ASPE ISSUE BRIEF

Impact of the Affordable Care Act Coverage Expansion on Rural and Urban Populations

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Provisions of the Affordable Care Act (ACA) have increased health insurance coverage rates in the U.S; we estimate that 20.0 million non-elderly adults gained health insurance coverage through early 2016.[1] At 9.1 percent, the uninsured rate for Americans of all ages is the lowest it has been on record.[2] These gains have been experienced across demographic and geographic groups. This brief examines health insurance coverage gains, Marketplace coverage and premium tax credits, and access to health care, with a special focus on individuals living in rural areas.[3]

Key Highlights

- **Coverage:** Rural individuals, like those living in urban and suburban areas, have seen large coverage gains under the ACA – about an 8 percentage point increase from before the first open enrollment period through early 2015.
- **Premium tax credits:** Among the 88 percent of rural HealthCare.gov consumers with premium tax credits, the average net monthly premium increased by $5, or 4 percent, between 2015 and 2016.
- **Access to care:** Individuals in rural areas have seen improvements in access to care; the share who report being unable to afford needed care declined by nearly 6 percentage points from before the first open enrollment period through early 2015.

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[1] Uberoi, N., Finegold, K., & Gee, E. (3 March 2016). "Health Insurance Coverage and the Affordable Care Act." *Issue Brief.* Office of the Assistant Secretary for Planning and Evaluation. Retrieved from https://aspe.hhs.gov/sites/default/files/pdf/187551/ACA2010-2016.pdf.

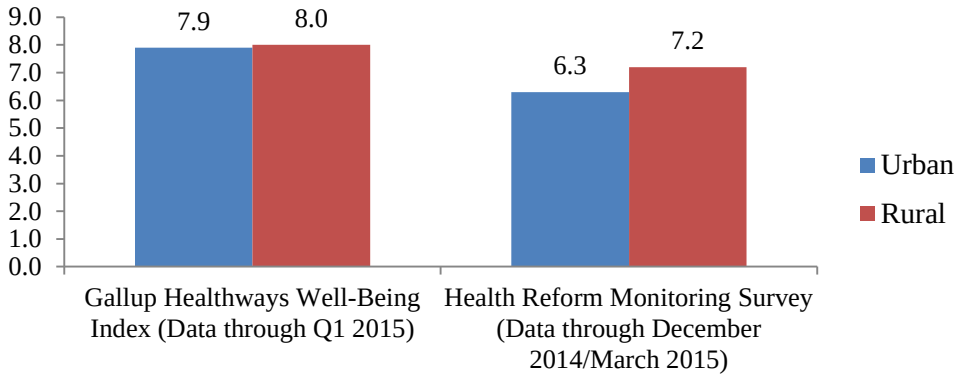
[2] Cohen, R.A., Martinez, M.E., & Zammitti, E.P. (17 May, 2016). "Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2015." National Center for Health Statistics. Retrieved from http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201605.pdf.

[3] Throughout this brief, "rural" refers to residence in a zip code classified as rural by the Federal Office of Rural Health Policy in the U.S. Department of Health and Human Services (Gallup Healthways Well-Being Index and Health Insurance Marketplace analyses) or residence in an area that is not part of a metropolitan statistical area (Health Reform Monitoring Survey and National Health Interview Survey analyses). "Urban" refers to residence in a zip code not classified as rural by the FORHP or residence in an area that is part of a metropolitan statistical area.

I. Change in Health Insurance Coverage

The Health Insurance Marketplace and Medicaid expansion provisions of the Affordable Care Act have contributed to large reductions in the uninsured rate in both rural and urban areas. According to an analysis of data from 2012 through the first quarter of 2015 from the Gallup Healthways Well-Being Index, coverage rates among non-elderly adult increased similarly in urban and rural areas, rising by 8.0 percentage points in rural areas and 7.9 percentage points in urban areas.[4] Similarly, an analysis of data from the Urban Institute's Health Reform Monitoring Survey (HRMS) found that rural individuals saw a 7.2 percentage point increase in coverage between mid-2013 and a period including late 2014 and early 2015 (a 33 percent decrease in the uninsured rate, from 21.6 percent in 2013 to 14.4 percent in 2015). This compares with a 6.3 percentage point increase in coverage for urban individuals (reducing the uninsured rate from 17.2 percent in 2013 to 10.9 percent in 2015) (See Figure 1).[5] Since early 2015, the national uninsured rate for non-elderly adults has continued to fall; both urban and rural individuals have shared in this additional progress.[6]

Figure 1. Survey Estimates of Percentage Point Increase in Coverage Rates for Non-Elderly Adults From Before the First Open Enrollment Period

