
Rural	1.9	3.0	2.8	1.6	1.4	1.6	1.8	2.4
West								
Urban	5.2	5.3	4.7	3.4	2.9	3.0	3.5	4.3
Rural	4.6	4.2	3.3	2.4	2.3	2.3	2.3	3.0

Data sources: Robert Wood Johnson Foundation (RWJF) 2014-2021 Individual Issuer County Report files; Center for Consumer Information and Insurance Oversight (CCIIO) 2014-2021 Qualified Health Plans Landscape Medical Individual Market files

AVAILABILITY OF MARKETPLACE PLANS (CONTINUED)

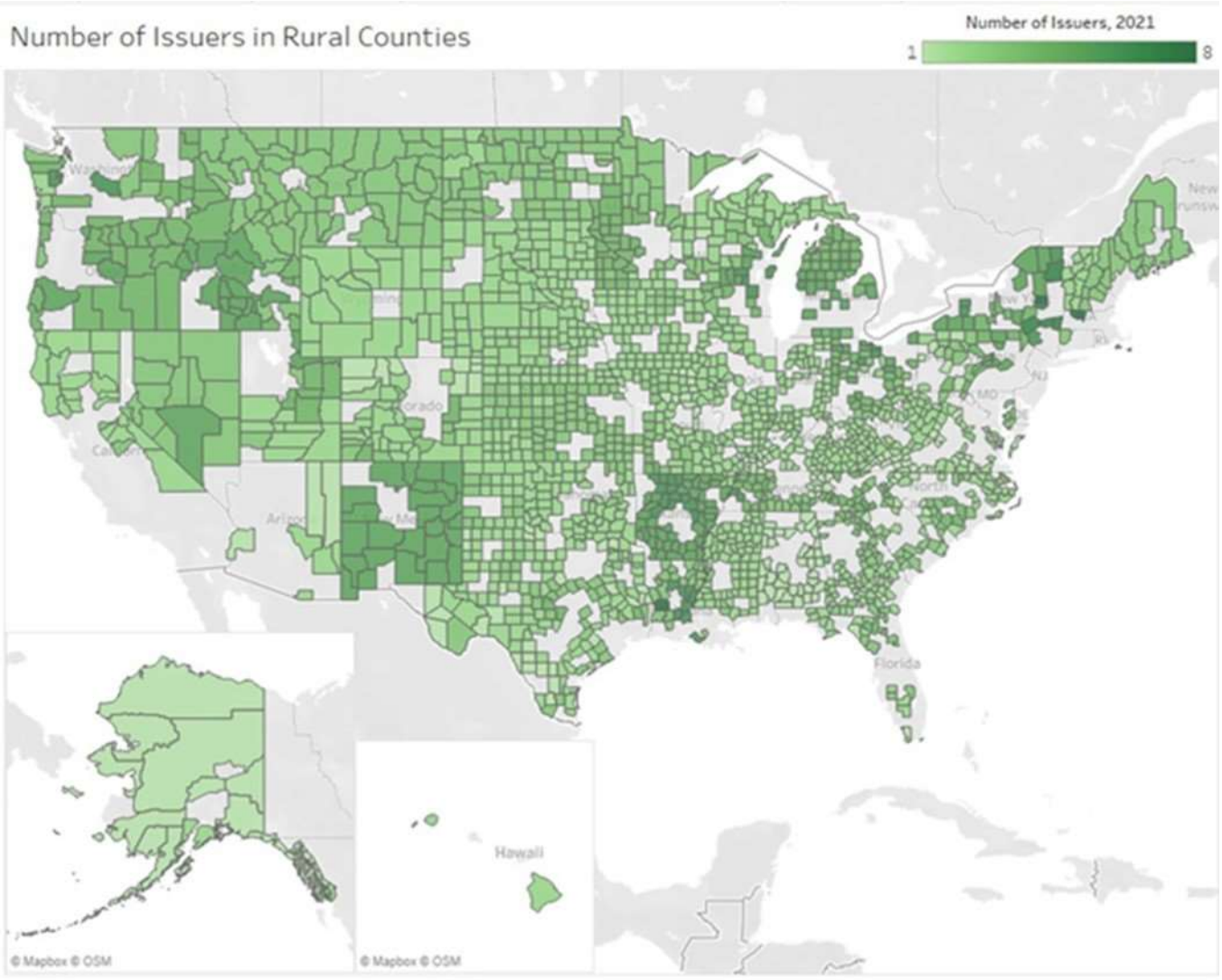
Quantifying access to Marketplace plans is an important component of the overall urban-rural comparison. That comparison is best made by separating urban and rural average numbers of issuers according to Medicaid expansion status.

As shown in the figure, rural counties in Medicaid expansion states were more likely to have additional Marketplace issuers offering plans (3.3 plans) as compared to non-expansion states (2.7 plans), which prior work suggests is a minimum for robust competition.[9]



Data sources: Robert Wood Johnson Foundation (RWJF) 2014-2021 Individual Issuer County Report files; Center for Consumer Information and Insurance Oversight (CCIIO) 2014-2021 Qualified Health Plans Landscape Medical Individual Market files

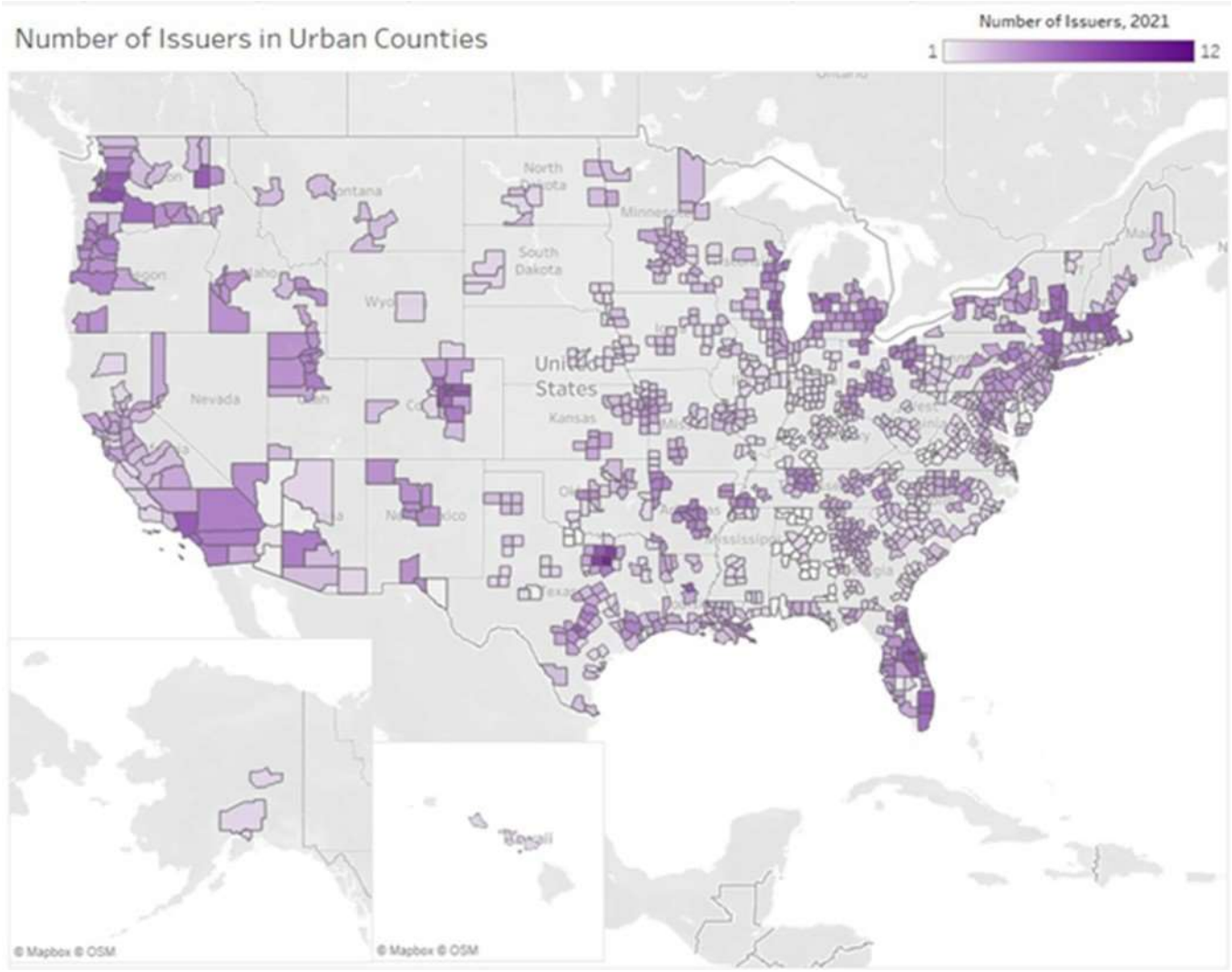
AVAILABILITY OF MARKETPLACE PLANS (CONTINUED)



