Rural Health, Universality, and Legislative Targeting

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Health disparities are persistent and worsening for rural communities, which have smaller patient populations with higher rates of uninsurance and greater incidence of the diseases and deaths of despair. Hospital closures and provider shortages are more common in rural than in urban areas, also contributing to worsening population health and crises in maternal and infant health. This paper posits that these disparities are tied to the unique rural features of space and population. Efforts to address persistent problems in health care through universal legislation, such as the ACA, have given rural communities important tools to address some long-standing health problems by improving insurance coverage, which facilitates better access to health for patients and more consistent payment for health-care providers. But some rural states have rejected the ACA's effort at universality while seeking targeted legislation to fill the gaps left by that choice. Drawing on Skocpol's work studying effective social programs, the paper suggests that state resistance to the ACA's universality impedes efforts to address health disparities and that targeted legislation can only minimally improve rural health disparities without universal baselines.

INTRODUCTION

Universality is a principle that indicates inclusion and equitability and is embodied by the Patient Protection and Affordable Care Act's (ACA) goal of covering everyone with some form of health insurance, regardless of income or health status.[1] The theory underlying the ACA's statutory goal of

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[1] Nicole Huberfeld, *The Universality of Medicaid at Fifty*, 15 YALE J. HEALTH POL'Y, L. & ETHICS 67 (2015) (describing the theory of universality underlying the ACA and noting the important exception of undocumented immigrants); *see also* Nicole Huberfeld & Jessica L. Roberts, *Medicaid Expansion as Completion of the Great Society*, 2014 U. ILL. L. REV. SLIP OPINIONS 1 (exploring how the universality of the ACA raises access to health care to the level of a civil right); Nicole Huberfeld & Jessica L. Roberts, *An Empirical Perspective on Medicaid as Social Insurance*, 46 U. TOL. L. REV. 545 (2015) (examining universality as an aspect of social justice).

universality is that health care is a civil right and the path toward achieving health for the population as a whole is inclusion and solidarity.[2] In the United States, insurance coverage is a gateway to more consistent access to health care, and the ACA's focus on it is rational policy making, but it is only one part of the health picture. Without adequate or consistent access to health-care providers and services, health insurance can be a gateway to nowhere. These are ongoing concerns for rural populations, especially in counties with small or no metropolitan centers.[3]

A sample of recent media reports illustrates the scope of rural health issues: Rural areas experience increasingly severe health-care provider "deserts."[4] Rural hospitals are struggling financially, leading to closures of key departments and entire hospitals.[5] Senators from rural states issued letters to the Secretary of the Department of Health and Human Services (HHS) spotlighting the health-care plight of rural communities.[6] Opioid addiction was proclaimed a national public health emergency, a nationwide crisis that is part of the cluster of rural health challenges.[7] Several articles

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[2] *See, e.g.*, Elizabeth Weeks Leonard, *State Constitutionalism and the Right to Health Care*, 12 U. PA. J. CONST. L. 1325 (2010) (discussing the concept that in international dialogue what is called "human rights" tends to be called "civil rights" in the United States; a civil right to health care is not protected by the U.S. Constitution).

[3] Peiyin Hung et al., *Access to Obstetric Services in Rural Counties Still Declining, With 9 Percent Losing Services, 2004-14*, 36 HEALTH AFFAIRS 1663 (2017) (noting that more than half of all rural counties have no hospital obstetrical services, and obstetrics units were more likely to close in poorer counties designated "noncore").

[4] *See, e.g.*, Leoneda Inge, *When A Rural NC Health Clinic Closes, Patients and Doctors Feel The Squeeze*, WUNC (Dec. 11, 2017), http://wunc.org/post/when-rural-nc-health-clinic-closes-patients-and-doctors-feel-squeeze#stream/0 [http://perma.cc/5LDP-YVYU] (describing a "primary care desert," with "half" a primary care physician for every ten thousand residents in Warren County, NC); Dan Margolies, *2 Kansas Hospitals Join Experiment Aimed At Bolstering Rural Health Care*, KCUR (Nov. 22, 2017), http://kcur.org/post/2-kansas-hospitals-join-experiment-aimed-bolstering-rural-health-care#stream/0 [http://perma.cc/X2G3-BMMU] ("Rural hospitals face tough financial challenges, especially in states like Kansas that have not expanded Medicaid. More than 80 rural hospitals have closed since 2010, including Mercy Hospital in Independence, Kansas, which shuttered in 2015. Nearly 700 more—or about a third of rural hospitals nationwide—are at risk of closure, according to a 2016 study sponsored by the National Rural Health Association.").

[5] Susannah Luthi, *Rural hospitals feel the squeeze as Medicare extender funding in flux*, MOD. HEALTHCARE (Dec. 13, 2017), http://www.modernhealthcare.com/article20171213/NEWS/171219960 [http://perma.cc/3ZHR-ZT2Y].

[6] Letter from Claire McCaskill, Sen. to Tom Price, Sec'y, HHS (Apr. 6, 2017), https://www.hsgac.senate.gov/download/mccaskill-letter-to-sec-price-re-rural-healthcare [http://perma.cc/NN7Q-6KVN]. Another letter from a group of rural state senators encouraged Secretary Price to simultaneously support rural health-care needs and keep the federal government's regulations to a minimum. Letter from Roger F. Wicker, Sen. to Tom Price, Sec'y, HHS (Feb. 14, 2017), https://www.wicker.senate.gov/public/_cache/files/7766fd22-801a-49a8-9e0d-cdca8799dbe6/senate-letter-to-sec.-price-on-rural-health-care.pdf [http://perma.cc/STL2-NRTN].

[7] Julie Hirschfeld Davis, *Trump Declares Opioid Crisis a 'Health Emergency' but Requests No Funds*, N.Y. TIMES (Oct. 26, 2017, 4:30 PM), https://www.nytimes.com/2017/10/26/us/politics/trump-opioid-crisis.html?hp&action=click&pgtype=homepage&clickSource=story-heading&module=first-column-region&region=top-news&WT.nav=top-news&_r=0 [http://perma.cc/NXX5-3A47]; Haeyoun Park & Matthew Bloch, *How the Epidemic of Drug Overdose Deaths Rippled Across America*, N.Y. TIMES (Jan. 19, 2016), https://www.nytimes.com/interactive/2016/01/07/us/drug-overdose-deaths-in-the-us.html?hp&action=click&pg

have spotlighted rural pregnant women and newborns,[8] with one summarizing:

> Financial pressures, insurance problems, and doctor shortages forced more than 200 hospitals to close maternity wards between 2004 and 2014. . . . In Texas fewer than half of 162 rural hospitals still deliver babies. More than two-thirds of rural counties in Florida, Nevada, and South Dakota have no obstetric services. Sixteen percent of Minnesota's rural counties lost maternity services in the past decade and one out of every three Wisconsin counties lacks an OB-GYN.[9]

Samantha Bee even highlighted the increasingly dire problem of maternal mortality, especially rural maternal mortality, in a seven-minute monologue on her late-night television program.[10]

Agencies tasked with studying rural health offer additional data highlighting the urban/rural divide. The Federal Office of Rural Health Policy (FORHP), a division of the Department of Health and Human Services (HHS) that assesses the impact of federal policy on rural populations, has a clearinghouse of data indicating disparities in rural health as compared to urban health, such as: lower rates of insurance coverage; limited access to

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type=homepage&clickSource=story-heading&module=first-column-region&region=top-news&WT.nav=top-news [http://perma.cc/48XE-6MJW]; Rural Am. In These Times, *Rural Drug Stats Say One Thing, Trump Says Another*, IN THESE TIMES (Oct. 26, 2017), http://inthesetimes.com/rural-america/entry/20637/opioid-crisis-donald-trump-rural-drug-overdoses-cdc-public-health-emergency [http://perma.cc/855C-J8HF]; Lisa R. Pruitt, *On Trump's declaration of a public health emergency over opioids—and rural angles on same*, LEGAL RURALISM BLOG (Oct. 26, 2017), http://legalruralism.blogspot.com/2017/10/on-turmps-declaration-of-public-health.html [http://perma.cc/T5JW-FJMQ] (exploring reporting on the President's declaration of a national public health emergency and possible disparities between rural and urban populations).

[8] *See, e.g.*, Taylor Blatchford, *Lack of maternal health care puts pregnant women at risk in rural Missouri*, MISSOURIAN (Dec. 20, 2017), https://www.columbiamissourian.com/news/state_news/lack-of-maternal-health-care-puts-pregnant-women-at-risk/article_d2866e12-e1c9-11e7-8b8c-93b934e103c5.html [https://perma.cc/FFR6-92VY] (reporting the decreasing access to maternity care, medical complications and deaths resulting, and rural physician training initiated by the University of Missouri School of Medicine to bend the downward curve of access to care); Katha Pollit, *The Story Behind the Maternal Mortality Rate in Texas Is Even Sadder Than We Realize*, NATION (Sept. 8, 2016), https://www.thenation.com/article/the-story-behind-the-maternal-mortality-rate-in-texas-is-even-sadder-than-we-realize/ [https://perma.cc/8259-T6ZT]; Ali Galante & Maggie Fox, *New Program Aims to Keep OB/GYNs in Rural America*, NBC NEWS (Aug. 19, 2017, 8:27 PM), https://www.nbcnews.com/health/health-news/new-program-aims-keep-ob-gyns-rural-america-n793991 [https://perma.cc/923D-4WFM]; Betsy McKay & Paul Overberg, *Rural America's Childbirth Crisis: The Fight to Save Whitney Brown*, WALL ST. J. (Aug. 11, 2017, 10:42 AM), https://www.wsj.com/articles/rural-americas-childbirth-crisis-the-fight-to-save-whitney-brown-1502462523 [https://perma.cc/WB8X-Z7G2].

[9] Galante & Fox, *supra* note 8.

[10] Samantha Bee, *No Country For Pregnant Women* (TBS television broadcast, Jan.10, 2018), https://www.youtube.com/watch?v=CA6A3ZlGlH8&feature=youtu.be&list=plur87nTwD0BtZA2ulNtIBIIybrNfnzPXv [https://perma.cc/V993-KEVT] (highlighting the problem of maternal mortality in the United States and especially the significantly higher maternal mortality rate in rural states).

primary care physicians, hospitals, and other health-care providers due to provider shortages and longer travel distances; higher rates of heart disease, diabetes, and other chronic diseases; and more poverty.[11] The National Rural Health Association (NRHA) offers similar information, noting that the "patient-to-primary care physician ratio in rural areas is only 39.8 physicians per 100,000 people, compared to 53.3 physicians per 100,000 in urban areas;"[12] that rural patients experience "transportation difficulties . . . , often traveling great distances to reach a doctor or hospital;"[13] and that rural areas have more "uninsured residents [and] higher rates of unemployment, leading to less access to care."[14]

In sum, no shortage of examples exists to spotlight the health disparities that are worsening for rural communities. As compared to urban areas, rural communities have smaller patient populations and more uninsured patients, which decreases payments to health-care providers, which leads to hospital closures and physician shortages, which leads to worsening care for rural communities. This paper first describes the loop of rural health challenges and how it is tied to the unique and fixed rural features of space and population. After exploring rural health disparities, the paper next describes policymakers' efforts to address persistent problems in U.S. health care through universal legislation such as the ACA. The paper then considers whether, in light of rural states' rejection of broader efforts at health reform, their efforts at targeted legislation can improve the health of rural populations. As used in this paper, the phrase "targeted legislation" refers to laws that offer relief for a particular issue or address the plight of a subpopulation, which may result from factors such as purposefully narrow policymaking or political compromise, but which avoid universal principles or tactics.[15] Drawing on a classic theory of successful social policies addressing poverty through "targeting within universalism," the paper concludes that some targeting may be helpful and even necessary to address rural health disparities but that

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[11] *See Rural Health Resources Guide*, FED. OFF. RURAL HEALTH POL'Y, U.S. DEP'T HEALTH & HUM. SERVS. (Nov. 2015), https://www.hrsa.gov/rural-health/resources/index.html [https://perma.cc/UB67-ULQ3]; *see also About Rural Health Care*, NAT'L RURAL HEALTH ASS'N, https://www.ruralhealthweb.org/about-nrha/about-rural-health-care [https://perma.cc/53AJ-M9DA] (last visited Nov. 18, 2018).