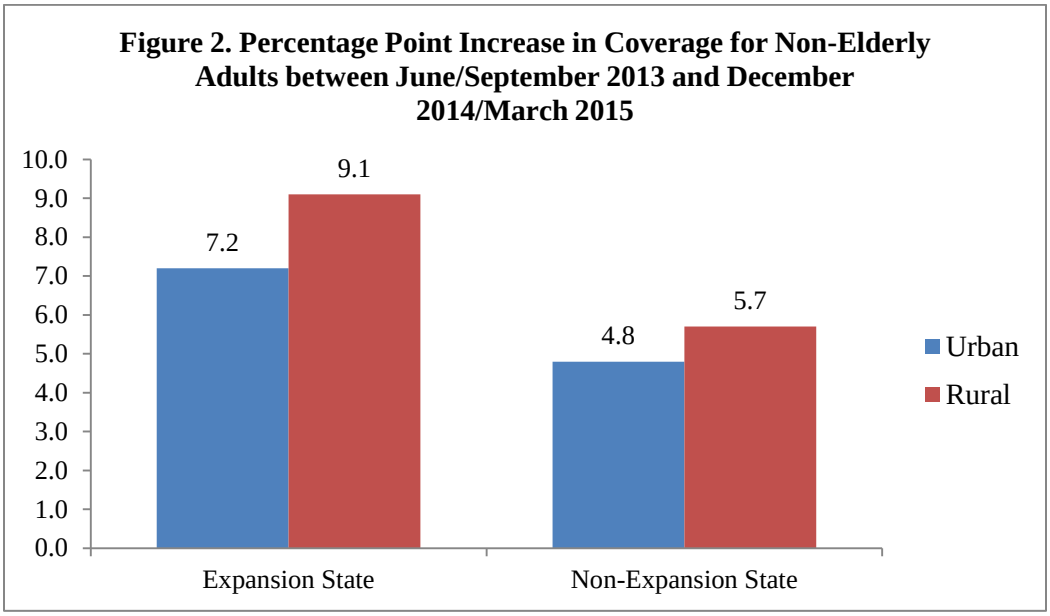


Sources: Sommers, B., Gunja, M., Finegold, K., & Musco, T. (28 July, 2015). "Changes in Self-reported Insurance Coverage, Access to Care, and Health Under the Affordable Care Act." Journal of the American Medicaid Association, 314(4): 366-374. Retrieved from http://jama.jamanetwork.com/article.aspx?articleid=2411283. Data are from 2012 through the first quarter of 2015. Models are adjusted for age, sex, race/ethnicity, marital status, employment, income, urban vs. rural residence, state-year specific unemployment rate, calendar month (to adjust for seasonality), and state of residence.
Karpman, M., Zuckerman, S., Kenney, G.M., & Odu, Y. (16 April, 2015). "Substantial Gains in Health Insurance Coverage Occurring for Adults in Both Rural and Urban Areas." Urban Institute. Retrieved from http://hrms.urban.org/quicktakes/Substantial-Gains-in-Health-Insurance-Coverage-Occurring-for-Adults-in-Both-Rural-and-Urban-Areas.html. Data are from June/September 2013 and December 2014/March 2015.

[4] Sommers, B., Gunja, M., Finegold, K., & Musco, T. (28 July, 2015). "Changes in Self-reported Insurance Coverage, Access to Care, and Health Under the Affordable Care Act." Journal of the American Medicaid Association, 314(4): 366-374. Retrieved from http://jama.jamanetwork.com/article.aspx?articleid=2411283.
[5] Karpman, M., Zuckerman, S., Kenney, G.M., & Odu, Y. (16 April, 2015). "Substantial Gains in Health Insurance Coverage Occurring for Adults in Both Rural and Urban Areas." Urban Institute. Retrieved from http://hrms.urban.org/quicktakes/Substantial-Gains-in-Health-Insurance-Coverage-Occurring-for-Adults-in-Both-Rural-and-Urban-Areas.html.
[6] ASPE analysis of Gallup Healthways Well-Being Index from 2012 to February 22, 2016.

Unsurprisingly, the HRMS, like many other surveys, shows that coverage gains were larger for individuals in states that took up the ACA Medicaid expansion. But within both expansion and non-expansion states, gains in coverage were modestly larger for rural than urban individuals (See Figure 2).[7]

Figure 2. Percentage Point Increase in Coverage for Non-Elderly Adults between June/September 2013 and December 2014/March 2015



Sources: Karpman, M., Zuckerman, S., Kenney, G.M., & Odu, Y. (16 April, 2015). "Substantial Gains in Health Insurance Coverage Occurring for Adults in Both Rural and Urban Areas." Urban Institute. Retrieved from http://hrms.urban.org/quicktakes/Substantial-Gains-in-Health-Insurance-Coverage-Occurring-for-Adults-in-Both-Rural-and-Urban-Areas.html.