The number of issuers (firms) offering Marketplace plans in rural areas varies by county with some counties having one issuer and some having as many as eight. Rural counties of New Mexico, Idaho, Arkansas, Michigan and New York have the highest numbers of issuers. All of these states have expanded Medicaid and have relatively large rural populations.

Data sources: Robert Wood Johnson Foundation (RWJF) 2014-2021 Individual Issuer County Report files; Center for Consumer Information and Insurance Oversight (CCIIO) 2014-2021 Qualified Health Plans Landscape Medical Individual Market files

AVAILABILITY OF MARKETPLACE PLANS (CONTINUED)

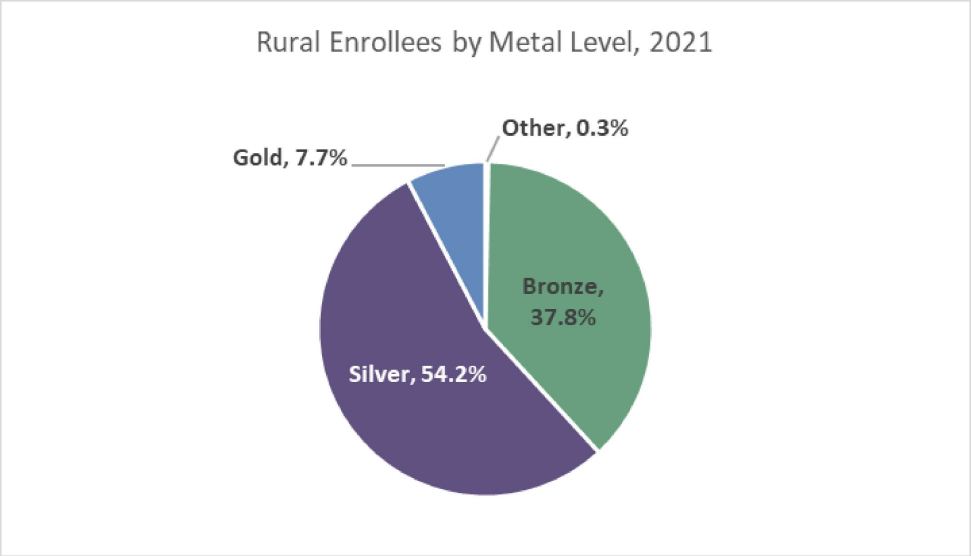


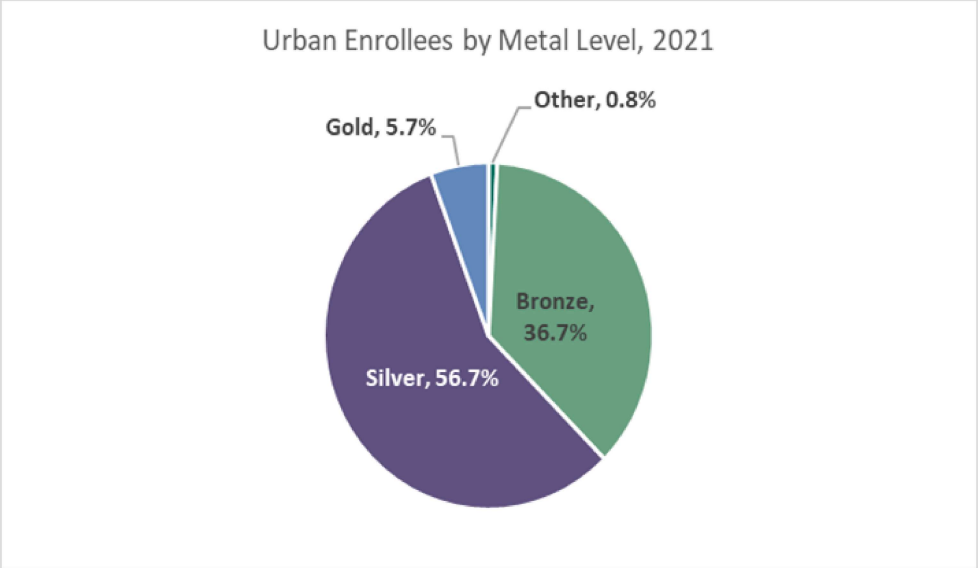
The number of firms offering Marketplace plans in urban areas varies by county with some counties having only one issuer and some having as many as twelve. The highest concentrations of issuers in urban areas were in the states of Florida, California, Washington, New York, Massachusetts, Colorado, Texas, and Michigan.

Data sources: Robert Wood Johnson Foundation (RWJF) 2014-2021 Individual Issuer County Report files; Center for Consumer Information and Insurance Oversight (CCIIO) 2014-2021 Qualified Health Plans Landscape Medical Individual Market files.

AVAILABILITY OF MARKETPLACE PLANS (CONTINUED)

There is very little difference in the distribution of enrollees in Marketplace plans by metal level between urban and rural enrollees, although it is interesting to note the higher share of gold plan enrollment (about a 2-percentage point difference) among rural enrollees. A phenomenon known as "Silver loading" describes the behavior of issuers in response to a lack of funding for reduced cost-sharing Silver plans, in which the issuer increases the premium for all Silver plans in order to cover these costs.[10] Since the subsidy level depends on the cost of the second-lowest silver plan, in rural counties this is more likely to translate to a substantially increased subsidy, which in turn makes Gold plans more affordable.





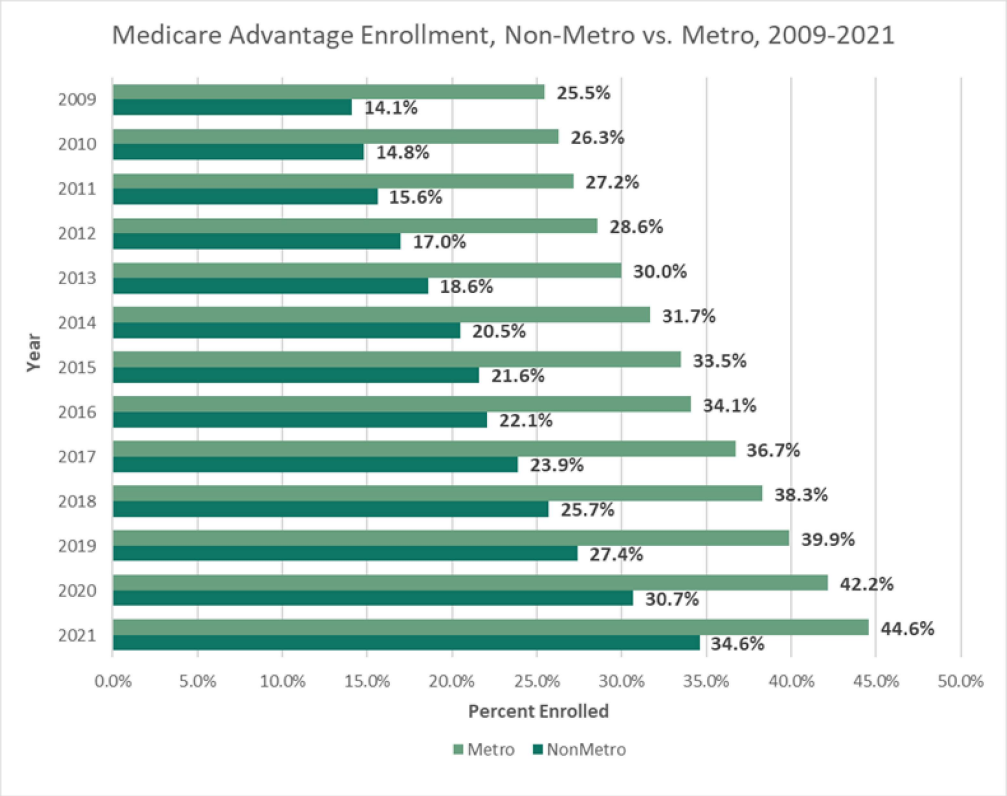
Data source: Centers for Medicare & Medicaid Services (CMS) 2021 Marketplace Open Enrollment Period (OEP) County- Level Public Use File. Other includes gold and platinum plans.