[12] NAT'L RURAL HEALTH ASS'N, *supra* note 11 (using urban physician/patient ratios to illustrate rural differences and deficits).

[13] *Id.*

[14] *Id.*

[15] "Targeted legislation" or "special legislation" can describe legislation that benefits an individual's particular interests, such as a law that effectively determines the outcome of a case in favor of one individual, which may violate separation of powers. *See, e.g.*, Evan C. Zoldan, *Is the Federal Judiciary Independent of Congress?*, 70 STAN. L. REV. ONLINE 135, 143–45 (2018), https://review.law.stanford.edu/wp-content/uploads/sites/3/2018/02/70-Stan.-L.-Rev.-Online-135-Zoldan.pdf [https://perma.cc/FUA9-TANH] ("American constitutional law reflects a long tradition of favoring legislative generality and disfavoring targeted legislation."). That is not the intended meaning here. Rather, I focus on legislation that addresses a narrow issue or issues to the exclusion of a more uniform or universal solution.

targeted efforts will be ineffective unless a universal baseline first exists.[16] The problems in rural health persist because of both population and space, which means they are cross-cutting, affect more than just the poor, and necessitate policy responses that are both targeted and comprehensive.

I. Rural Health: Space, Population, and Health

A. The Meaning of "Rural"

To understand the layers of issues contributing to disparities in rural health, it helps to define "rural." While rural has no single definition, it has certain fixed features that must be factored into addressing rural health disparities: geography, meaning topographic features as well as the sometimes vast space between people, homes, and businesses; and population, meaning the characteristics of individuals residing in such spaces.

"Rural" is defined differently by federal agencies, complicating efforts to pinpoint both the disparities experienced by—and how to address the needs of—rural communities. For example, the Census Bureau and the Office of Management and Budget (OMB) offer two angles on the meaning of "rural." The Census Bureau classifies geographic spaces as: "Urbanized Areas (UAs) of 50,000 or more people; Urban Clusters (UCs) of at least 2,500 and less than 50,000 people. 'Rural' encompasses all population, housing, and territory not included within an urban area."[17] The Census Bureau does not specifically define "rural" but acknowledges its existence as the inverse of "urban." The Census Bureau estimates that "about 21% of the US population in 2000 was considered rural but more than 95% of the land area was classified as rural. In the 2010 Census, 59.5 million people, 19.3% of the population, was rural while more than 95% of the land area is still classified as rural."[18] This definition may lead to over-inclusiveness in counting rural counties because reliance on "urban" means that some suburban areas could be categorized as rural. But, suburban areas tend to be more densely populated and better resourced than rural areas, which could lead to misunderstanding of rural needs. These numbers also reflect a decline in rural population between the two Census studies.

The OMB classifies counties for statistical purposes with more nuanced designations that account for economically connected areas surrounding ur-

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[16] *See* Theda Skocpol, *Targeting within Universalism: Politically Viable Policies to Combat Poverty in the United States*, *in* The Urban Underclass 411 (Christopher Jencks & Paul E. Peterson eds., 1991); John V. Jacobi, *Multiple Medicaid Missions: Targeting, Universalism, or Both?*, 15 Yale J. Health Pol'y, L. & Ethics 89, 89, 100–101 (2015) (arguing for serving the very poor and very vulnerable within Medicaid because their needs otherwise go unaddressed).

[17] *Urban and Rural*, U.S. Census Bureau (Dec. 8, 2016), https://www.census.gov/geo/reference/urban-rural.html [http://perma.cc/TE4B-YTZW].

[18] *Defining Rural Population*, Fed. Off. Rural Health Pol'y, U.S. Dep't Health & Hum. Servs. (Jan. 2017), https://www.hrsa.gov/rural-health/about-us/definition/index.html [http://perma.cc/K94U-5WTW].

ban cores.[19] A Metropolitan county has a core urban population of 50,000 or more, and a Micropolitan county has an urban core with at least 10,000 but less than 50,000 individuals. Rural counties are those that are not part of a Metropolitan Statistical Area (MSA), and Micropolitan counties are counted as "rural" by OMB. Using these definitions, OMB concludes that "about 17% of the population in 2000 was considered Non-Metro while 74% of the land area was contained in Non-Metro counties. After the 2010 Census, the Non-Metro counties contained 46.2 million people, about 15% of the total population, and covered 72% of the land area of the country."[20] In contrast to the Census Bureau, the OMB definition may lead to undercounting rural counties, but the issues are similar—misunderstanding rural disparities and sourcing proposed solutions appropriately. But, like the Census Bureau, OMB also counted a declining rural population.

Professor Lisa Pruitt adds nuance to the meaning of "rural," noting that legal "definitions of 'rural' illustrate not only the concept's malleability and multi-dimensionality, but also its elusiveness and circularity. . . . '[R]ural' refers not only to one type of place, but rather to a range of places that share some characteristics."[21] Pruitt's scholarship uses the word rural "primarily to signify sparsely populated places. . . . [and] the conglomeration of characteristics generally associated with rural areas. Rural people labor under various structural disadvantages that stem generally from poor economic and educational opportunities, but also arise from specific deficits in transportation, child care, and housing, among others."[22] Pruitt emphasizes that no single definition of "rural" exists in case law or legislation.[23]

Taking Professor Pruitt's qualitative definition and accounting for federal agencies' quantified definitions, it becomes apparent that population and geography are distinct, intertwined, and essential components of rurality.[24]

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[19] *Metropolitan and Micropolitan*, U.S. CENSUS BUREAU, https://www.census.gov/programs-surveys/metro-micro/about.html [http://perma.cc/V3LJ-LFDM] (OMB link is broken under Trump Administration).

[20] *Defining Rural Population*, *supra* note 18.

[21] Lisa R. Pruitt, *Rural Rhetoric*, 39 CONN. L. REV. 159, 177–179 (2006) (canvassing the meaning of "rural" in legal opinions and the judicial ignorance behind use of the term). Pruitt continues: "Whatever criteria are used to define rural, it clearly does not have a single, simple definition in law." *Id.* at 184.

[22] Lisa R. Pruitt, *Toward a Feminist Theory of the Rural*, UTAH L. REV. 421, 424 (2007) (decrying legal indifference to "rural realities" and detailing longstanding sociological, economic, cultural, and political problems for rural women).

[23] Lisa R. Pruitt, *Gender, Geography, & Rural Justice*, 23 BERKELEY J. GENDER, L. & JUST. 338, 345–48 (2008).

[24] The Federal Office of Rural Health Policy uses a hybrid of the two described approaches:

> The FORHP accepts all non-Metro counties as rural and uses an additional method of determining rurality called the Rural-Urban Commuting Area (RUCA) codes. Like the MSAs, these are based on Census data that is used to assign a code to each Census Tract. Tracts inside Metropolitan counties with the codes 4-10 are considered rural. While use of the RUCA codes has allowed identification of rural census tracts in Metropolitan counties, among the more than 70,000 tracts in the U.S. there are some that are extremely large. In these larger tracts, use of RUCA codes alone fails to account for distance to services and sparse population. In response to these

The lack of consensus reflects not so much conflict but rather imprecision and variability, which in turn may contribute to ineffective policymaking. Yet, at the point of overlap, sparseness of population—and population decline—as well as geographic distance are crucial features of rural communities. While each is a fixed feature, rural populations are declining and space is increasing, exacerbating existing rural health challenges. These challenges are explored in the next Section.[25]

B. Overview of Disparities in Rural Health

Underscoring the role of declining population and vast space in rural health, researchers have demonstrated that a gap between urban and rural health has been growing over the last few decades.[26] The story of increasing rural health disparities can be viewed through health and economic features of the patient population, which are intertwined with dynamics of provider instability.

As the Census Bureau and OMB measures discussed above indicated, the rural population has been decreasing in proportion to the rest of the U.S. population, a trend that began in the 1970s, from nearly 25% to around 15% of the population.[27] This decline has an impact on the rural patient profile,[28] as the population that remains is older, lower income,[29] less edu-

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> concerns, FORHP has designated 132 large area census tracts with RUCA codes 2 or 3 as rural. These tracts are at least 400 square miles in area with a population density of no more than 35 people. Following the 2010 Census the FORHP definition included approximately 57 million people, about 18% of the population and 84% of the area of the USA.

Defining Rural Population, *supra* note 18.

[25] This idea relates to the "tyranny of distance" originally explored as a facet of Australia's unique culture in GEOFFREY BLAINEY, THE TYRANNY OF DISTANCE: HOW DISTANCE SHAPED AUSTRALIA'S HISTORY (1975) (coining the phrase and describing the role of Australia's distance from England in the power wielded by the colony's governor and in the history of the nation as a whole). Here, the idea is useful to indicate the space that may be at the root of intractable problems for rural Americans. *See, e.g.*, Pruitt, *Rural Rhetoric*, *supra* note 21, at 177–179; Pruitt, *Toward a Feminist Theory*, *supra* note 22, at 424.

[26] *See, e.g.*, Gopal K. Singh & Mohammad Siahpush, *Widening Rural–Urban Disparities in Life Expectancy, U.S., 1969–2009*, 46 AM. J. PREVENTIVE MED. e19 (2014) ("Between 1969 and 2009, residents in metropolitan areas experienced larger gains in life expectancy than those in nonmetropolitan areas, contributing to the widening gap."); Di Zeng et al., *A closer look at the rural-urban health disparities: Insights from four major diseases in the Commonwealth of Virginia*, 140 SOCIAL SCI. & MED. 62 (2015); Katy B. Kozhimannil et al., Letter to the Editor, *Reducing maternal health disparities: the rural context*, 216 AM. J. OBSTETRICS & GYNECOLOGY 193 (2017) ("[A]ccess to maternity care is declining rapidly in rural areas, where women must travel farther and farther each time a hospital or obstetric unit closes.").

[27] NAT'L CTR. FOR HEALTH STATISTICS, U.S. DEP'T OF HEALTH & HUMAN SERVS., HEALTH, UNITED STATES, 2016: WITH CHARTBOOK ON LONG-TERM TRENDS IN HEALTH, 15, 43 (2017) [hereinafter CHARTBOOK ON LONG-TERM TRENDS], https://www.cdc.gov/nchs/data/hus/hus16.pdf [https://perma.cc/2PGP-MCN3]; *see also infra* Section I.A.

[28] *Id.*

[29] VANN R NEWKIRK II & ANTHONY DAMICO, KAISER FAMILY FOUND., THE AFFORDABLE CARE ACT AND INSURANCE COVERAGE IN RURAL AREAS (May 2014), https://kaiserfamilyfoundation.files.wordpress.com/2014/05/8597-the-affordable-care-act-and-insur-

cated,[30] and less healthy than urban populations,[31] with measurably greater rates of both disease and injury.[32] For example, the Centers for Disease Control (CDC) issued a 2017 report indicating that people living in rural areas are more likely to die of the leading causes of death—heart disease, cancer, accidental injury, chronic lower respiratory disease, and stroke—than urban dwellers: "In 2014, approximately 62% of all 1,622,304 deaths in the United States were related to the five leading causes of death. During 2014, the number of potentially excess deaths from the five leading causes in rural areas was higher than those in urban areas."[33] The CDC further noted that: "rural counties . . . have a higher uninsured rate; experience health-care workforce shortages . . . ; often lack subspecialty care . . . , critical care units, or emergency facilities; have limited transportation options; and experience longer time to services caused by distance."[34]

Similarly, research shows that rural populations suffer in greater numbers from the "deaths of despair,"[35] and the diseases and deaths of despair (suicide, chronic substance use, overdose) are both more prevalent and more deadly for rural populations.[36] Appalachia, which accounts for nearly half of the nation's rural population, has experienced measurably greater increases in

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ance-coverage-in-rural-areas1.pdf [https://perma.cc/YE79-G9EY] ("One-quarter of the nonelderly rural population has family income below the federal poverty level . . . compared to about one-fifth of the nonelderly population in metropolitan areas. Conversely, a greater share of the nonelderly population in metropolitan areas is in families with incomes over 400% FPL than rural families.").