The overall coverage gains for rural individuals are particularly striking in light of the fact that uninsured rural individuals are disproportionately concentrated in states that have not expanded Medicaid. ASPE analysis of 2015 data from the National Health Interview Survey (NHIS) found that 65 percent of the 4.5 million rural nonelderly uninsured lived in states that had not expanded Medicaid. In comparison, 51 percent of the nonelderly uninsured in urban areas lived in states that had not expanded Medicaid.[8] Medicaid expansion in additional states would thus be of particular benefit to rural Americans.

II. Marketplace Enrollment and Premium Tax Credits among Rural Individuals

Health Insurance Marketplace administrative data show that individuals in rural ZIP Codes comprise nearly 1 in 5 Marketplace plan selections. In the third open enrollment period for 2016

[7] Karpman, M., Zuckerman, S., Kenney, G.M., & Odu, Y. (16 April, 2015). "Substantial Gains in Health Insurance Coverage Occurring for Adults in Both Rural and Urban Areas." Urban Institute. Retrieved from http://hrms.urban.org/quicktakes/Substantial-Gains-in-Health-Insurance-Coverage-Occurring-for-Adults-in-Both-Rural-and-Urban-Areas.html.

[8] ASPE analysis of National Health Interview Survey (NHIS) Preliminary Quarterly Microdata Files for all 50 states and the District of Columbia, January-December 2015. For these estimates, states are classified as expanding or not expanding based on their status at the beginning of 2015. Alaska (expanded September 2015), Montana (expanded January 2016), and Louisiana (expanding July 2016) are thus counted as not expanding. See Appendix for analysis of the characteristics of the rural and urban uninsured.

coverage, 1.71 million consumers living in rural areas signed up for or had their coverage automatically renewed through the HealthCare.gov platform. This was an increase of 11 percent over 2015 for rural consumers, compared with 8 percent for other consumers (See Table 1).

Table 1. Selected Characteristics of Plan Selections through the Marketplaces in HealthCare.gov States

	2015 Total Plan Selections	2016 Total Plan Selections	Percent Growth from 2015 to 2016
Total Number of Individuals Who Have Selected a 2016 Plan Through the Marketplaces in the HealthCare.gov States	8.84 million	9.63 million	9%
Individuals in ZIP Codes designated as rural who have selected a Marketplace plan	1.54 million	1.71 million	11%
Individuals in ZIP Codes designated as urban who have selected a Marketplace plan	7.30 million	7.92 million	8%

Source: Office of the Assistant Secretary for Planning and Evaluation. (11 March, 2016). "Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report For the period: November 1, 2015 – February 1, 2016." *Issue Brief.* Retrieved from https://aspe.hhs.gov/sites/default/files/pdf/187866/Finalenrollment2016.pdf.

Of the 1.71 million rural individuals who selected a Marketplace plan in the third Open Enrollment Period, 88 percent were eligible for premium tax credits (See Table 2).

Table 2. Percentage of Urban and Rural Plan Selections with Tax Credits through the Marketplaces in HealthCare.gov States, 2016

2016	Total Plan Selections	Plan Selections With Tax Credits	Percent with Tax Credits
All	**9.63 million**	**8.15 million**	**85%**
Rural	1.71 million	1.51 million	88%
Urban	7.92 million	6.64 million	84%

Numbers may not sum due to rounding. Information is for enrollees in the 37 states that used the HealthCare.gov platform for 2015 and in the 38 states that used the HealthCare.gov platform for 2016. 2015 enrollees are those who selected plans during the second Open Enrollment Period. 2016 enrollees include those who had an active Marketplace plan selection as of 2/1/2016 but exclude those whose plans were terminated prior to that date.

The premium tax credit is based on the premium of the second-lowest cost silver plan (also known as the benchmark plan) available to an eligible consumer and the tax credit amount a consumer is eligible for adjusts if the benchmark plan's premium changes. Thus, if premiums for all plans in an area rise similarly, the increase is essentially fully offset for eligible consumers by a higher premium tax credit. As previous ASPE analysis has shown, because tax credits are designed to ensure that affordable options are available to consumers, the average out-of-pocket premium obligation consumers with tax credits paid rose just 4 percent, or $4 a month, between 2015 and 2016.[9] Rural and urban consumers alike benefit from the design of tax credits; the increase in average net monthly premium among rural individuals with tax credits was $5 a month between 2015 and 2016 (See Table 3).