AVAILABILITY OF MEDICARE ADVANTAGE PLANS

Medicare Advantage (MA) enrollment has been growing in recent years. The MA program allows individuals who are eligible for Medicare Part B coverage to enroll in a health insurance plan through a private insurer in lieu of traditional fee-for-service Medicare coverage. As of March 2021, over 26.5 million Medicare beneficiaries were enrolled in Medicare Advantage plans with 3.8 million living in non-metropolitan areas and 22.8 million living in metropolitan areas.

Medicare Advantage Enrollment, Non-Metropolitan and Metropolitan Areas, 2009-2021

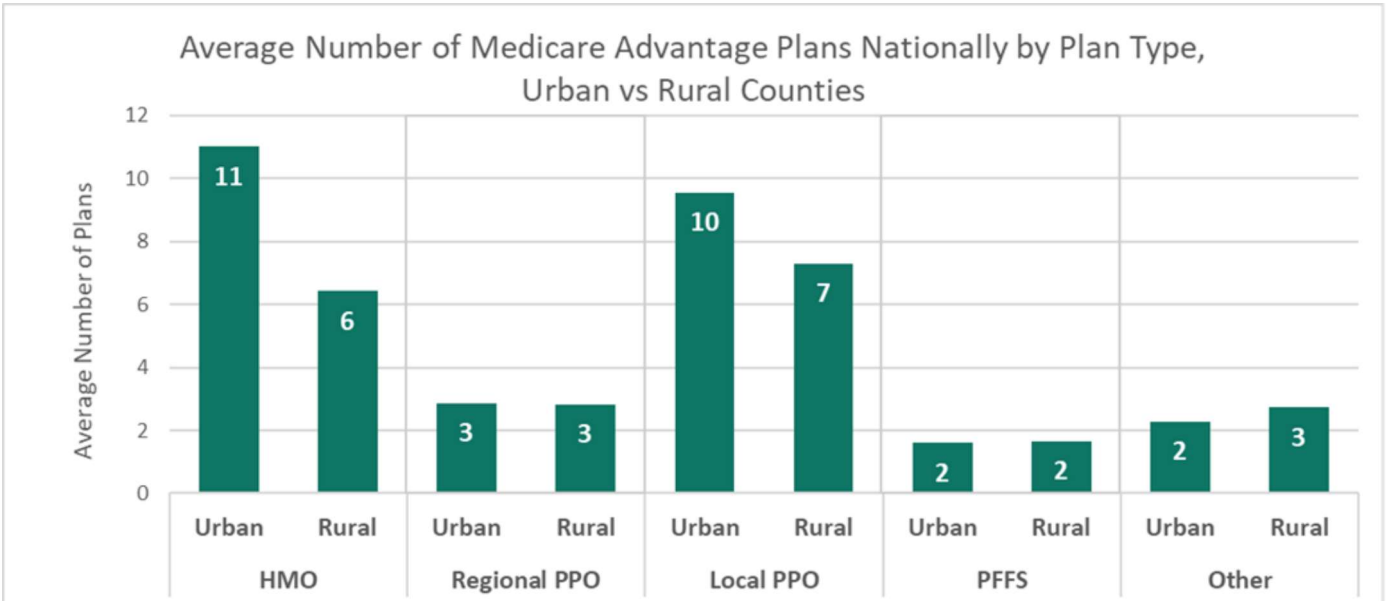
Year	Count (in thousands)		Percent	
	Non-Metropolitan	Metropolitan	Non-Metropolitan	Metropolitan
2021	3,763	22,758	34.6%	44.6%
2020	3,295	21,437	30.7%	42.2%
2019	2,896	19,756	27.4%	39.9%
2018	2,660	18,437	25.7%	38.3%
2017	2,431	17,198	23.9%	36.7%
2016	2,225	15,423	22.1%	34.1%
2015	2,115	14,619	21.6%	33.5%
2014	1,966	13,456	20.5%	31.7%
2013	1,753	12,339	18.6%	30.0%
2012	1,559	11,304	17.0%	28.6%
2011	1,394	10,359	15.6%	27.2%
2010	1,300	9,744	14.8%	26.3%
2009	1,222	9,224	14.1%	25.5%



The percentage of non-metropolitan beneficiaries enrolled in an MA plan has grown from 14.1 percent in 2009 to 34.6 percent in 2021. MA plans often offer Supplemental benefits to enrollees, as contrasted to traditional fee-for-service Medicare.

Data source: Medical Expenditure Panel Survey (MEPS) 2017-2018 Full-Year Consolidated Files

AVAILABILITY OF MEDICARE ADVANTAGE PLANS (CONTINUED)



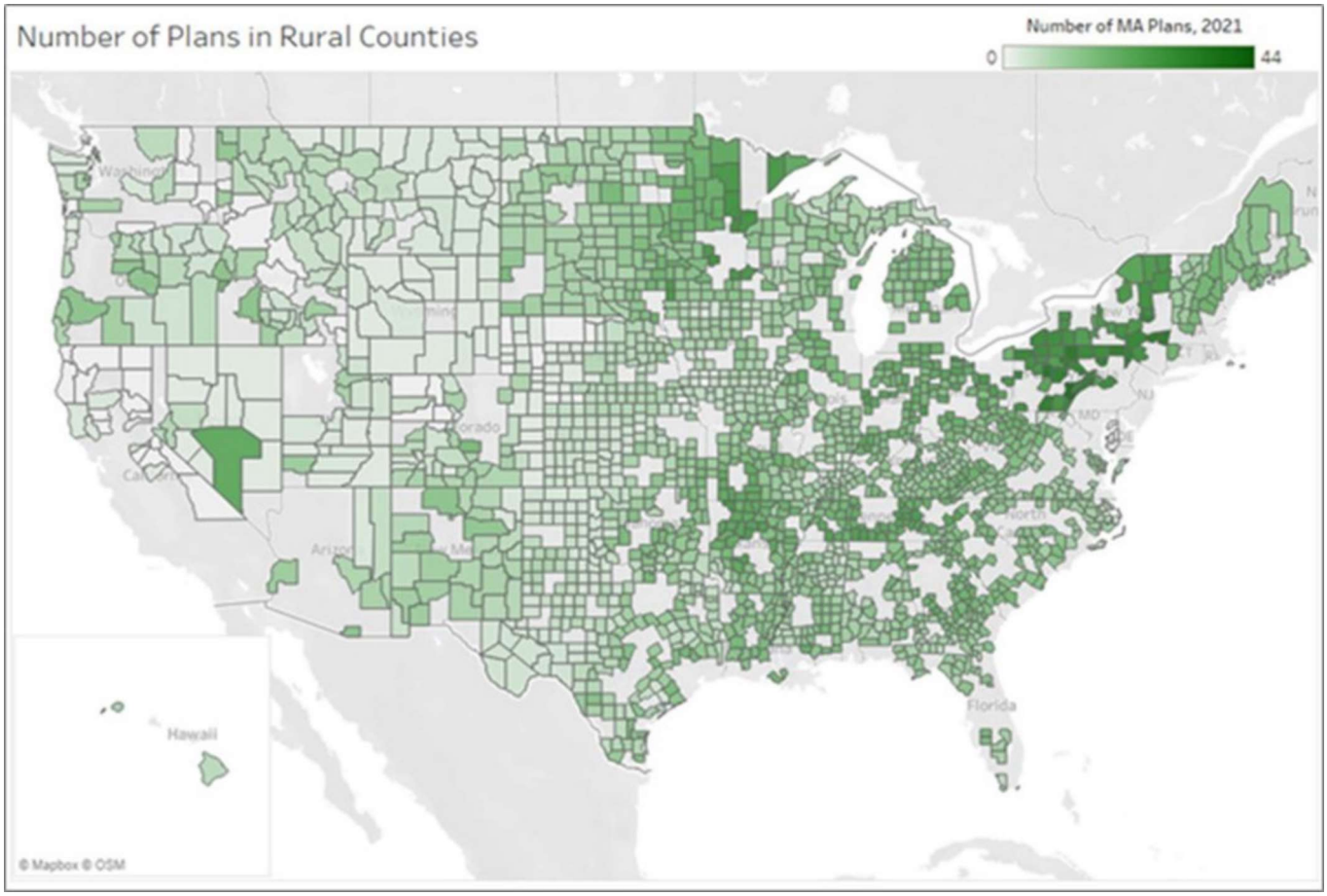
By Region										
West	11	4	2	2	7	5	1	1	2	2
South	10	6	3	3	9	7	2	2	2	2
Northeast	17	14	2	2	14	14	3	2	2	2
Midwest	11	6	3	3	11	7	1	2	3	4