[30] Sarah Brown & Karin Fischer, *A Dying Town*, CHRON. HIGHER EDUC. (Dec. 29, 2017), at https://www.chronicle.com/interactives/public-health [https://perma.cc/M693-WBK3].

[31] *Id.*

[32] Relatedly, Case and Deaton have suggested that "cumulative disadvantage" contributes to the widening gaps in health for white non-Hispanic males, who now have higher mortality rates than many other populations. Anne Case & Angus Deaton, *Mortality & Morbidity in the 21st Century*, BROOKINGS PAPERS ON ECON. ACTIVITY, Spring 2017 at 397, 429–439.

[33] Macarena C. Garcia et al., Ctrs. for Disease Control & Prevention, *Reducing Potentially Excess Deaths from the Five Leading Causes of Death in the Rural United States*, MORBIDITY & MORTALITY WKLY. REP.: SURVEILLANCE SUMMARIES, Jan. 13, 2017, at 1, 2, https://www.cdc.gov/mmwr/volumes/66/ss/pdfs/ss6602.pdf [https://perma.cc/WGJ7-QZU3].

[34] *Id.* at 3.

[35] *See* Anne Case & Angus Deaton, *Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century,* 112 PROC. NAT'L ACAD. SCI. 15078, 15081 (2015) (identifying so-called deaths of despair by documenting a trend of increasing mortality for middle-aged white Americans and linking it to an "epidemic of pain, suicide, and drug overdoses"); Case & Deaton, *Mortality & Morbidity*, *supra* note 32, at 398 (exploring "deaths of despair" and amending the 2015 work by adding complexity to the idea); *see also, e.g.*, MICHAEL MEIT ET AL., APPALACHIAN REG'L COMM'N, APPALACHIAN DISEASES OF DESPAIR (Aug. 2017), https://www.arc.gov/assets/research_reports/AppalachianDiseasesofDespairAugust2017.pdf [https://perma.cc/V79Y-Y732]. Diseases of despair refers to the same three major sources of the "deaths of despair": "alcohol, prescription drug and illegal drug overdose; suicide; and alcoholic liver disease/cirrhosis of the liver." *Id.* at 1.

[36] *See, e.g.*, Elizabeth M. Stein et al., *The Epidemic of Despair Among White Americans: Trends in the Leading Causes of Premature Death, 1999–2015*, 107 AM. J. PUB. HEALTH 1541, 1545 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5607670/pdf/AJPH.2017.303941.pdf [https://perma.cc/L6YJ-XXGM].

mortality from diseases of despair.[37] Rural populations are "less likely to recognize [mental] illness. . . . Rural youth are twice as likely to commit suicide."[38] More than "50[%] of vehicle crash-related fatalities happen in rural areas, even though less than one-third of miles traveled in a vehicle occur there."[39] Unintentional injuries are 50% more likely to result in death than the same injuries in urban settings.[40]

Rural residents also experience health-care finance differences, such as lower rates of employer sponsored health insurance coverage and higher rates of uninsurance and Medicaid enrollment than urban counterparts.[41] Rural individuals experience lower rates of employment and hold lower-income jobs, which are less likely to offer health insurance as an employment benefit.[42] Private health insurance covers 64% of nonelderly urbanites but 61% of nonelderly rural residents.[43] Rural individuals gained insurance coverage under the ACA,[44] which facilitated coverage for those who could not obtain employer sponsored health insurance.[45] But the states with the greatest rural spaces and populations have also resisted expanding Medicaid eligibility under the ACA (discussed further in Section II),[46] contributing to continued

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[37] *See* MEIT ET. AL, *supra* note 35; *see also* JULIE L. MARSHALL ET AL., ROBERT WOOD JOHNSON FOUND., CREATING A CULTURE OF HEALTH IN APPALACHIA: DISPARITIES AND BRIGHT SPOTS (Aug. 2017), https://www.arc.gov/assets/research_reports/Health_Disparities_in_Appalachia_August_2017.pdf [https://perma.cc/7Q5H-ECLB]. The Appalachian Region is defined by federal law as

> a 205,000-square-mile region that follows the spine of the Appalachian Mountains from southern New York to northern Mississippi. It includes all of West Virginia and parts of 12 other states: Alabama, Georgia, Kentucky, Maryland, Mississippi, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, and Virginia. 42% of the Region's population is rural, compared with 20% of the national population. . . . The Region includes 420 counties in 13 states . . . . and is home to more than 25 million people.

The Appalachian Region, APPALACHIAN REG'L COMM'N, https://www.arc.gov/appalachian_region/TheAppalachianRegion.asp [https://perma.cc/5ZST-TGYR].

[38] NAT'L RURAL HEALTH ASS'N, *supra* note 11.

[39] *Id.*

[40] Kay Miller Temple, *Rural Unintentional Injuries: They're Not Accidents—They're Preventable*, RURAL MONITOR (Nov. 29, 2017), https://www.ruralhealthinfo.org/rural-monitor/unintentional-injuries/ [https://perma.cc/6N5K-UBZA].

[41] JULIA FOUTZ ET AL., KAISER FAMILY FOUND., THE ROLE OF MEDICAID IN RURAL AMERICA 4 (Apr. 2017), http://files.kff.org/attachment/Issue-Brief-The-Role-of-Medicaid-in-Rural-America [https://perma.cc/BYW6-YTAN].

[42] *Id.*

[43] *Id.*

[44] *Changes in Insurance Coverage in Rural Areas under the ACA: A Focus on Medicaid Expansion States*, KAISER FAMILY FOUND. (May 4, 2017), https://www.kff.org/medicaid/fact-sheet/changes-in-insurance-coverage-in-rural-areas-under-the-aca-a-focus-on-medicaid-expansion-states/ [https://perma.cc/LD6T-YBAL].

[45] *See* Abbe R. Gluck & Nicole Huberfeld, *What Is Federalism in Health Care For?*, 70 STAN. L. REV. 1689 (2018) (discussing the history of the ACA and the societal need for its two major federalism-oriented initiatives, Medicaid expansion and health insurance exchanges).

[46] *See* Lauren Weber & Andy Miller, *A Hospital Crisis Is Killing Rural Communities. This State Is 'Ground Zero.'*, HUFFINGTON POST (Sept. 27, 2017, 5:01 AM), https://www.huffing

higher rates of uninsurance in rural areas, declining access to care,[47] and increasing disparities in health in rural areas.[48]

Rural hospitals have been experiencing significant financial distress, which complicates their ability to serve these poorer and sicker communities. Rural hospitals comprise half of the total number of hospitals in the nation yet serve around 15% of the population, so they tend to be smaller and have lower profit margins than urban and suburban hospitals.[49] A recent study reports rural hospitals are more likely to close in states that have not expanded Medicaid eligibility under the ACA,[50] and rural hospitals have been closing crucial departments[51] or closing entirely.[52] Indeed, more than eighty rural hospitals have closed in the last six years,[53] and the closures are concentrated in Southern rural states, most of which have not expanded Medicaid eligibility.[54] These hospitals anchor rural communities, which experience fur-

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tonpost.com/entry/rural-hospitals-closure-georgia_us_59c02bf4e4b087fdf5075e38 [https://perma.cc/8MHC-XRY6] (embedding a map that shows the substantial overlap).

[47] *See generally* INST. OF MED., AMERICA'S UNINSURED CRISIS: CONSEQUENCES FOR HEALTH AND HEALTH CARE (2009) [hereinafter IOM]. The authors were concerned that the IOM's reports on declining insurance coverage and the impact lack of insurance coverage has on population and individual health were going unheeded by policy makers. They wrote in a forceful introduction to the report:

> Here, we report new, rigorous, and persuasive evidence that the lack of health insurance is injurious to health. This core finding applies to individuals of all ages. Gaining access to coverage improves health outcomes especially for those with chronic disease. Some evidence suggests that living in a community with large numbers of the uninsured may impair the quality of health care even for those individuals who have insurance.

Id. at ix.

[48] *See* FOUTZ ET AL., *supra* note 41, at 5.

[49] *See Rural Hospital Programs*, FED. OFF. RURAL HEALTH POL'Y, U.S. DEP'T HEALTH & HUM. SERVS. (Oct. 2018), https://www.hrsa.gov/rural-health/rural-hospitals/index.html [https://perma.cc/EZH8-J9FC]; *see also* CECIL G. SHEPS CTR. FOR HEALTH SERVS. RESEARCH, U.N.C., PROFITABILITY OF RURAL AND URBAN HOSPITALS INFOGRAPHIC (Aug. 2016), http://www.shepscenter.unc.edu/programs-projects/rural-health/infographics/ [https://perma.cc/697F-6A35].

[50] Richard C. Lindrooth et al., *Understanding the Relationship Between Medicaid Expansions and Hospital Closures*, 37 HEALTH AFFAIRS 111, 111 (2018).

[51] PEIYIN HUNG ET AL., UNIV. MINN. RURAL HEALTH RESEARCH CTR., CLOSURE OF HOSPITAL OBSTETRIC SERVICES DISPROPORTIONATELY AFFECTS LESS-POPULATED RURAL COUNTIES (Apr. 2017), http://rhrc.umn.edu/wp-content/files_mf/1491501904UMRHRCOBclosuresPolicyBrief.pdf [https://perma.cc/K6UL-XTSR].

[52] *See, e.g.*, JANE WISHNER ET AL., KAISER FAMILY FOUND., A LOOK AT RURAL HOSPITAL CLOSURES AND IMPLICATIONS FOR ACCESS TO CARE: THREE CASE STUDIES (July 2016), http://files.kff.org/attachment/issue-brief-a-look-at-rural-hospital-closures-and-implications-for-access-to-care [https://perma.cc/JS54-V7AE].

[53] *See 90 Rural Hospital Closures: January 2010 – Present*, N.C. RURAL HEALTH RES. PROGRAM, http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/ [https://perma.cc/CY7A-T2XT] (last visited Nov. 20, 2018).

[54] HEALTH RES. & SERVS. ADMIN., HOSPITAL CLOSINGS LIKELY TO INCREASE (Oct. 2017), https://www.hrsa.gov/enews/past-issues/2017/october-19/hospitals-closing-increase.html [https://perma.cc/L72R-6WX8] (HRSA reports that "[m]ore than 120 rural hospitals have gone out of business since 2005, and the trend has been accelerating since 2010 . . . . 'The hotspot for closures and financial distress continues to be the South – particularly Florida, Alabama, Tennessee, Arkansas and Virginia . . . as well as Texas.' . . . 'A lot of states in the Midwest have no hospitals that are rural and at high risk of financial distress.'").

ther economic and population drain and community decline when a community hospital closes.[55] This phenomenon became apparent decades ago when so many small community hospitals were closing that a special Medicare reimbursement designation called "Critical Access Hospital" was created, with special rules and higher payment rates, to slow the rate of hospital closures.[56]

As populations have declined and hospitals have suffered, doctors, nurses, and other health-care providers have drifted away from rural practice toward suburban and urban practices.[57] When physicians are lured to practice in rural areas through special payments, loan forgiveness, and other incentives, they may choose not to linger, further restricting access to health-care providers, and particularly specialists, who may not be able to find sufficient density of patients to sustain their practices.[58]

In sum, rural patients are sicker and poorer than urban patients on the whole (though of course variation exists from state to state and from county to county within each state). Rural patients are faced with diminishing access to health-care providers, longer travel times as rural hospitals close, and provider shortages in many settings—if they can pay for care at all.