[9] Office of the Assistant Secretary for Planning and Evaluation. (12 April, 2016). "Marketplace Premiums After Shopping, Switching, and Premium Tax Credits, 2015-2016." *Issue Brief*. Retrieved from https://aspe.hhs.gov/pdf-report/marketplace-premiums-after-shopping-switching-and-premium-tax-credits-2015-2016.

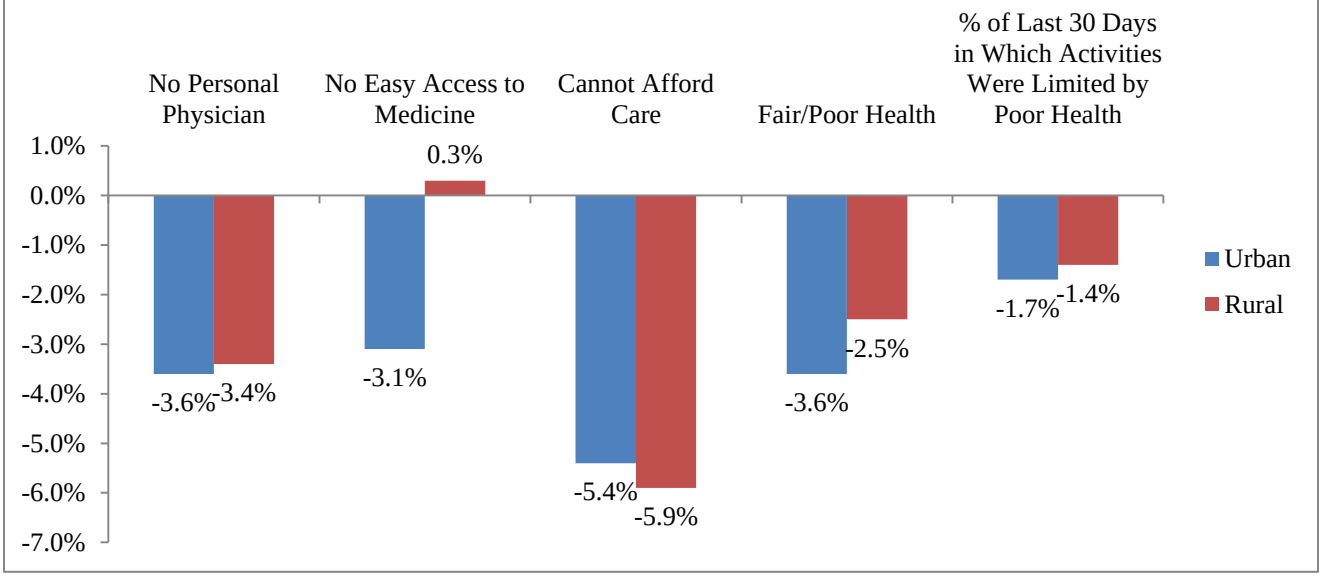
Table 3. Health Insurance Marketplace Monthly Premium Changes for 2015 – 2016 in HealthCare.gov States				
	2015 Average Monthly Premium	2016 Average Monthly Premium	Increase in Average Monthly Premium	
			Dollars	% Change
***Net* monthly premium among plan selections with premium tax credits**	**$102**	**$106**	**$4**	**4%**
in rural areas	$108	$113	$5	4%
in urban areas	$100	$105	$4	4%

Numbers may not sum due to rounding. Information is for enrollees in the 37 states that used the HealthCare.gov platform for 2015 and in the 38 states that used the HealthCare.gov platform for 2016. 2015 enrollees are those who selected plans during the second Open Enrollment Period. 2016 enrollees include those who had an active Marketplace plan selection as of 2/1/2016 but exclude those whose plans were terminated prior to that date.

III. Access to Care

Previous analyses of Gallup Healthways Well-Being Index data show improved access to care since the ACA's major coverage provisions took effect. Like the coverage gains discussed above, these gains have been seen by both urban and rural Americans. For example, among rural individuals, the share without access to a personal physician dropped 3.4 percentage points and the share unable to afford needed care dropped 5.9 percentage points (See Figure 4). ASPE analysis of NHIS data also indicates that rural and urban individuals have comparable access to care (See Appendix Table 1).

Figure 4. Percentage Point Change in Self-reported Access to Care and Health from 2012 Through Early 2015



Source: Sommers, B., Gunja, M., Finegold, K., & Musco, T. (28 July, 2015). "Changes in Self-reported Insurance Coverage, Access to Care, and Health Under the Affordable Care Act." Journal of the American Medicaid Association, 314(4): 366-374. Retrieved from http://jama.jamanetwork.com/article.aspx?articleid=2411283. Models are adjusted for age, sex, race/ethnicity, marital status, employment, income, urban vs. rural residence, state-year specific unemployment rate, calendar month (to adjust for seasonality), and state of residence.