One factor affecting the enrollment in MA plans is the number of MA plans available in metropolitan and non-metropolitan areas, which is highly variable. Typically individuals living in metropolitan areas have many more MA plans available than those living in non-metropolitan areas. In addition, some types of MA plans are more likely to be offered in rural or urban areas. For example, nationally the average number of Health Maintenance Organization (HMO) plans available in urban counties is 11, while the average number of HMO plans available in rural counties is 6. However, the average number of regional Preferred Provider Organization (RPPO) and Private Fee-For-Service (PFFS) plans were the same in both rural and urban counties. There is also regional variation in the availability of MA plans by plan type. There are more HMO and local PPO plans offered in the Northeast region of the United States, while the West and South have a fewer number of such plans available.

Data source: Centers for Medicare & Medicaid Services (CMS) 2014-2021 MA Landscape Source Files

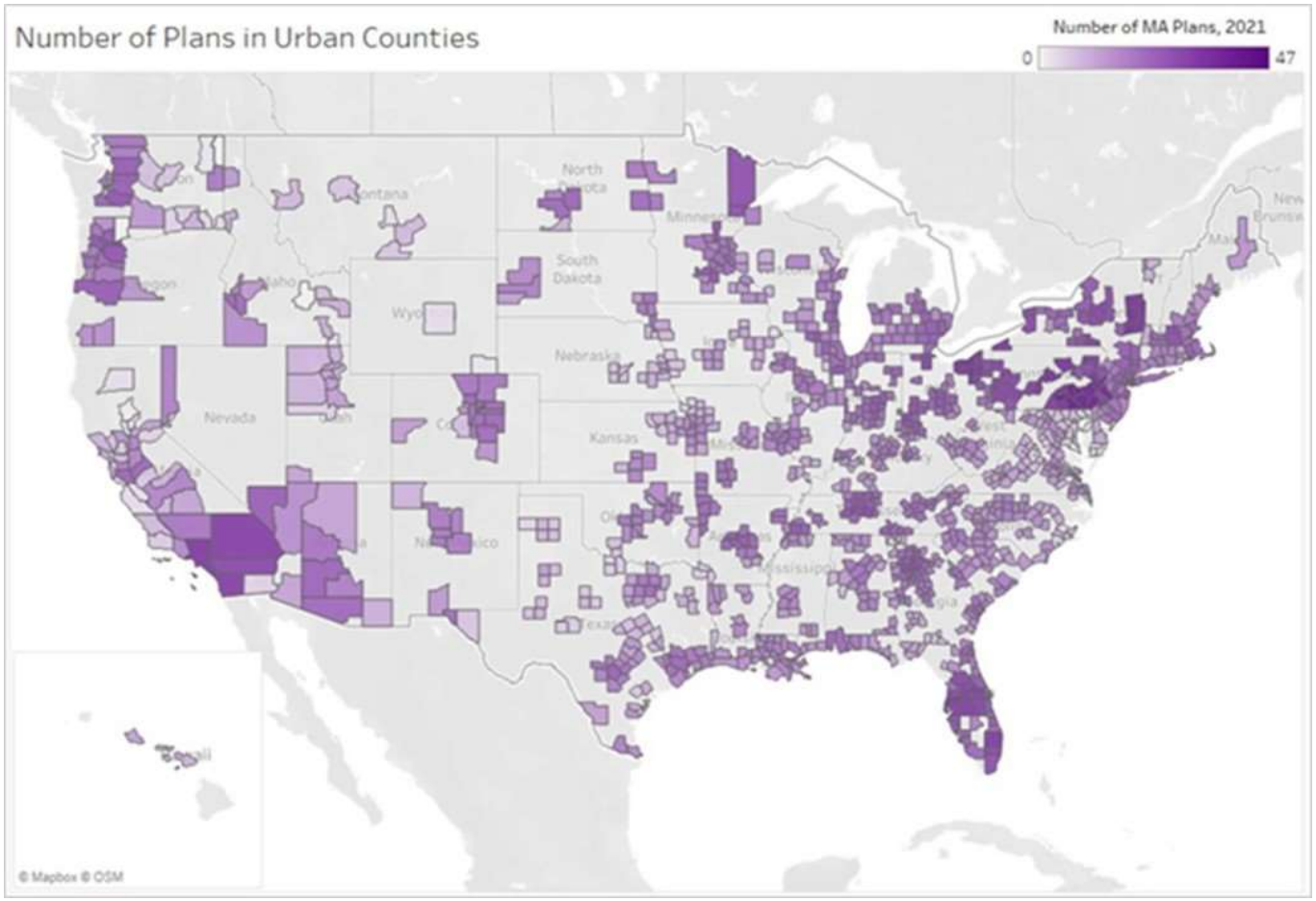
AVAILABILITY OF MEDICARE ADVANTAGE PLANS (CONTINUED)

The Northeast region has the greatest number of MA plans available on average; however, the plans available at the county level vary significantly from county to county within this and the other regions. The greatest concentration of MA plans available in rural areas is located in Pennsylvania and the surrounding areas, and in the upper Midwest. MA plans are less available in rural areas of the western and mountain regions of the country.