C. Women's Health as a Bellwether of Rural Health

Women's health represents the arc of life in the health-care setting, as reproduction ties women to children's and adults' health through birth, childhood, reproductive years, and elder health. As such, women's health is indicative of the larger challenges for health care in rural America. Distant geography and sparse population feed "maternity deserts," meaning that rural women of reproductive age have trouble in accessing prenatal care, dangerously long drives for childbirth, and a lack of continuing care after childbirth that leads to health complications and maternal mortality.[59] Unsurprisingly,

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[55] *See generally* George M. Holmes et al., *The Effect of Rural Hospital Closures on Community Economic Health*, 41 HEALTH SERVS. RES. 467 (Apr. 2006) (noting that "the closure of a hospital can have detrimental effects on a rural community"). This study found that "hospital closures have a negative direct effect on the economic health of the county only if the hospital is the only hospital in the community . . . ." *Id.* at 477. "The results presented here suggest that the closure of a rural county's sole hospital decreases the economic well-being of the community and likely places the local economy in a downward cycle that may be very difficult to recover from." *Id.* at 481. *See also Economic Contribution of Hospitals*, AM. HOSP. ASS'N, https://www.aha.org/2017-11-17-economic-contribution-hospitals [https://perma.cc/GES2-826L] (last visited Nov. 20, 2018) (hospital trade group maintaining information regarding the economically positive role hospitals play in communities).

[56] *See* Holmes et al., *supra* note 55, at 468.

[57] CHARTBOOK ON LONG-TERM TRENDS, *supra* note 27, at 26.

[58] *See id.*; *see also* Roger A. Rosenblatt & L. Gary Hart, *Physicians and rural America*, 173 WESTERN J. MED. 348 (2000), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1071163/pdf/wjm17300348.pdf [https://perma.cc/V3SP-RJB2] (exploring the trends in physician distribution toward urban and suburban areas and noting the different choices made by primary care and specialist physicians); Matthew R. McGrail et al., *Mobility of US Rural Primary Care Physicians During 2000–2014*, 15 ANNALS FAM. MED. 322 (2017).

[59] *See supra* notes 9–11 and accompanying text.

racial and ethnic minority women experience even greater challenges, facing the same kinds of barriers to care that exist in urban areas but with the added difficulties of living in rural areas.[60] Given that childbirth is the most common reason patients enter hospitals,[61] the trend in maternal and child harm[62] raises a red flag for the health of all rural populations.[63]

In addition, rural women are more likely to be uninsured than their urban counterparts, and they rely in greater proportions on Medicaid.[64] Medicaid covers prenatal care for women who become pregnant, but in states that have not expanded Medicaid eligibility under the ACA (discussed in Section II), women comprise nearly half of the nonelderly uninsured, and women who are uninsured are less likely to have regular access to preventive and other medical care; consequently, they are less healthy when they conceive, which jeopardizes both maternal and child health.[65] Even when women are covered by Medicaid, payment for abortions is limited by the Hyde Amendment,[66] and the ACA extended the Hyde Amendment by including limitations on abortion coverage for the private insurance purchased through health insurance exchanges.[67] States passed laws preventing coverage of abortion in private insurance after the ACA, and the majority of those states are rural.[68]

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[60] Julia T. Caldwell et al., *Intersection of Living in a Rural Versus Urban Area and Race/Ethnicity in Explaining Access to Health Care in the United States*, 106 AM. J. PUB. HEALTH 1463 (2016).

[61] *See HCUP Fast Stats—Most Common Diagnoses for Inpatient Stays, 2015*, AGENCY FOR HEALTHCARE RES. & QUALITY (Nov. 2017), https://www.hcup-us.ahrq.gov/faststats/NationalDiagnosesServlet [https://perma.cc/W6RM-F6GG].

[62] Nina Martin & Renee Montagne, *U.S. Has The Worst Rate Of Maternal Deaths In The Developed World*, NAT'L PUB. RADIO (May 12, 2017, 10:28 AM), https://www.npr.org/2017/05/12/528098789/u-s-has-the-worst-rate-of-maternal-deaths-in-the-developed-world [https://perma.cc/FA7V-QT47] (reporting that the US has the highest maternal death rate in the developed world and the rate is rising).

[63] Studies link maternal health to lifelong wellness. For a basic identification of the correlation between health risks, maternal health, and child health, *see, e.g.*, *Maternal, Infant, and Child Health*, OFF. DISEASE PREVENTION & HEALTH PROMOTION, https://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health [https://perma.cc/TDN5-V69N] (describing the role of conditions such as diabetes, hypertension, and depression in maternal health) (last visited Mar. 26, 2018).

[64] FOUTZ ET AL., *supra* note 41.

[65] *See* RACHEL GARFIELD & ANTHONY DAMICO, Kaiser Family Found., The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid 3 (Oct. 2017), http://files.kff.org/attachment/Issue-Brief-The-Coverage-Gap-Uninsured-Poor-Adults-in-States-that-Do-Not-Expand-Medicaid [https://perma.cc/69KG-B6DF]. Half of all pregnancies in the United States are unplanned, and even before the ACA, more than two-thirds of unplanned pregnancies were covered by Medicaid. *See* ADAM SONFIELD & KATHRYN KOST, GUTTMACHER INST., PUBLIC COSTS FROM UNINTENDED PREGNANCIES AND THE ROLE OF PUBLIC INSURANCE PROGRAMS IN PAYING FOR PREGNANCY-RELATED CARE: NATIONAL AND STATE ESTIMATES FOR 2010 (Feb. 2015), https://www.guttmacher.org/sites/default/files/report_pdf/public-costs-of-up-2010.pdf [https://perma.cc/LGV3-CBPN].

[66] Pub. L. No. 95-205, § 101, 91 Stat. 1460 (1977). The Hyde Amendment is a rider on Department of Health and Human Services funding that is renewed annually in appropriations bills.

[67] 42 U.S.C.A. § 18023 (2016).

[68] *See Interactive: How State Policies Shape Access to Abortion Coverage*, KAISER FAMILY FOUND. (Sept. 21, 2018), https://www.kff.org/interactive/abortion-coverage/ [https://

In other words, rural women's insurance coverage is more limited because of the policy choices of the states in which they live, in addition to the challenges of geography and population that feed the growth of maternity deserts. A recent economic study showed that state legislative choices that lead to the closure of reproductive services clinics demonstrably diminish access to care for such services, especially for women living in "remote" areas.[69] Rural women—like other rural residents—have fewer insurance options,[70] which itself can limit access to care.[71] When hospitals close their obstetrics units or close altogether, that care is further limited.[72]

These challenges exist for all facets of rural women's reproductive health, for pregnancy and childbirth as well as for abortion. The Supreme Court recognized the predicament of rural space in *Whole Women's Health v. Hellerstedt*,[73] in which Texas enacted targeted regulation of abortion provider laws ("TRAP laws") designed to close reproductive care clinics providing abortions.[74] The Court decided that the state's TRAP laws exacerbated the vast distances women in Texas had to travel for care and constituted an undue burden on women seeking an abortion.[75] The majority's opinion was a

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perma.cc/3LT9-29GX] (showing how state laws limiting insurance coverage for abortion changed after the ACA was passed).

[69] Yao Lu & J.G. Slusky, *Women's Health Clinic Closures & Preventive Care*, 8 AM. ECON. J. 100, 120–21 (2016) ("Compared to these policies that seek to increase health insurance coverage or access to affordable health care, our estimates suggest a relatively large impact of geographic access on preventive care utilization, especially among women of lower educational attainment who live in remote areas and experience a large increase in distance to the nearest clinic. Even among less-educated women who experience an increase in distance of only 10 miles, their annual utilization of clinical breast exams falls by 1.78 percentage points, which is similar in magnitude to the increase that Wherry finds from Medicaid family planning expansions.").

[70] *See*, *e.g.*, Caitlin Brandt & Alice M. Rivlin, *Insurer competition in rural areas: A bipartisan challenge*, BROOKINGS (Aug. 9, 2017), https://www.brookings.edu/blog/up-front/2017/08/09/insurer-competition-in-rural-areas-a-bipartisan-challenge/ [https://perma.cc/RFP2-3W8V] (reporting that most counties with one insurer are rural, a problem linked to few patients and lack of health-care providers in rural areas); *see also supra*, notes 41–47 and accompanying text.

[71] *See* IOM, *supra* note 47, chapter 3 (detailing how lack of insurance detrimentally affects access to care and health).

[72] *See* Jilian Mincer, *More hospital closings in rural America add risk for pregnant women*, REUTERS (July 18, 2017), https://www.reuters.com/article/us-usa-healthcare-rural/more-hospital-closings-in-rural-america-add-risk-for-pregnant-women-idUSKBN1A30C5 [https://perma.cc/SHB7-7LPA] (describing the limitations in reproductive care documented to occur with hospital and obstetrics department closures).

[73] 136 S. Ct. 2292 (2016).

[74] *Id.* at 2312–13, 2316 (finding that the admitting privileges requirement led to "the closure of half of Texas' clinics, or thereabouts" and that the surgical center requirements would close all but seven or eight clinics in major cities); *see also, e.g.*, Christy Hoppe, *Lt. Gov. Dewhurst says in tweet that abortion bill all about shutting down accessibility*, DALLAS NEWS (June 2013), https://www.dallasnews.com/news/politics/2013/06/19/lt-gov-dewhurst-says-in-tweet-that-abortion-bill-all-about-shutting-down-accessibility (reporting Lieutenant Governor Dewhurst's tweet showing a map of Texas with the clinics that would close under the state's then newly passed laws); David Dewhurst, TWITTER, 7:41 AM, June 19, 2013, https://twitter.com/davidhdewhurst/status/347363442497302528?lang=EN [https://perma.cc/7YA8-8A26].

[75] *Hellerstedt*, 136 S. Ct. at 2318 ("We agree with the District Court that the surgical-center requirement, like the admitting-privileges requirement, provides few, if any, health ben-

notable acknowledgement that law and geography can, in combination, operate to the detriment of women's health.[76]

In sum, a circle of issues faces rural populations because they are "sicker, . . . less likely to have private health insurance, and . . . suffer from a shortage of health-care providers."[77] Where geography produces low and diffuse populations, patients are fewer and sicker; they holder fewer jobs that pay lower wages and are less likely to offer employment benefits such as health insurance coverage; patients rely more heavily on Medicaid; and health-care providers are fewer and farther between.[78] Further, fewer patients draw fewer new health-care providers, which leads to fewer health-care resources for both the patient and the provider; all of the features in this cycle contribute to a spiral of diminishing health-care access for rural populations.[79] Rural patients may be rendered even more powerless than their urban counterparts in health-care decisions that affect their communities,[80] as it is harder to effect change that is not purely local and more difficult to affect the broader economic and social calculus that draws health-care providers to a community and keeps them operating in a financial balance.[81]

Yet state politicians sometimes resist health-care reform efforts that would address problems related to geography and population for political reasons as well as economic reasons. Whether targeted legislation can overcome the spatial, sociological, and political barriers that rural health has experienced for decades is addressed in the next Section.

II. Universal versus Targeted Laws

Rural health and its ongoing disparities tend to be folded into broader legislative efforts. Rural populations are lower income, sicker, and older, and so they are likely to be enrolled in federal spending programs such as Medi-

efits for women, poses a substantial obstacle to women seeking abortions, and constitutes an 'undue burden' on their constitutional right to do so.").

[76] *See* Michele Statz & Lisa R. Pruitt, *To Recognize the Tyranny of Distance: A Spatial Reading of* Whole Woman's Health v. Hellerstedt, Env't & Plan. A (2018).

[77] Sidney D. Watson, *Mending the Fabric of Small Town America: Health Reform & Rural Economies*, 113 W. Va. L. Rev. 1, 5 (2010) (conveying how health services researchers think about the problem of rural health).

[78] *See id.* at 5–10.

[79] *See supra* note 73.

[80] Patients are disadvantaged in the health-care setting, as evidenced by the common law treatment of health-care providers as fiduciaries. *See* Dayna Bowen Matthew, *Implementing American Health Care Reform: The Fiduciary Imperative*, 59 Buffalo L. Rev. 715, 726-32 (2011) (discussing the history and nature of fiduciary responsibilities in health care). Dr. Elisabeth Rosenthal advocates for patients to take some power back in her book dissecting the high cost of American health care. *See generally* Elisabeth Rosenthal, An American Sickness (2017).