IV. Conclusion

Provisions of the Affordable Care Act have helped improve health insurance coverage and access to care across rural and urban areas. Rural individuals comprise nearly 1 in 5 Marketplace plan selections and, due to the design of premium tax credits, the increase in average net monthly premium among rural individuals with tax credits was $5 a month between 2015 and 2016. Despite being disproportionately likely to live in states that have not expanded Medicaid, rural individuals have seen similar coverage gains under the ACA as other individuals, because they have been major beneficiaries from access to the Health Insurance Marketplace, from the ACA's other coverage reforms, and from Medicaid expansion in states that chose to expand. Rural individuals would be expected to benefit disproportionately if the remaining 19 states chose to take up the ACA's Medicaid expansion.

Acknowledgements

ASPE appreciates the assistance of the Centers for Disease Control and Prevention National Center for Health Statistics Research Data Center in facilitating our access to and analysis of the restricted NHIS Preliminary Quarterly Microdata Files. The findings and conclusions in this brief are those of the authors and do not necessarily represent the views of the Research Data Center, the National Center for Health Statistics, or the Centers for Disease Control and Prevention.

Appendix: Characteristics of the Rural and Urban Uninsured

Uninsured rural individuals share some similarities with their uninsured urban counterparts. Urban and rural areas have similar distributions of nonelderly uninsured individuals across income, age and gender, with uninsured individuals in rural areas somewhat more likely to be age 55 to 64 and somewhat less likely to be age 18 to 25. Uninsured individuals living in rural areas are much less likely to be Hispanic and much more likely to be White than those living in urban areas. While uninsured rural individuals are somewhat less likely to report being in excellent health than urban individuals, more uninsured rural individuals report having access to a usual source of care than uninsured urban individuals, and uninsured rural and urban individuals report similar rates of delaying or forgoing care due to cost.

Appendix Table 1. Characteristics of Rural and Urban Nonelderly (0-64) Uninsured, National Health Interview Survey, 2015

	Rural	Urban
Income		
<100% FPL	23.5%	24.8%
100-138% FPL	15.5%	14.3%
139-250%FPL	33.5%	32.2%
250-399% FPL	17.0%	17.5%
>400% FPL	10.5%	11.2%
Total	100.0%	100.0%
Age		
0-17	14.0%	11.2%
18-25	14.6%	18.9%
26-34	22.9%	24.1%
35-54	34.6%	35.6%
55-64	13.9%	10.3%
Total	100.0%	100.0%
Gender		
Male	54.9%	56.3%
Female	45.1%	43.7%
Total	100.0%	100.0%
Race/Ethnicity		
Hispanic/Latino (all races)	20.6%	41.5%
White (non-Latino)	60.7%	38.2%
Black (non-Latino)	12.6%	13.6%
Asian (non-Latino)	0.5%	4.2%
Other (non-Latino)*	5.6%	2.6%
Total	100.0%	100.0%

Health Status		
Excellent	28.6%	32.0%
Very Good	29.9%	28.9%
Good	27.9%	29.3%
Fair/Poor	13.7%	9.9%
Total	100.0%	100.0%
Usual Source of Care		
Has Usual Source of Care	56.6%	47.4%
No Usual Source of Care	43.4%	52.6%
Total	100.0%	100.0%
Delayed or Did Not Receive Care Due to Cost (Last 12 Months)		
Yes	26.5%	27.2%
No	73.5%	72.8%
Total	100.0%	100.0%
Education (18-64 only)		
Less than High School	26.5%	28.2%
High School/GED	39.7%	33.0%
Post-High School	33.8%	38.9%
Total	100.0%	100.0%
Employment Status (18-64 only)		
Employed	63.4%	68.7%
Unemployed	10.8%	11.1%
Not in Workforce	25.8%	20.2%
Total	100.0%	100.0%
Marital Status (18-64 only)		
Married	44.3%	39.0%
Not Married	55.7%	61.0%
Total	100.0%	100.0%

Source: ASPE analysis of National Health Interview Survey (NHIS) Preliminary Quarterly Microdata Files for all 50 states and the District of Columbia, January-December 2015.
*Estimates for non-Hispanic personas of races other than white only, black only, and Asian only (such as American Indian or Alaskan Native, or Native Hawaiian or Pacific Islander), or of multiple races, are combined to the "Other" category.