Data source: Centers for Medicare & Medicaid Services (CMS) 2014-2021 MA Landscape Source Files

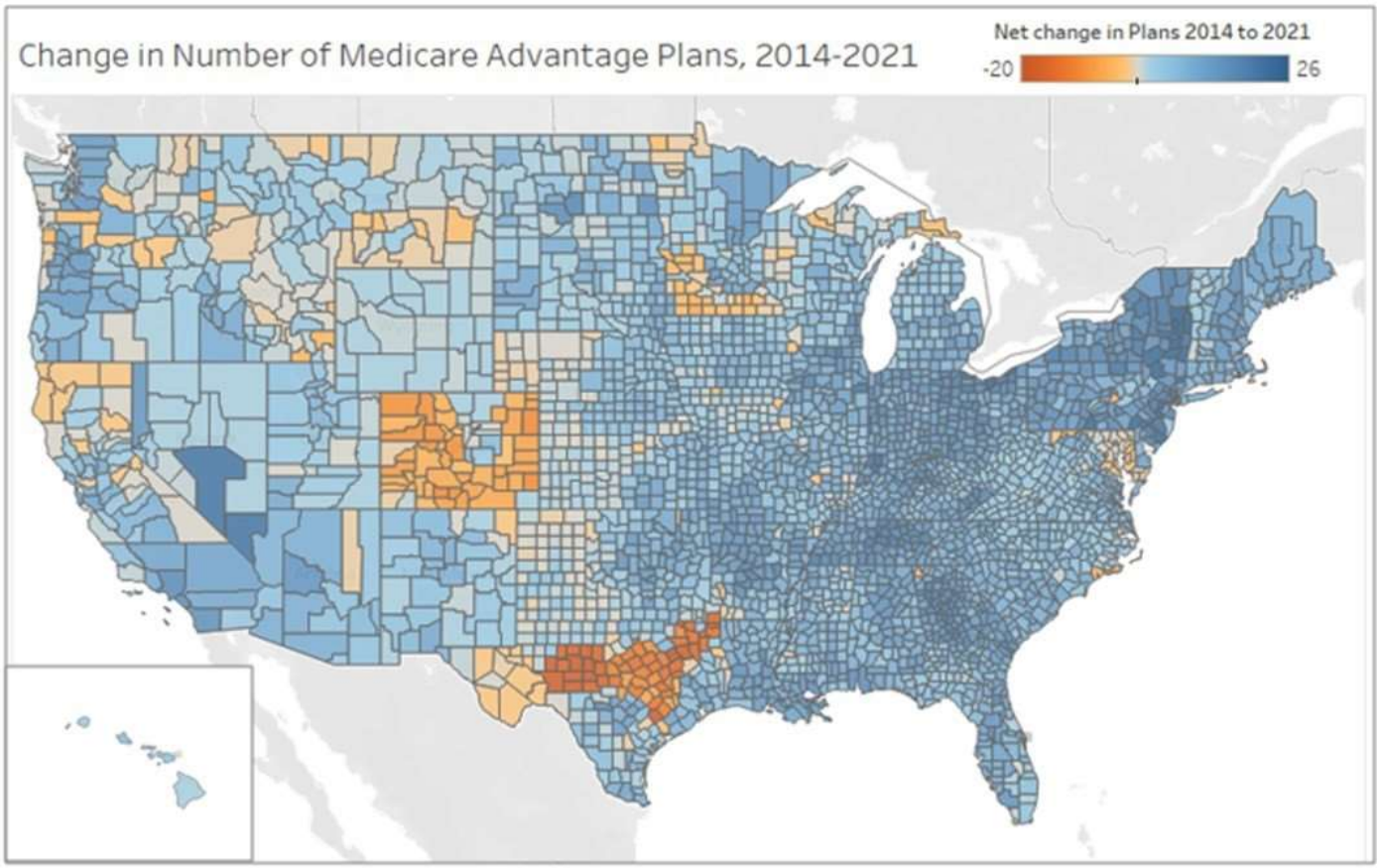
AVAILABILITY OF MEDICARE ADVANTAGE PLANS (CONTINUED)



In metropolitan areas of the country MA plan availability also varies by region with the greatest number of plans available in metropolitan areas in Pennsylvania, Florida and the western regions of the country.

Data source: Centers for Medicare & Medicaid Services (CMS) 2014-2021 MA Landscape Source Files

AVAILABILITY OF MEDICARE ADVANTAGE PLANS (CONTINUED)

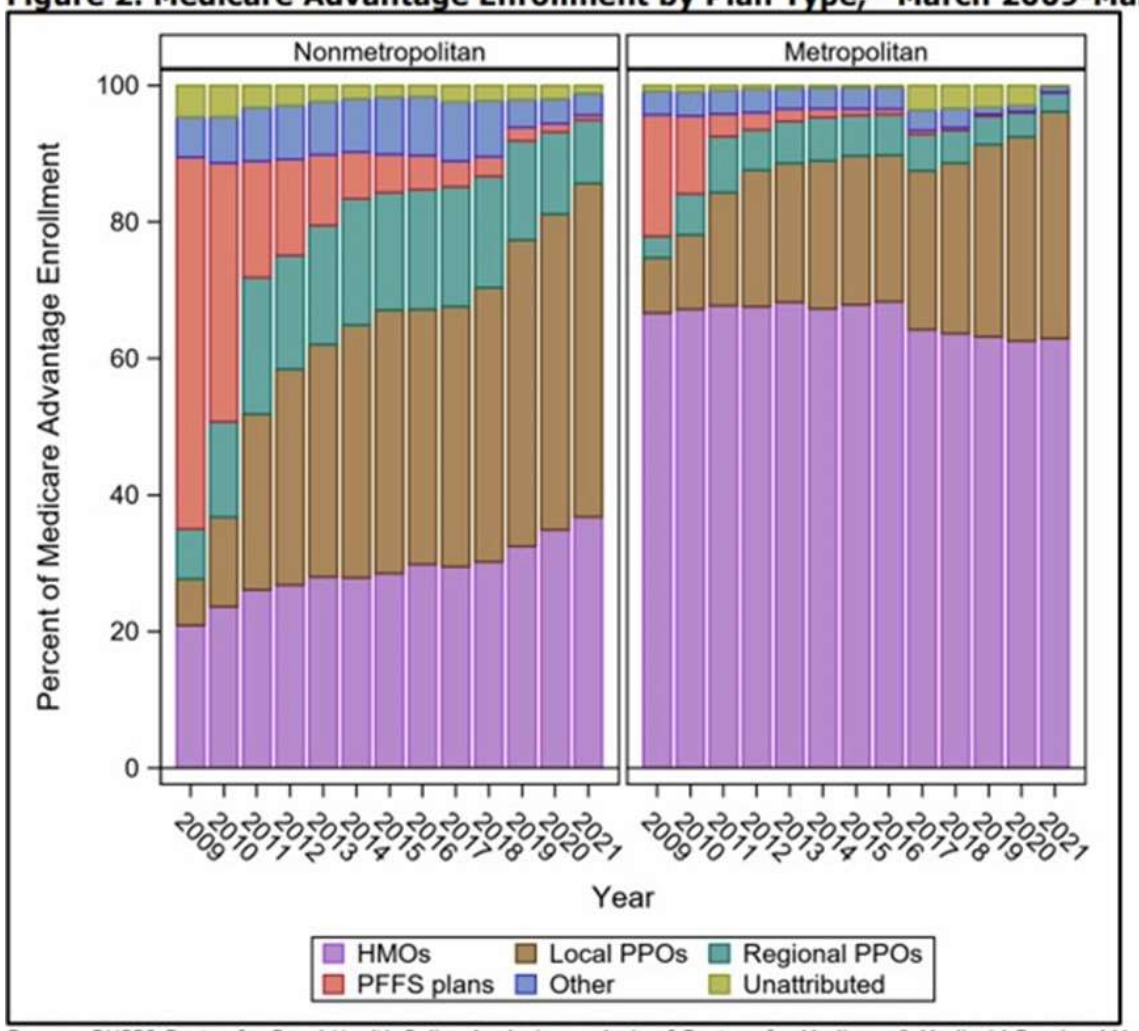


MA plans have the opportunity to enter and exit insurance markets every year and to change their plan offerings in areas where they are currently administering MA plans. From 2014 through 2021, some areas of the country have had significant declines in the number of MA plans offered in their area, particularly in the western half of the country and in the state of Texas. However, the majority of counties have had gains in the number of MA plans available.