[81] *But see* Tim Marema, *While Lower In Health Rankings, Rural Counties Still Have Advantages*, The Daily Yonder (Nov. 15, 2017), http://www.dailyyonder.com/rural-counties-score-lower-health-rankings-still-public-health-advantages/2017/11/15/22296/ [https://perma.cc/8TW3-EZGM] (rural areas continue to struggle in health but community connections can facilitate local change).

care (social insurance for the elderly and permanently disabled), Medicaid (public health insurance for the poor), and the Children's Health Insurance Program (CHIP) (public health insurance for children in families earning too much income for Medicaid).[82] The ACA built on these programs, as well as existing private insurance markets, to create universal insurance coverage, but some states with significant rural populations have resisted implementing the ACA while seeking targeted laws to fill gaps left by refusing to implement health reform.[83] This Section examines the current health reform landscape to assess whether targeted legislative policymaking that rejects universal norms holds any potential to address disparities in rural health.

A. The ACA's Universality and Rural Health Disparities

Though the ACA is long and complex, its dominant feature is universality, which applies principles of equitability and inclusion to those seeking to obtain access to health care through the gateway of health insurance coverage, regardless of geography, age, employment, wellness, or other characteristics.[84] This reform was meant to be the proverbial rising tide that lifts all boats, responding to studies demonstrating that the multi-year trend of ever-increasing uninsurance—which had reached a record high when the ACA was enacted—was detrimental to health,[85] that medical debt was the leading cause of personal bankruptcy in the United States,[86] and that insurance coverage not only improves access to care and improves well-being but also decreases financial strain.[87] Many rural individuals fall into insurance coverage gaps that the ACA was designed to fill.[88]

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[82] 42 U.S.C. § 1395 (2012) (Medicare); 42 U.S.C. § 1396 (2012) (Medicaid); 42 U.S.C. § 1397a (2012) (Children's Health Insurance Program).

[83] *See* FOUTZ ET AL., *supra* note 41, at 5 (describing the role of the ACA in rural states that have resisted implementing provisions of the ACA).

[84] *But see* 42 U.S.C. § 300gg(a) (2012) (allowing private insurers to consider age as a factor, but prohibiting them from charging more than a 3:1 difference).

[85] *See* IOM, *supra* note 47, at 1 (summarizing findings that lack of insurance harms health); *see also* Phil Galewitz and Andrew Villegas, *Number of Uninsured Americans Hits Record High*, NBC NEWS (Sept. 16, 2010), http://www.nbcnews.com/id/39215770/ns/health-health_care/t/number-uninsured-americans-hits-record-high/#.Wv7hiUgvybg (reporting new Census Bureau data indicating that the number and percentage of uninsured Americans reached an "all time high" in 2009 as health-care reform was being debated).

[86] *See* David U. Himmelstein, et al., *Illness and Injury as Contributors to Bankruptcy*, 24 HEALTH AFFAIRS W5-63 (Feb. 8, 2005), https://perma.cc/K8HQ-KF6R (showing medical debt as a driver of filing for personal bankruptcy).

[87] THE OREGON HEALTH INSURANCE EXPERIMENT: RESULTS, http://www.nber.org/oregon/3.results.html [https://perma.cc/ZKA7-8VFU] (last visited Nov. 20, 2018) (relaying a set of studies rooted in Oregon's lottery to expand Medicaid eligibility before the ACA, researchers found that "[c]overage significantly lowered medical debt, and virtually eliminated the likelihood of having a catastrophic medical expenditure").

[88] The ACA regulates private insurance markets to make small group and individual insurance broadly available through health insurance exchanges ("exchanges"), tax credits for purchasing insurance on exchanges, uniformity in insurance benefits, and restrictions on cherry picking by insurers. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 1201, 1311, 1401, 124 Stat 119. These private market reforms have decreased uninsurance

Part of the reason many of the poor were uninsured before the ACA was that Medicaid provided a limited safety net, and it varied in eligibility and benefits based on state choices within federal law. [89] The federalism design of the Medicaid Act allows states to, for example, cover more beneficiaries at higher levels than federal law requires, resulting in different rules regarding eligibility and other features of the Medicaid program across states.[90] This variability has aided—yet also amplified—disparities for rural populations. For example, Medicaid covers more than 40% of all births nationwide and more than 60% of births in some states that are largely rural (Arkansas, Louisiana, Maine, Mississippi and Oklahoma).[91] By federal Medicaid law, pregnant women earning up to 133% of the federal poverty level (FPL) are eligible for Medicaid coverage from the start of pregnancy through approximately sixty days postpartum.[92] While the median eligibility level for pregnant women across the country is 200% of the FPL, state choices result in extensive variation,[93] so that a pregnant woman in Kentucky who earns up to 200% of the FPL is eligible, but in neighboring West Virginia she is eligible up to 163% of the FPL.[94] Such variability sometimes increases the number of rural uninsured because rural states tend to be poorer states, and poorer states tend not to provide generous social welfare benefits.[95]

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in rural areas, though they were not targeted specifically to rural disparities in coverage. Watson, *supra* note 77, at 18–30. At the end of 2017, Congress enacted a tax law that undermined the reforms by repealing the ACA's so-called individual mandate. Pub. L. No. 115-97, § 11081 (Dec. 22, 2017), 131 Stat 2054. That repeal may lead healthy people to resist purchasing health insurance coverage, which would subtract healthier individuals from risk pools, making health insurance costlier because fewer people who are inexpensive to cover will seek insurance coverage. CONG. BUDGET OFFICE, REPEALING THE INDIVIDUAL HEALTH INSURANCE MANDATE: AN UPDATED ESTIMATE (Nov. 2017), https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf[https://perma.cc/72EL-YXRR]. This is important for rural populations because their risk pools tend to have fewer healthy participants to begin with. *See* Section I.B.

[89] *See* Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 444–49 (2011).

[90] State Plans for Medical Assistance, 42 U.S.C. § 1396a (2018).

[91] KAISER FAMILY FOUND., Medicaid's Role for Women (June 22, 2017), https://www.kff.org/womens-health-policy/fact-sheet/medicaids-role-for-women/ [https://perma.cc/DF53-HXT9].

[92] 42 U.S.C. §§ 1396a(a)(10)(A)(iii), 1396d(n) (2012); 42 C.F.R. 435.116; 42 C.F.R. 440.210.

[93] KAISER FAMILY FOUND., MEDICAID AND CHIP INCOME ELIGIBILITY LIMITS FOR PREGNANT WOMEN AS A PERCENT OF THE FEDERAL POVERTY LEVEL (Jan. 1, 2018), https://www.kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-pregnant-women-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D#note-1 [https://perma.cc/34LX-7U6A].

[94] *Id.*

[95] In part this reflects American bias against welfare programs. *See* David G. Smith & Judith D. Moore, Medicaid Politics and Policy 31 (2008). In part it is due to racial bias, *see id.* at 10 (opposition to national health insurance was rooted partly in racism and the "Southern question," as Southern states worried the federal government would use health programs to desegregate).

The ACA was designed to level some of this variability by expanding Medicaid eligibility to all non-elderly adults earning up to 138% of the FPL.[96] This population historically was excluded from Medicaid but also was increasingly unable to obtain private health insurance through employment because part-time and low-wage jobs have been decreasingly providing health insurance as an employment benefit.[97] Further, the employers dropping such benefits were the kinds of jobs rural communities were more likely to hold, such as agriculture, manufacturing, and mining.[98]

As drafted, the ACA supported Medicaid expansion through provisions designed to increase both insurance coverage and access to care for the newly insured population. For example, the ACA included increased Medicaid payments for primary care physicians before the implementation date of January 1, 2014 so that more doctors would see newly insured patients.[99] The ACA also improved enrollment processes so that people could enroll in the right kind of insurance regardless of their starting point applying for coverage.[100] The ACA promoted maternal and child health by, for example, covering previously-excluded childless adult women who had no consistent source of care before Medicaid expansion, which facilitates better health before and after a woman becomes pregnant.[101] Interestingly, the ACA uses the word "rural" 124 times, addressing issues related to rural health such as special help for enrollment in Medicaid and special state options to provide coordinated care through health homes for rural Medicaid enrollees with

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[96] Patient Protection and Affordable Care Act of 2010 § 2001(a)(1), 42 U.S.C. § 1396a (2016)); the Health Care and Education Reconciliation Act was companion amending legislation that created a 5% income disregard, raising eligibility for the new category to 138% of FPL. HCERA, Pub. L. No. 111-152, § 1004(e)(2), 124 Stat. 1029, 1036 (codified at 42 U.S.C. § 1396a(e)(14)(I) (2016)).

[97] Huberfeld & Roberts, *supra* note 1, at 549–50. Studies show that employer-sponsored health insurance has been decreasing for decades. *See, e.g.*, Deborah Chollet, *Employer-Based Health Insurance In A Changing Work Force*, 13 HEALTH AFFAIRS 315 (1994), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.13.1.315 [https://perma.cc/97UH-YBTH] ("[A]t least since 1985 economic expansion has failed to produce growth of employer-sponsored health insurance among workers and their dependents. Between 1985 and 1991 the number of jobs that provided health insurance declined by nearly 2%; 1.2 million fewer workers were covered by their own employer in 1991 than had been covered six years earlier. Since 1988 the loss of employer-insured jobs has accelerated.").

[98] *See* Chollet, *supra* note 97, at 317, 320–21 ("[I]n both manufacturing and mining—industry groups that historically have had among the highest rates of employer-insured workers—the rate of loss of employer-insured jobs has exceeded the rate of decline in total employment.").

[99] *See* Pub. L. No. 111–152 §1202 (the HCERA is considered companion legislation to the ACA).

[100] *See* Pub. L. No. 111–148 § 10202.

[101] *See, e.g.*, Lisa Rosenbaum, *Understanding the Planned Parenthood Divide—Albert Lasker and Women's Health*, 377 NEW ENG. J. MED. 2409, 2409–2411 (2017) ("The Affordable Care Act . . . allowed nearly 9 million women to gain access to maternal and newborn care . . . ."). Access to preventive care with no copayments is especially important for lower income patients and management of chronic diseases. This includes Medicaid, which covers comprehensive care, and Essential Health Benefits that are required of private insurance sold through exchanges.

chronic conditions.[102] These features of the ACA demonstrate a broad, or universal, approach to legislating while targeting specific disparities, which was meant to insure most Americans and facilitate greater access to needed medical care.

Nationwide, health disparities would be improved by the changes the ACA was intended to generate, including not only universal health insurance coverage but also better access to care, higher quality care, and improved payment systems for providers.[103] But the ACA's implementation was altered by the Supreme Court's decision in *NFIB v. Sebelius*,[104] which endorsed states' challenge to the constitutionality of Medicaid expansion and effectively allowed states to opt out of it.[105] *NFIB* thwarted the legislative effort to create a national baseline of universal coverage by empowering states to resist Medicaid expansion and later to negotiate their own version of expansion.[106] As of this writing, fourteen states remain opted out, though they may reconsider expanding now that efforts to repeal the law appear to have stalled[107] and new kinds of expansion negotiations are being encouraged by HHS.[108]

After several years of ACA implementation, studies show that Medicaid expansion offers a variety of health and health-related benefits, such as marked increases in insurance coverage, improvements in the health of new enrollees, preventing delay of needed medical care, decreasing uncompensated care costs for health-care providers, and a noticeably positive impact on rural health in particular.[109] Research published early in 2018 found that

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[102] *See* Pub. L. No. 148–111, § 2201 (enrollment simplification and coordination with state health insurance exchanges) & § 2703 ("health home" providers treat people with chronic conditions through integration and coordination of primary, acute, behavioral health, and long-term services and supports with the goal of treating the whole person).

[103] *See, e.g.*, *King v. Burwell*, 135 S. Ct. 2480, 2492–94 (2015) (interpreting central intent of the ACA); Molly Frean, Jonathan Gruber & Benjamin D. Sommers, *Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act*, 53 J. HEALTH ECON. 72, 73 (2017) (summarizing intent of ACA).

[104] 567 U.S. 519 (2012).

[105] *Id.* at 583–88.

[106] Gluck & Huberfeld, *supra* note 45, at 1729–31 (exploring *NFIB*'s disruption of the federalism scheme of the ACA as written and how *NFIB* impacted the implementation of Medicaid expansion and health insurance exchanges).