Data source: Centers for Medicare & Medicaid Services (CMS) 2014-2021 MA Landscape Source Files

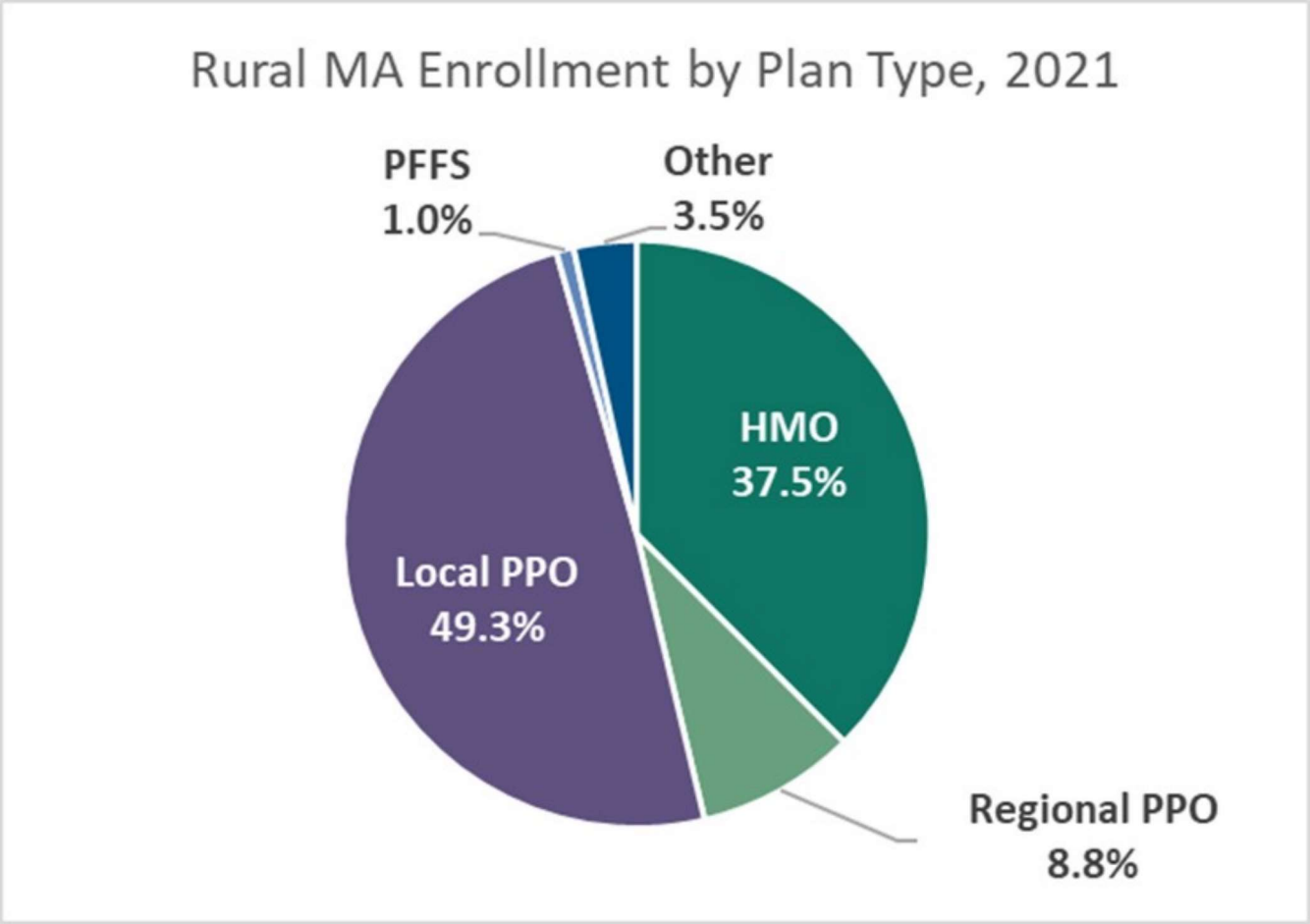
The composition of the types of MA plans offered in non-metropolitan and metropolitan areas has varied and changed over time. Enrollment trends reflect the same changes. In 2009, more than half of enrollment in MA plans offered in non-metropolitan areas was in PFFS plans, but by 2021, enrollment in these types of plans was virtually insignificant, replaced with local PPO plan enrollment. In metropolitan areas, the same pattern is visible but is less pronounced, as PFFS plans were not common even in 2009. HMO plans dominated the metropolitan MA plan enrollment over the period 2009 to 2021.

Figure 2. Medicare Advantage Enrollment by Plan Type,* March 2009-March 2021



Source: RUPRI Center for Rural Health Policy Analysis, analysis of Centers for Medicare & Medicaid Services' Medicare Advantage enrollment data.
* 'Other' plans include 1876 Cost, HCPP - 1833 Cost, and National PACE plans. 'Unattributed' refers to beneficiaries that could not be assigned to a plan type because of CMS reporting restrictions on county/plans with 10 or fewer enrollees.

Data source: Centers for Medicare & Medicaid Services (CMS) 2014-2021 MA Landscape Source Files

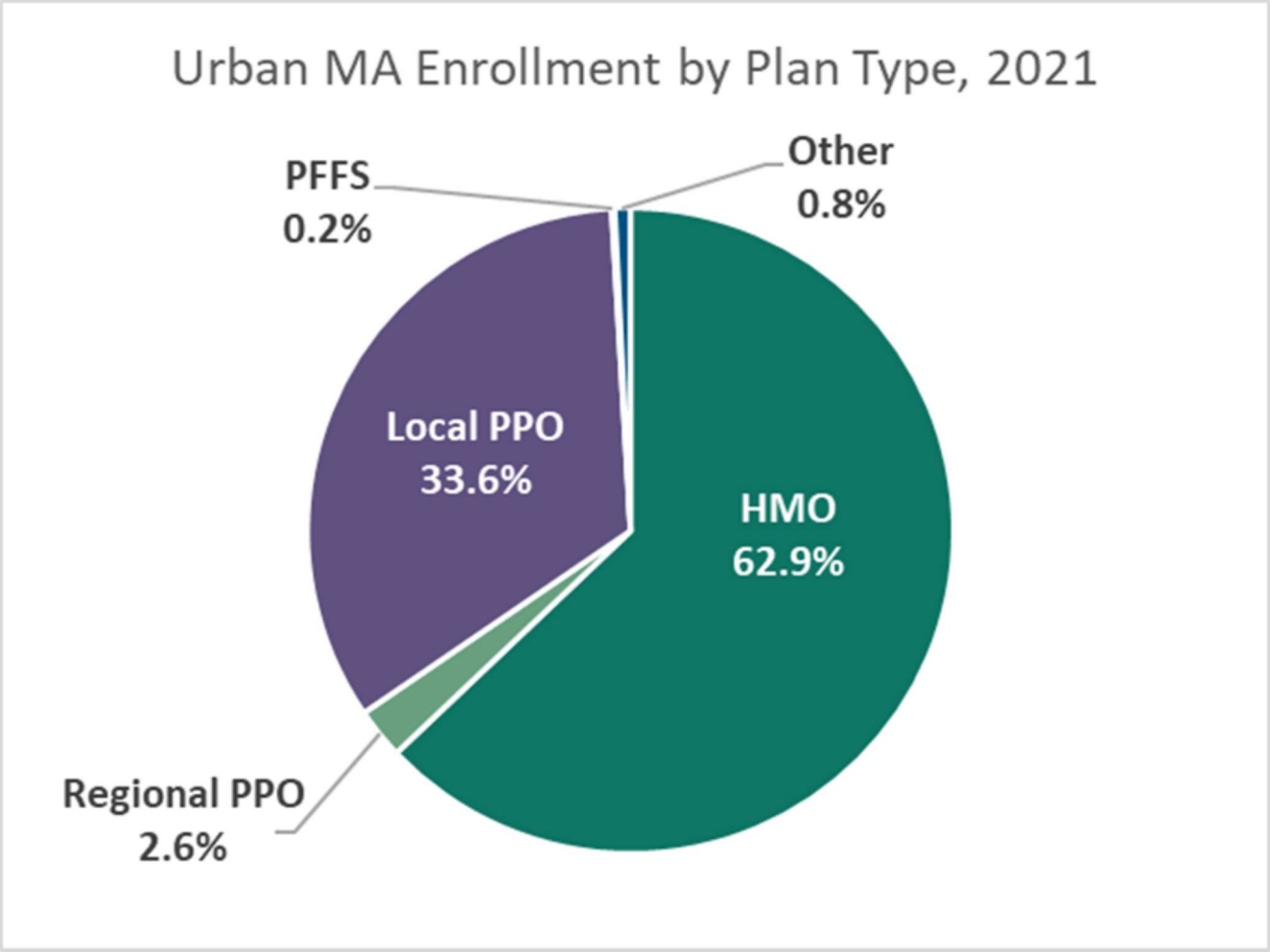


In 2021, Local PPO MA plans had nearly half (49 percent) of total MA enrollment in rural areas, while 38 percent of rural MA beneficiaries were enrolled in an HMO plan and 9 percent were enrolled in a Regional PPO. The domination of HMO plans in metropolitan areas is largely a historical artifact of how the MA program developed, since initially to enter the market a plan had to be an HMO. Initially, HMOs were present in metropolitan areas, but were seldom available in nonmetropolitan areas in the late 1980s and early 1990s.

Only with the passage the Balanced Budget Act of 1997, which expanded the type of plans that could be offered under the MA program to PPOs and other types, did the current patterns begin to emerge.

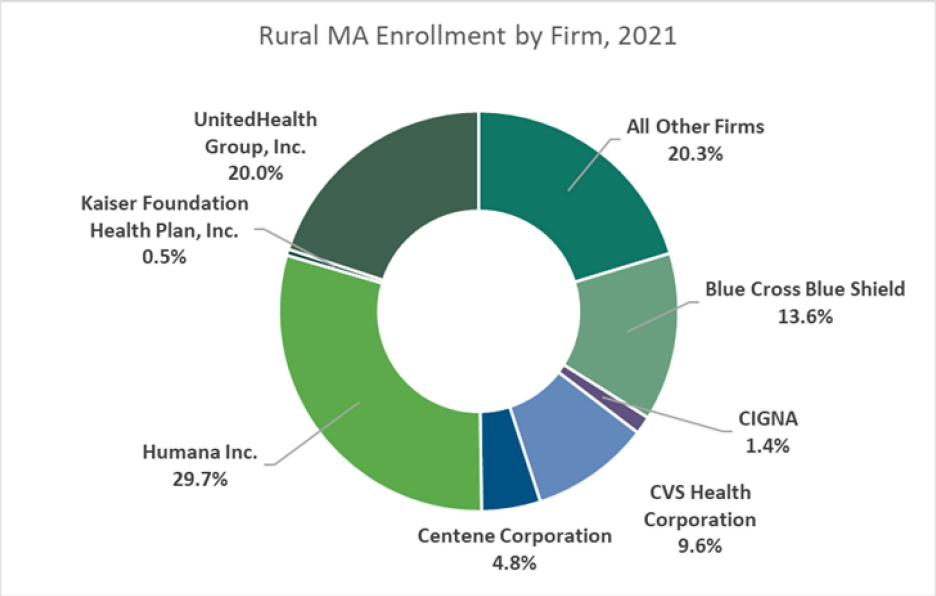
Data source: Centers for Medicare & Medicaid Services (CMS) Monthly MA Enrollment by State/County/Plan Type file

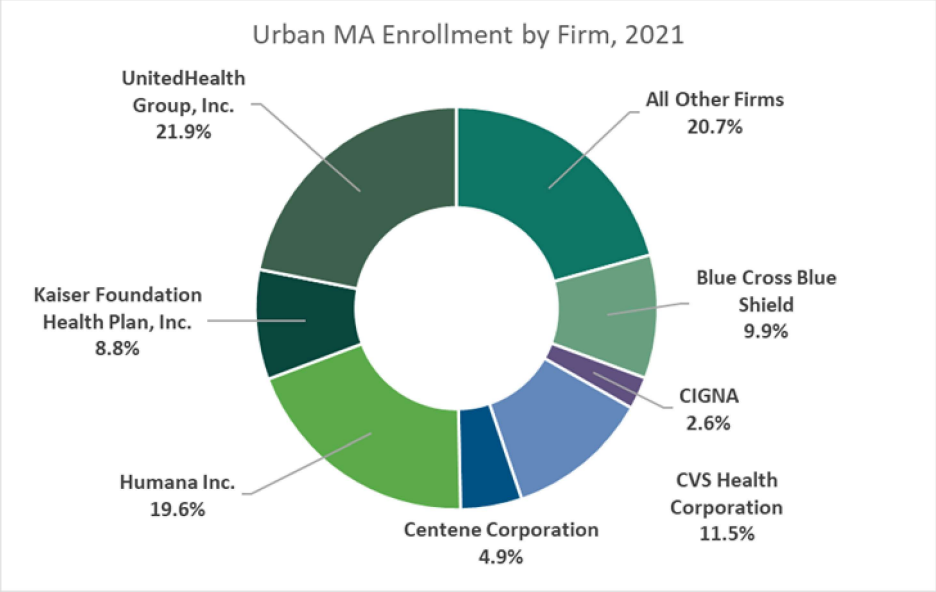
The majority (62.9 percent) of MA enrollment in urban areas is in HMO plans, while 33.6 percent are enrolled in Local PPOs. Only 2.6 percent of urban MA beneficiaries are enrolled in Regional PPO plans, and there is almost no enrollment in PFFS plans.



Data source: Centers for Medicare & Medicaid Services (CMS) Monthly MA Enrollment by State/County/Plan Type file

Issuer participation and beneficiary enrollment differs somewhat in rural and urban areas. Humana controls 30 percent of the MA market share in rural areas, but only 19 percent in urban areas. The Kaiser Foundation Health Plan has 9 percent of MA market share in urban areas but very minimal enrollment in rural areas. United Health Group, Blue Cross Blue Shield, Centene, and CVS Health Corporation have similar enrollment in rural and urban areas.





Data sources: Centers for Medicare & Medicaid Services (CMS) Monthly MA Enrollment by State/County/Plan Type file; 2021 MA Plan Directory

IMPACT OF PANDEMIC

The results presented in this Chartbook are based on the last available data from national surveys, which allow for comparisons of rural and urban coverage rates. Generally, this data comes from surveys collected in 2019. The first recorded case of COVID-19 was identified in December 2019 in China, and the first identified case in the U.S. was in January 2020.

The specific impact of the pandemic on insurance coverage will not be known – at least for calendar year 2020 -- from survey data until the release of the American Community Survey (ACS) and Current Population Survey (CPS) data. The recession linked to the pandemic was the worst recession in the U.S. since the Great Depression, even though the recession was the shortest on record. In two months, the US lost 25.4 million jobs, leading to an officially measured unemployment rate of 14.8 percent in April 2020[11] the highest recorded rate since 1940, and significantly higher than the unemployment rate of 4.4 percent in March 2020.[12,13] In aggregate, most of the jobs lost during the recession have returned. The official unemployment rate had dropped from the peak of 14.8 percent in April 2020 to 5.2 percent in August 2021, and the employment level had increased by 19.8 million. Thus by August 2021 employment levels were 5.6 million less than they were before the pandemic began.

To understand how insurance coverage estimates have been affected by the pandemic, without access to much survey data, researchers can draw upon on research that has estimated the link between changes in the economy and insurance coverage rates.[12] In particular, since the majority of people in the US obtain health insurance through employer sponsored health insurance (ESI), when the economy contracts and people lose jobs, usually some employees and their family members lose ESI insurance coverage.

Since the unemployment rate increased from 4.4 percent but then has returned to pre-pandemic levels by May 2022 the effects on insurance coverage may be – on net – minimal. It is also worth noting that during the pandemic Medicaid coverage rates were not affected because during the Public Health Emergency (PHE) states were encouraged not to drop anyone from their Medicaid rolls.

Thus, caution is warranted when attempting to extrapolate from knowledge of previous recorded post- WWII recessions to make conjectures about the impact of this one. It has been both the largest recession recorded since the Great Depression and the only one caused by a factor that might fundamentally alter people's attitudes toward workforce participation.