[107] For an exploration of the waves of Medicaid expansion and ACA implementation, *see* Gluck & Huberfeld, *supra* note 45. CMS has expressed newfound flexibility in granting states' requests for Medicaid variations, which may also inspire more expansion. *See* Thomas E. Price & Seema Verma, U.S. Dep't of Health & Human Servs., Letter to Governors on Medicaid (Mar. 14, 2017), https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf [https://perma.cc/B7ZD-VLW7] ("Today, we commit to ushering in a new era for the federal and state Medicaid partnership where states have more freedom to design programs that meet the spectrum of diverse needs of their Medicaid population"); *Status of State Action on the Medicaid Expansion Decision*, KAISER FAMILY FOUND. (Nov. 26, 2018), https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/? [https://perma.cc/GK47-UKGA].

[108] *See, e.g.,* Price & Verma, *supra* note 107.

[109] DEBORAH BACHRACH ET AL., ROBERT WOOD JOHNSON FOUND., THE IMPACT OF MEDICAID EXPANSION ON UNCOMPENSATED CARE COSTS: EARLY RESULTS AND POLICY IMPLICATIONS FOR STATES (June 2015), https://www.rwjf.org/content/dam/farm/reports/is-

Medicaid expansion benefitted rural institutions, stating that expansion "was associated with improved hospital financial performance and substantially lower likelihoods of closure, especially in rural markets and counties with large numbers of uninsured adults before Medicaid expansion."[110] This comprehensive study found a direct correlation between Medicaid expansion and the financial health of rural hospitals. Other research has shown the significance of Medicaid expansion to rural populations, finding that Medicaid covers "a larger share of nonelderly adults and children in rural and small-town areas than in metropolitan areas; this trend is strongest among children."[111] The same study highlights the role of Medicaid in decreasing uninsurance for rural populations, noting:

> The importance of Medicaid for families in small towns and rural areas has grown over time. The share of adults in these areas who receive their health coverage from Medicaid increased from 11[%] to 16[%] between 2008-2009 and 2014-2015 . . . . All states showing the largest increase in adult enrollment are states that adopted the Medicaid expansion under the ACA.[112]

Other research shows that adult enrollment has a spillover effect on children's enrollment, including children who were already eligible for Medicaid.[113]

A concern often heard in the capitals of opt-out states is that Medicaid expansion increases enrollment, thus increasing the overall cost of the program (for both the federal government and states); but studies indicate that Medicaid expansion is a net gain for most states by shoring up hospitals and other industry stakeholders, creating jobs, and freeing state funds for other needs because of cost-shifting to the federal government.[114] A March 2018 study of states that have expanded Medicaid reported: "The strong balance of objective evidence indicates that actual costs to states so far from expanding Medicaid are negligible or minor, and that states across the political

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sue_briefs/2015/rwjf420741 [https://perma.cc/ME9K-EVYS]. For a summary of the findings from various researchers, see LARISA ANTONISSE ET AL., KAISER FAMILY FOUND., THE EFFECTS OF MEDICAID EXPANSION UNDER THE ACA: UPDATED FINDINGS FROM A LITERATURE REVIEW (Sept. 2017), https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-september-2017/ [https://perma.cc/F252-Y4YG] (updating a prior literature review with similar findings); *see also* AM. MED. ASS'N, RESEARCH SUMMARY: BENEFITS OF MEDICAID EXPANSION (2017), https://www.ama-assn.org/sites/default/files/media-browser/research-summary-benefits-of-medicaid-expansion.pdf [https://perma.cc/467V-D4LF].

[110] Lindrooth et al., *supra* note 50, at 111.

[111] JACK HOADLEY ET AL., N.C. RURAL HEALTH RESEARCH PROGRAM, MEDICAID IN SMALL TOWNS AND RURAL AMERICA: A LIFELINE FOR CHILDREN, FAMILIES, AND COMMUNITIES 1 (June 2017), https://ccf.georgetown.edu/wp-content/uploads/2017/06/Rural-health-final.pdf [https://perma.cc/RZ82-R85P].

[112] *Id.* at 7.

[113] *See, e.g.*, Frean et al., *supra* note 103, at 81, 83.

[114] *See* ANTONISSE ET AL., *supra* note 109, at 1.

spectrum do not regret their decisions to expand Medicaid."[115] Yet a number of rural states have resisted the ACA as a general policy matter and Medicaid expansion in particular, often claiming it is too expensive for their budgets.[116] As of this writing, states that have not expanded include Alabama, Florida, Georgia, Kansas, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming.[117] Maine is in the process of expanding as the result of a voter referendum that occurred in November 2017, though the governor resisted.[118] Virginia's governor signed legislation expanding Medicaid as this Article went to print.[119] Three more states expanded by voter referendum in the November 2018 election: Idaho, Nebraska, and Utah.[120] Expansion is a dynamic and moving target.[121]

But, in the meantime, individuals living in non-expansion states who are eligible for Medicaid under federal law but not at the state level fall into the "coverage gap," meaning they are too poor to obtain private health insurance and qualify for Medicaid expansion under the ACA but cannot obtain Medicaid coverage in the state in which they live.[122] *NFIB* reintroduced variability where it was not intended to exist within the ACA's universal coverage scheme. More than 25% of those in the coverage gap live in Texas, and 89% of all individuals in the coverage gap live in the South.[123] Most of the people in the coverage gap also live in states with health professional shortage areas ("HPSA"s), which indicate shortages in primary, dental, or

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[115] Mark Hall, *Do States Regret Expanding Medicaid?*, USC-BROOKINGS SCHAEFFER ON HEALTH POL'Y (Mar. 26, 2018), https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2018/03/26/do-states-regret-expanding-medicaid/ [https://perma.cc/BE8L-NGX3].

[116] *See, e.g.*, Austin Huguelet, *Despite Failure of GOP Health Care Bill, Greitens Remains Opposed to Medicaid Expansion*, ST. LOUIS POST-DISPATCH (Mar. 28, 2017), http://www.stltoday.com/news/local/govt-and-politics/despite-failure-of-gop-health-care-bill-greitens-remains-opposed/article_a7c15c13-b314-5384-bf3a-a78f32aa348d.html [https://perma.cc/86UX-W3MB] (discussing the Missouri governor's opposition to Medicaid expansion due to concern about the cost of the program being consistent with other non-expansion states' concerns about cost).

[117] *A Fifty State Look at Medicaid Expansion*, FAMILIES USA (Jan. 2018), http://familiesusa.org/product/50-state-look-medicaid-expansion [https://perma.cc/RT2D-KE6D].

[118] *See* Bruce Jaspen, *In Red States, Medicaid Expansion Heads To 2018 Ballot Measures*, FORBES (Dec. 24, 2017), https://www.forbes.com/sites/brucejapsen/2017/12/24/in-red-states-medicaid-expansion-heads-to-2018-ballot-measures/#7b71a03a484a [https://perma.cc/FCN6-7NRU] (reporting on Maine's ballot and states that have interest in their own ballot initiatives, including Florida, Idaho, Utah, and Nebraska).

[119] *See* Doug Stanglin, *Virginia, after 5-year battle, passes Medicaid expansion for 400,000 poor people*, USA TODAY (May 31, 2018), https://www.usatoday.com/story/news/2018/05/31/virginia-after-5-year-battle-becomes-33rd-state-pass-medicaid-expansion/658785002/ [https://perma.cc/A9DC-3YFR].

[120] Kaiser Family Foundation, *supra* note 107.

[121] *See* Gluck & Huberfeld, *supra* note 45, at 1740–46.

[122] *See generally* GARFIELD & DAMICO, *supra* note 65 (describing the coverage gap's features and implications).

[123] *See id.*

mental health care that are based on geography, population, or facility.[124] Non-expansion states Texas, Florida, Georgia, and Missouri have some of the greatest shortages of primary care providers, based on qualifying for HPSA payments from HHS.[125] Even if rural populations in these states can access a health-care provider, they are likely to have trouble paying for care due to the unavailability of Medicaid expansion.

B. Targeted Legislation to Offset ACA Resistance

While states have rejected implementation of the ACA, legislators from those same states have introduced a handful of bills targeting discrete rural health issues. The states that have held out the longest on Medicaid expansion resisted the ACA's goal of universal insurance coverage from the start; legislators that represent non-expansion states in Congress voted against the ACA's passage: Both senators voted "Nay" from Alabama, Georgia, Idaho, Kansas, Mississippi, Oklahoma, South Carolina, Tennessee, Texas, Utah, and Wyoming; one senator voted "Nay" from Florida, Missouri, Nebraska, North Carolina, and South Dakota.[126] Their counterparts in the House voted similarly; no Republicans voted for the ACA in the Senate or the House.[127] Of these states, Texas has the highest percentage of uninsured citizens (16.6%), followed by Oklahoma (13.8%), Georgia (12.9%), Florida (12.5%), Mississippi (11.8%), and Wyoming (11.5%).[128]

Federal legislators' voting history is undeniably just one facet of a state's decision to reject or implement the ACA, which also involves complex factors such as intrastate political decision making, economic considerations, and negotiation with HHS as to how implementation could occur.[129] Consider as one example a "red state" such as Kentucky. Kentucky Senator Mitch McConnell voted against the ACA, and then-Senator Bunning did not

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[124] *Shortage Areas, Health Resources & Services Administration Data Warehouse*, U.S. DEP'T. HEALTH & HUMAN SERVS., https://datawarehouse.hrsa.gov/topics/shortageareas.aspx [https://perma.cc/P7GT-A5QJ] (last visited Apr. 2, 2018).

[125] *Primary Care Health Professional Shortage Areas (HPSAs)*, KAISER FAMILY FOUND. (Dec. 31, 2016), https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Total%20Primary%20Care%20HPSA%20Designations%22,%22sort%22:%22desc%22%7D [https://perma.cc/9PZA-4X4P]; *see also Health Professional Shortage Areas*, HEALTH RESOURCES & SERVS. ADMIN. (Oct. 2016), https://bhw.hrsa.gov/shortage-designation/hpsas [https://perma.cc/652Z-KHXE] (defining the HPSA designation, which could occur in any geographic location, not just rural areas); *Types of Designations*, HEALTH RESOURCES & SERVS. ADMIN. (Oct. 2016), https://bhw.hrsa.gov/shortage-designation/types [https://perma.cc/5S2A-6V4Q] (mapping federal designations such as HPSA and Medically Underserved Area/Population onto federal funding, special facilities, and other targeted aid).

[126] *H.R. 3590 (111th): Patient Protection and Affordable Care Act*, GOVTRACK, https://www.govtrack.us/congress/votes/111-2009/s396 [https://perma.cc/QYJ2-6F5K] (last visited Nov. 24, 2018).

[127] *Id.*

[128] Dot Plot, U.S. CENSUS BUREAU (Sept. 25, 2017), https://www.census.gov/library/visualizations/interactive/health-insurance-dotplot.html [https://perma.cc/874V-WSJ9]. By comparison, the overall U.S. uninsured rate in 2016 was 8.6%. *Id.*

[129] *See* Gluck & Huberfeld, *supra* note 45, at 1746–78.

vote.[130] But Kentucky Democratic Governor Steve Beshear pursued implementation of the ACA, which was a national model of successful state engagement with implementing the ACA.[131] His Republican successor Matt Bevin campaigned on an anti-ACA platform but then obtained permission for the nation's first Medicaid demonstration waiver to require work as a condition of Medicaid enrollment for the newly eligible enrollees, and he threatened to roll back Medicaid expansion if litigation challenging the permissibility of work requirements is successful.[132] This one state highlights the hot politics of the ACA, the dynamic implementation of the ACA that defies simple political generalizations, and the ongoing conflict even where implementation has been successful.

Yet the national politics of the ACA have additional implications here, because sometimes legislation targeting rural health issues is hidden within nationwide legislation addressing other topics, such as the bills preventing decreases in Disproportionate Share Hospital (DSH) payments. DSH payments help to pay for care provided in hospitals that serve a high proportion of Medicaid and uninsured patients, which the ACA reduced because its universal insurance coverage design would have made DSH less crucial.[133] The ACA's DSH payment reductions have been delayed five times by federal legislation and have not taken effect as of this writing.[134] The delays have hidden inside broader legislation, but it is notable that these bills often have been sponsored by representatives from states that reject Medicaid expansion. The following Acts continued DSH payments to rural hospitals and provide examples of hidden targeting: The Middle Class Tax Relief and Job Creation Act of 2012[135] was introduced in 2011 by Representative Camp, Republican of Michigan (which had not then expanded Medicaid eligibil-

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[130] *Roll Call Vote 111th Congress—1st Session*, U.S. SENATE, https://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=111&session=1&vote=00396 [https://perma.cc/2X6H-PV2W] (last visited Apr. 2, 2018).

[131] *See, e.g.*, Sarah Kliff and Byrd Pinkerton, *Interview: Former Gov. Steve Beshear explains how he sold deep-red Kentucky on Obamacare*, VOX (Feb. 27, 2017, 8:20 AM), https://www.vox.com/policy-and-politics/2017/2/27/14725782/steve-beshear-kentucky-obamacare [https://perma.cc/8HHU-6P4M].

[132] *See* Amy Goldstein, *Kentucky becomes the first state allowed to impose Medicaid work requirement*, WASH. POST (Jan. 12, 2018), https://www.washingtonpost.com/national/health-science/kentucky-becomes-the-first-state-allowed-to-impose-medicaid-work-requirement/2018/01/12/b7b56e3e-f7b4-11e7-b34a-b85626af34ef_story.html?utm_term=.38bef171509e [https://perma.cc/6LBP-SG9V]. Bevin's waiver limitations also include enforceable cost sharing and are predicted to unenroll up to 100,000 beneficiaries. *See id.*

[133] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2551, 14 Stat. 312–314 (2010); 42 C.F.R. § 447.294 (2013). Medicare also contains DSH payments that were adjusted by the ACA but not as much as Medicaid DSH payments. 42 C.F.R. § 412.106 (2017); *see also Disproportionate Share Hospital (DSH)*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html [https://perma.cc/Z3B3-WM9T] (last visited Nov. 24, 2018).

[134] *Disproportionate share hospital payments*, MEDICAID & CHIP PAYMENT & ACCESS COMM'N, https://www.macpac.gov/subtopic/disproportionate-share-hospital-payments/ [https://perma.cc/A859-RAZT] (last visited Nov. 24, 2018) (describing DSH and noting all five laws that have delayed DSH payment reductions).

[135] Middle Class Tax Relief and Job Creation Act of 2012, Pub. L. No. 112-96, 126 Stat. 156 (codified as amended in scattered sections of U.S.C.).

ity), and was cosponsored by Republicans from Alabama, California, Michigan, Oklahoma, and Florida.[136] The American Taxpayer Relief Act of 2012[137] was also sponsored by Representative Camp of Michigan and had 28 Republican cosponsors, including representatives from Texas, Florida, Georgia, Kansas, Louisiana, Missouri, Nebraska, South Carolina, Tennessee, and Wisconsin (all of which remain non-expansion states except Louisiana).[138] The Medicare Access and CHIP Reauthorization Act of 2015[139] was introduced by Representative Burgess of Texas and had bipartisan support.[140] DSH payments are important to rural hospitals for reasons discussed in Section I, including more uninsured patients, lower patient density, and more patients covered by public rather than private insurance, features of rural health that make all forms of payment important for rural hospitals.[141]

A second example more pointedly aims at a non-expansion state problem. The "Improving Access to Maternity Care Act" (H.R. 315) is a bill that

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[136] Middle Class Tax Relief and Job Creation Act of 2012: Cosponsors: H.R. 3630 — 112th Congress (2011-2012), CONGRESS.GOV (Dec. 9, 2011), https://www.congress.gov/bill/112th-congress/house-bill/3630/cosponsors [https://perma.cc/68TP-WSTR] (noting the cosponsors for Middle Class Tax Relief and Job Creation Act of 2012, Pub. L. No. 112-96, 126 Stat. 156 (codified as amended in scattered sections of U.S.C.)). California was an early Medicaid expansion state and has historically maximized available federal funding. *See* Gluck & Huberfeld, *supra* note 45, at 1734–35 (detailing early Medicaid expansion states' choices); Teresa A. Coughlin & Stephen Zuckerman, *States' Use of Medicaid Maximization Strategies to Tap Federal Revenues: Program Implications and Consequences*, URBAN INST. (June 2002), https://www.urban.org/sites/default/files/publication/60176/310525-States-Use-of-Medicaid-Maximization-Strategies-to-Tap-Federal-Revenues.PDF [https://perma.cc/MP65-A6R7] (describing California's efforts to maximize federal Medicaid funding and the impact those efforts had on federal policies).

[137] American Taxpayer Relief Act of 2012, Pub. L. No. 112-240, 126 Stat. 2313 (codified as amended in scattered sections of U.S.C.).

[138] H.R.8 - American Taxpayer Relief Act of 2012: Cosponsors: H.R.8 — 112th Congress (2011-2012), CONGRESS.GOV (July 24, 2012), https://www.congress.gov/bill/112th-congress/house-bill/8/cosponsors [https://perma.cc/G3JF-MB57] (noting the cosponsors for American Taxpayer Relief Act of 2012, Pub. L. No. 112-240, 126 Stat. 2313 (codified as amended in scattered sections of U.S.C.).

[139] Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, 129 Stat. 87 (codified as amended in scattered sections of 16 and 42 U.S.C.).

[140] Medicare Access and CHIP Reauthorization Act of 2015: Cosponsors: H.R.2 — 114th Congress (2015-2016), CONGRESS.GOV (Mar. 24, 2015), https://www.congress.gov/bill/114th-congress/house-bill/2/cosponsors [https://perma.cc/K4TS-HV5U] (noting the cosponsors for Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, 129 Stat. 87 (codified as amended in scattered sections of 16 and 42 U.S.C.).

[141] Although urban hospitals receive more DSH money than rural hospitals, raw dollars do not paint a full picture. A commission reported for 2016:

> Although public teaching hospitals in urban settings received the largest share of total DSH funding, more than half (54[%]) of rural hospitals also received DSH payments, including many critical access hospitals which receive a special payment designation from Medicare because they are small and often the only provider in their geographic area.

MEDICAID & CHIP PAYMENT & ACCESS COMM'N, CHAPTER 2: ANALYZING DISPROPORTIONATE SHARE HOSPITAL ALLOTMENTS TO STATES 58 (Mar. 2017), https://www.macpac.gov/wp-content/uploads/2017/03/Analyzing-Disproportionate-Share-Hospital-Allotments-to-States.pdf [https://perma.cc/J8K5-3TUM].

designates "maternity health care professional shortage areas."[142] H.R. 315 was sponsored by a Republican representative from Texas, a non-expansion state in which 19% of women are uninsured, in which rural hospitals have closed obstetrics units or closed entirely, which enacted TRAP laws to limit abortion services,[143] and which has one of the highest maternal mortality rates in the United States.[144] H.R. 315 was signed into law on December 17, 2018, and amends the federal Public Health Service Act "to identify . . . maternity care health professional target areas . . . , which are areas within health professional shortage areas that have a shortage of maternity care health professionals, for purposes of . . . assigning maternity care health professionals to those areas."[145] The bill provides no other details as to how such a designation would work, but it could influence physicians to choose rural areas for obstetrics practice by directing special federal funding to HPSAs.[146] A 2018 study found that infant mortality rates decreased nationwide from 2010 to 2016 (when the ACA was passed and implemented) but that expansion states had significantly greater decreases in infant mortality; and, from 2014 to 2016, infant mortality increased slightly in non-expansion states.[147] The study suggests that Medicaid's coverage of preventive services, maternal health, infant and child health, and the related "reductions in unintended pregnancies and improved preconception, prenatal and maternal chronic dis-

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[142] Improving Access to Maternity Care Act, H.R. 315, 115th Cong. §2 (2017), https://www.congress.gov/bill/115th-congress/house-bill/315 [https://perma.cc/7WLX-G2LS]) (introduced by Rep. Michael C. Burgess January 5, 2017 and passed by the House on Jan. 9, 2017). Other efforts exist but are smaller bites at the apple, such as the 21st Century Cures Act, which incorporated the "Bringing Postpartum Depression Out of the Shadows Act" for funding to states to establish, improve, or maintain programs to train professionals to screen, assess, and treat for maternal depression in women who are pregnant or have given birth within the preceding 12 months. 21st Century Cures Act, Pub. L. No. 114-255, 130 Stat. 1033 (codified as amended in scattered sections of 21 and 42 U.S.C.); *see also* Caroline Bologna, *Congress Passes Groundbreaking Postpartum Depression Legislation*, HUFFINGTON POST (Dec. 7, 2016), https://www.huffingtonpost.com/entry/congress-passes-groundbreaking-postpartum-depression-legislation_us_584053a6e4b09e21702d2a43 [https://perma.cc/K3BX-WUFE] (describing incorporation of postpartum depression funding into the 21st Century Cures Act).

[143] *See supra* note 76, and accompanying text.

[144] *See* Marissa Evans, *Dangerous Deliveries*, TEX. TRIB. (Jan. 16, 2018), https://apps.texastribune.org/dangerous-deliveries [https://perma.cc/R9QZ-G9ZV] (exploring the high rate of maternal mortality in Texas); Marissa Evans, *A shrinking number of rural Texas hospitals still deliver babies. Here's what that means for expecting moms.*, TEX. TRIB. (Jan. 17, 2018), https://www.texastribune.org/2018/01/17/shrinking-number-rural-texas-hospitals-still-deliver-babies-heres-what/ [https://perma.cc/U692-F49T] (discussing the problem of rural hospital closures in Texas).

[145] Improving Access to Maternity Care Act, H.R. 315, 115th Cong. § 2 (2017) (as passed by the House on Jan. 9, 2017).

[146] COMM. ON HEALTH CARE FOR UNDERSERVED WOMEN, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, COMMITTEE OPINION: HEALTH DISPARITIES IN RURAL WOMEN (Feb. 2014), https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co586.pdf?dmc=1&ts=20180403T0056066359 [https://perma.cc/JK3R-C35H].

[147] *See generally* Chintan B. Bhatt & Consuelo M. Beck-Sagué, *Medicaid Expansion and Infant Mortality in the United States*, 108 AM. J. PUB. HEALTH 565, 565–67 (April 2018) (noting that Southern and rural states had higher infant mortality rates even before the ACA).

ease, and mental health management for mothers throughout their child's infancy" could have contributed to mortality reduction.[148] While Maternity HPSAs could possibly increase the number of rural obstetricians, patients in rural non-expansion states would still lack consistent means of payment for their services outside of the limited pregnancy/post-partum window of Medicaid coverage.

The "Save Rural Hospitals Act" provides a third example;[149] this bill is sponsored by a Republican representative from Missouri,[150] a non-expansion state that has struggling rural hospitals, [151] and a Republican representative from Iowa, a state that expanded through a waiver.[152] (The bill originally was co-sponsored by representatives from other non-expansion states including Texas, Wisconsin, Mississippi, Florida, Oklahoma, Tennessee, and Utah.[153]) The bill's introduction indicates the plight of rural hospitals, including findings such as:

> (5) Six hundred and seventy-three hospitals are at risk of closing, . . . such closings would impact 11,700,000 patient encounters, 99,000 community jobs would be lost, 137,000 healthcare jobs would be lost, and $277,000,000,000 would be lost from the gross domestic product (over 10 years). . . . (7) Seventy-seven percent of rural counties in the United States are designated as primary care health professional shortage areas while 9[%] have no physicians at all. (8) Seniors living in rural areas are forced to travel significant distances for care. (9) On average, trauma victims in rural areas must travel twice as far as victims in urban areas to the closest hospital, and, as a result, 60[%] of trauma deaths occur in rural areas, even though only 20[%] of Americans live in rural areas."[154]

The bill allocates special Medicare and Medicaid funding to rural hospitals, resumes the ACA's increased Medicaid payments to primary care providers (which expired at the end of 2014), offers grants, and reduces certain Medi-

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[148] *Id.* at 566.