IMPACT OF PANDEMIC (CONTINUED)

Preliminary estimates from the National Health Interview Survey indicate that the un-insurance rate was 9.7 percent in 2020, lower but not statistically significantly lower than the rate of 10.3 percent in 2019. The same report did not report a breakdown of rural and urban uninsured rates. In the NHIS data, private coverage rates for dropped by a negligible, statistically insignificant amount, from 67.5 percent to 66.8 percent, and the percentage of persons with public coverage remained unchanged at roughly 20.4 percent.

Other analyses, using other surveys and methods, reached similar findings. Using the Health Monitoring Survey, Karpman and Zuckerman (2021) found that the uninsured rate held steady at 11 percent and did not rise during the pandemic, from March 2019 to April 2021.[14] In good part, this was because a rise in the number of people with public coverage (7.9 million) offset a decline of those with ESI (5.5 million). As noted, more analysis will need to be done, with additional survey data, to confirm these results and to explain them. While it may seem surprising that the uninsurance rates may not have risen more during the worst recession the U.S. has experienced since the Great Depression, some factors may explain this:

- The 2020 recession was the shortest (two months) ever officially recorded by the National Bureau of Economic Research, and in aggregate 78 percent of the jobs lost in Spring 2020 have returned. However, estimates indicate that millions still lost ESI coverage during the pandemic.[15]
- Some workers who left the labor market in spring 2020 were able to retain their health insurance, especially if they were furloughed and not laid off.[16]
- The 2020 recession had a much harsher impact on low-income workers (primarily those working in retail, travel and leisure), and the uninsurance rate among these workers was already higher before the recession began; thus, these workers and their families may not have lost insurance coverage.

IMPACT OF PANDEMIC

- HHS re-opened the Health Insurance Marketplaces (HIM), allowing those who needed the coverage to sign up for coverage through most of 2021. More than 2 million people signed up for coverage during this open enrollment period. In addition, Medicaid enrollment rose nationwide due to changes in regulation, requiring states not to drop individuals during the pandemic.[17] These two changes likely led to either stabilization of the public insurance coverage rates, or increases, that offset small drops in other private coverage.

The final story of the impact of the pandemic on insurance coverage – especially the breakdown between rural and urban persons – will not be told until disaggregated survey data are available. In the meantime, preliminary data suggests the impact may be relatively minimal in the short term.

REFERENCES

[1] Linda Li, Matthew Najarian, Abigail R. Barker, Timothy D. McBride, and Keith J. Mueller. 2021. "Sources of Insurance Coverage in Nonmetropolitan Areas: The Role of Public and Private Insurance Since 2009," Policy Brief 2021-5, March 2021: https://rupri.public-health.uiowa.edu/publications/policybriefs/2021/Sources percent20of percent20Insurance percent20Coverage.pdf

[2] Abigail Barker, Timothy McBride, Keith Mueller. 2019. "Can the Market Deliver Affordable Health Insurance Options in Rural Areas," Health Affairs, January 2019: 10.1377/hblog20190104.599904

[3] Median age: Average Median Age for Metro and Nonmetro Counties: https://www.ruralhealthinfo.org/charts/29; Poverty rates: USDA, Economic Research Service, "Poverty Over Time," https://www.ers.usda.gov/topics/rural- economy-population/rural-poverty-well-being/#historic; employer firm size: Federal Reserve, "2016 Small Business Credit Survey: Report on Rural Employer Firms," https://www.fedsmallbusiness.org/survey/2017/ report-on-rural-employer-firms

[4] Kaiser Family Foundation, "Status of State Action on Medicaid Expansion," https://www.kff.org/health-reform/state- indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

[5] Linda Li, Matthew Najaran, Abigail Barker, Timothy McBride, Keith Mueller. 2021. "Sources of Health Insurance Coverage in Nonmetropolitan Areas: The Role of Public and Private Insurance Since 2009," Rural Policy Research Institute (RUPRI) Rural Health Panel Policy Brief 2021-5, March 2021. https://rupri.public-health.uiowa.edu/ publications/policy briefs/2021/Sources percent20of percent20Insurance percent20Coverage.pdf

[6] USDA, Economic Research Service, 'What is Rural?": https://www.ers.usda.gov/topics/rural-economy-population/ rural-classifications/what-is-rural/

[7] Elizabeth A. Dobis, Thomas Krumel, John Cromartie, Kelsey L. Conley, Austin Sanders, and Ruben Ortiz, "**Rural America at a Glance: 2021 Edition,**" November 2021 https://www.ers.usda.gov/publications/pub-details/?pubid=102575

[8] J. Park et al., "High Out-of-pocket Health Care Cost Burden Among Medicare Beneficiaries With Diabetes, 1999-2017," Diabetes Care, https://pubmed.ncbi.nlm.nih.gov/34183427/

[9] Barker AR, Kemper LM, McBride TD, Mueller KJ. 2016. "Health Insurance Marketplaces: Premium Trends in Rural Areas." Rural Policy Brief, May 2016. https://rupri.public-health.uiowa.edu/publications/policybriefs/2016/HIMspercent20rural_percent20premium_percent20trends.pdf

REFERENCES (CONTINUED)

[10] Anderson D, Abraham JM, Drake C. Rural-urban differences in individual-market health plan affordability after subsidy payment cuts. Health Affairs. 2019 Dec 1;38(12):2032-40.

[11] Employment rates officially reported by the U.S. Bureau of Labor Statistics: https://data.bls.gov/cgi-bin/surveymost? ln

[12] Bureau of Labor Statistics. "Labor Force, Employment, and Unemployment, 1929-39: Estimating Methods." Monthly Labor Review.

[13] There is widespread agreement, though, that this estimate of the unemployment rate underestimated the number of people who were unemployed at the peak of the pandemic, since measures to estimate unemployment do not adequately measure individuals for are furloughed, who are discouraged workers who leave the labor force. See: "Ranks of Discouraged Workers and Others Marginally Attached to the Labor Force Rise During Recession, Issues in Labor Statistics, April 2009: https://www.bls.gov/opub/btn/ archive/ranks-of-discouraged-workers-and-others-marginally-attached-to-the-labor-force-rise-during- recession.pdf. By one measure the total unemployed plus all persons marginally attached to the labor force and discouraged workers rose from 7.0 percent in February 2020 to a peak of 22.9 percent in April 2020. For a recording of this historical measure of unemployment (U-6) see: St. Louis Federal Reserve, FRED, Total Unemployed, Plus All Persons Marginally Attached to the Labor Force, Plus Total Employed Part Time for Economic Reasons, as a percent of the Civilian Labor Force Plus All Persons Marginally Attached to the Labor Force (U-6), https://fred.stlouisfed.org/series/U6RATE

[14] M. Karpman and S. Zuckerman. 2021. "The Uninsurance Rate Held Steady During the Pandemic as Public Coverage Increased, Urban Institute, August 23, 2021: https://www.rwjf.org/en/library/research/2021/08/the-uninsurance-rate-held-steady-during-the-pandemic-as-public-coverage-increased.html

[15] M. Karpman and S. Zuckerman. 2021. "The Uninsurance Rate Held Steady During the Pandemic as Public Coverage Increased, Urban Institute, August 23, 2021: https://www.rwjf.org/en/library/research/2021/08/the-uninsurance-rate-held-steady-during-the-pandemic-as-public-coverage-increased.html; Economic Policy Institute, "Health insurance and the COVID-19 shock," policy brief, August 26, 2020. Found at: https:// www.epi.org/publication/health-insurance-and-the-covid-19-shock/

[16] Economic Policy Institute, "Health insurance and the COVID-19 shock," Policy Brief, August 26, 2020. Found at: https://www.epi.org/publication/health-insurance-and-the-covid-19-shock/

[17] CMS, "Health Care Sign Ups Surpass 2 Million During 2021 Special Enrollment Period Ahead of Aug. 15 Deadline," press release, July 14, 2021: https://www.cms.gov/newsroom/press-releases/health-care-sign- ups-surpass-2-million-during-2021-special-enrollment-period-ahead-aug-15-deadline