[149] H.R. 2957, 115th Cong. (2017); *see also NRHA endorses reintroduction of Save Rural Hospitals Act to new Congress*, NAT'L RURAL HOSP. ASS'N (June 20, 2017), https://www.ruralhealthweb.org/NRHA/media/Emerge_NRHA/Press%20releases/NRHA-Release-2017-Save-Rural-Hospitals-Act.pdf [https://perma.cc/39R2-EDRL] (endorsing and explaining the Save Rural Hospitals Act).

[150] Introduced by Representative Sam Graves of Missouri's Sixth Congressional District. *See* https://www.govtrack.us/congress/bills/115/hr2957 [https://perma.cc/9LRZ-EX3Q].

[151] *See, e.g.*, Brittany Ruess, *Rural Hospitals Struggle in Missouri*, COLUMBIA DAILY TRIB. (Sept. 30, 2017), http://www.columbiatribune.com/news/20170930/rural-hospitals-on-life-support-in-missouri [https://perma.cc/6NJR-RH7V] (reporting on the economic woes of Missouri hospitals and noting the role opting out of Medicaid expansion may be playing).

[152] *See* H.R. 2957, 115th Cong. (2017).

[153] H.R. 3225 Save Rural Hospitals Act: Cosponsors: H.R.3225—114th Congress, CONGRESS.GOV (July 27, 2015), https://www.congress.gov/bill/114th-congress/house-bill/3225/cosponsors [https://perma.cc/9TFP-JUEB] (noting the cosponsors for H.R. 2957, 115th Cong. (2017)).

[154] Save Rural Hospitals Act, H.R. 2957, 115th Cong. (2017).

care administrative requirements.[155] It is notable that the co-sponsors are from a non-expansion and an expansion state, discussed in the next section.

A fourth example highlights that federal programs for assisting low-income individuals have ongoing acute benefits for rural areas but can occupy a precarious position, such as Community Health Centers (CHCs), which provide integrated primary care to low-income patients,[156] or the National Health Service Corps (NHSC), which offers loan forgiveness to medical students for relocation to rural areas designated as medically underserved.[157] Congress allowed funding for CHIP, CHCs, and the NHSC to lapse in the fall of 2017, jeopardizing direct access to care for rural communities that have been supported by such programs for more than fifty years.[158] CHIP was renewed in January 2018, funding for CHCs and NHSC was renewed in the budget bill passed in February 2018,[159] and rural health received more targeted money in the March 2018 budget bill.[160] Efforts to specially fund and support telemedicine also specifically benefit rural populations but are sporadic.[161]

These legislative efforts suggest that members of Congress from non-expansion states are trying to work around the deficits that are at least in part the result of their state's non-expansion choice. These targeted legislative maneuvers are largely reactionary gap-fillers that could be less necessary if the remaining opt-out states expanded Medicaid eligibility.

C. The Role of the Rising Tide

The federal government has been addressing the health of rural communities since the early 1900s, when laws such as the Sheppard-Towner Act created public health programs for women and children that particularly benefited the rural poor.[162] The lapsed funding for key anti-poverty programs

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[155] *See id.*

[156] *What is a Health Center?*, HEALTH RESOURCES & SERVS. ADMIN., https://bphc.hrsa.gov/about/what-is-a-health-center/index.html [https://perma.cc/P8M9-E5T5] (last visited Nov. 24, 2018).

[157] Thomas M. Selden et al., *Medicaid Expansion And Marketplace Eligibility Both Increased Coverage, With Trade-Offs In Access, Affordability*, 36 HEALTH AFFAIRS 2069 (2017).

[158] Michelle Ollove, *Community Health Centers at Risk of Closing Without Congressional Action*, GOVERNING (Dec. 18, 2017), http://www.governing.com/topics/health-human-services/sl-community-health-centers-congress.html [https://perma.cc/VSA6-6CX9].

[159] Letter to Speaker Paul Ryan and Democratic Leader Nancy Pelosi (Oct. 27, 2017) https://tsongas.house.gov/uploads/CHCLetter2.pdf [https://perma.cc/WHT4-M6DL].

[160] Susannah Luthi, *Insurance market stabilization out: a look at Congress' spending omnibus*, MODERN HEALTHCARE (Mar. 21, 2018), http://www.modernhealthcare.com/article/20180321/NEWS/180329973 [https://perma.cc/NAE6-844F] (discussing features of the March 2018 budget bill including features targeted toward rural health needs).

[161] *See, e.g.*, Ctrs. for Medicare & Medicaid Servs., *Telemedicine*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/benefits/telemed/index.html [https://perma.cc/V8RZ-J9E3] (explaining telemedicine payments within Medicaid) (last visited Nov. 30, 2018).

[162] Theda Skocpol, *Targeting Within Universalism: Politically Viable Policies to Combat Poverty in the United States, in* THE URBAN UNDERCLASS 411, 423–425 (Christopher Jencks & Paul E. Peterson eds., 1991) (discussing the import of the Sheppard-Towner programs and how they morphed into an aspect of the much more universal Social Security Act).

noted above indicates that such efforts can easily lose ground, even when they are long-standing. After a century of attempting various kinds of health reform through largely incremental legislation, Congress set a new national baseline in the ACA.[163] The ACA's architecture provided all individuals, metropolitan and rural alike, with a rising tide of universal insurance coverage that was designed to lead to health-care improvements across all populations and states.[164] The ACA's universal approach would aid anyone, but most of all low-income individuals and anyone else historically excluded from health insurance and health care, such as rural communities.[165]

Where the ACA has been implemented as it was designed, as discussed above, studies are finding that health insurance coverage improves health and financial stability for the newly enrolled populations (both those covered by private insurers and Medicaid).[166] The results of these studies indicate that the ACA's architecture is consistent with a classic political science theory explaining why some anti-poverty laws are more successful than others, which Professor Theda Skocpol calls "targeting within universalism."[167] Professor Skocpol's theory contextualizes the successes of certain social policies, pointing to a historical pattern indicating that the most effective anti-poverty laws have been packaged so that they do not look like special care for the needy. Skocpol points to policies such as Civil War veterans' benefits and the Social Security Act that deployed widespread government benefits and enabled federal assistance to the poor as having the greatest success and the least political resistance.[168] Skocpol asserts that universal legislative efforts are more successful than targeted legislative efforts precisely because they are universal.[169] According to Skocpol, policies targeting the poor, especially those facing additional discrimination such as racial and ethnic minorities or the rural poor, can backfire because they focus attention on those deemed undesirable, and special help can increase stigma and undermine the longev-

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[163] *See* Gluck & Huberfeld, *supra* note 45, at 1706–16 (discussing incremental efforts at health-care reform starting with veterans' benefits after the Civil War).

[164] *See id.* at 1726–28 (discussing the tools given to states through the use of federalism within the national baseline of the ACA).

[165] *See, e.g.*, JESSICA C. BARNETT & MARINA S. VORNOVITSKY, U.S. DEP'T OF COMMERCE, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2016 at tbl.4, https://www.census.gov/content/dam/Census/library/publications/2017/demo/p60-260.pdf [https://perma.cc/6S66-HVJ9] (noting that individuals earning less than 250% of the FPL have the highest uninsurance rates).

[166] *See, e.g.*, ANTONISSE ET AL., *supra* note 109 (summarizing studies that show Medicaid expansion under the ACA has resulted in coverage gains, improved access to care, greater affordability of care, improved self-reported health, and enhanced health outcomes; expansion also reduced uncompensated care costs for hospitals and did not lead to dropped employment, which some feared); Selden et al. *supra* note 154 (studying the impact of public versus private insurance on adults earning 100% to 138% of the Federal Poverty Level under the ACA and determining that coverage of both types increases access to medical care and prevents delaying medical care due to cost; those in expansion states had greater reductions in out-of-pocket spending but faced some difficulty accessing physician care).

[167] *See generally* Skocpol, *supra* note 161.

[168] *Id.* at 414.

[169] *Id.*

ity and effectiveness of social programs.[170] Skocpol observes that "room has been made within certain universal policy frameworks for extra benefits and services that disproportionately help less privileged people without stigmatizing them,"[171] and she concludes that success lies in "cross-class social policies," which emphasize benefits for all Americans rather than those most benefited by federal anti-poverty programs.[172]

In the realm of health, Medicare and Medicaid offer examples of what I will call intentional and unplanned universalism. Medicare demonstrates the kind of legislative targeting within universalism Skocpol advocates. Medicare was created to address the medical needs of all of the nation's elderly, who were being impoverished by medical care necessitated by their participation in the world wars and facilitated by rising health-care costs.[173] The elderly successfully lobbied for a nationalized, unified program that would end state variability in health policy,[174] an approach that originally was attacked as "socialism" but has become one of the nation's most durable and politically stable social programs. Medicare offers intentional universalism: everyone who has paid social security taxes for forty quarters is enrolled at age sixty-five regardless of other characteristics such as wealth, health, or geography—and, at the same time, Medicare has reduced significantly the poverty rates of the nation's elderly through what is also an effective income redistribution program.[175] Because Medicare measurably improves the later life of all Americans, it has become a political "third rail."[176] But, most importantly here, Medicare is understood as a universal program, which makes targeting more effective within Medicare (such as special payments for Critical Access Hospitals, discussed above) because benefits for the poor are hidden within its "cross-class social policy" scheme.

Medicaid, on the other hand, has been characterized alternately as a health insurance program or as a form of charity, depending on the speaker—the kind of targeted legislation that historically has not been as successful or durable because it is characterized as welfare.[177] Yet, despite targeting only the deserving poor for its first five decades, Medicaid now covers half of all births, more than a third of all children, and is the primary payor for long-term care—anyone who lives long enough is highly likely to be a Medicaid beneficiary.[178] Medicaid's greatest expenses are elderly and

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[170] *Id.* at 420.
[171] *Id.* at 414.
[172] *Id.* at 420.
[173] *See* Gluck & Huberfeld, *supra* note 45 (discussing the long history of federal interventions in health policy).
[174] *See* Huberfeld, *Federalizing Medicaid*, *supra* note 89, at 449.
[175] *See* Skocpol, *supra* note 161, at 426–27.
[176] *See, e.g.*, Aaron Blake & Chris Cillizza, *Medicare: the new Third Rail of American politics?*, WASH. POST (May 26, 2011), https://www.washingtonpost.com/blogs/the-fix/post/medicare-the-new-third-rail-of-american-politics/2011/05/25/AGzWLuBH_blog.html?utm_term=.0a043e080acb [https://perma.cc/ZX8S-CSXM].
[177] *See generally* Huberfeld, *Universality*, *supra* note 1.
[178] *See id.*

disabled individuals.[179] Medicaid slowly has achieved universality, despite its original design targeting the deserving poor and facing frequent political headwinds.[180]

The ACA lies somewhere between Medicare's intentional universalism and Medicaid's unplanned universalism because it offers intentional universality but does so without a uniform program by attempting to weave together America's uniquely disparate and fragmented forms of health insurance. The ACA patches together employer-sponsored health insurance, subsidized small- and non-group private insurance, Medicaid, and Medicare to form a more complete safety net[181] and relied heavily on making Medicaid an intentional universal program for low-income individuals. The ACA's attempt at converting Medicaid's targeted legislative program into an intentionally universal one has not been an entirely smooth transition. Consistent with Skocpol's writing, Medicaid's historical targeting led to stigma, which has been a hurdle to acceptance of its newly intentional universality and very likely has contributed to backlash against the ACA. Further, the ACA's principle of universality without a corresponding uniform program may be a design flaw exacerbated by implementation hurdles.

It appears that states have been coming to understand the need for Medicaid's strengthened role within the ACA's architecture, and the polity is too, in light of the grassroots opposition to 2017's "Repeal and Replace" efforts against the ACA; but the ACA remains an ongoing source of conflict.[182] Not only have states resisted expanding Medicaid eligibility, but some will only consider expanding if they can introduce new exclusionary elements into their expansions that undermine the ACA's universalism.[183] The legislative universalism approach should make social programs stronger by facilitating "cross-class" stewardship; if everyone benefits from a social policy, it becomes easier to support, like Medicare. But Medicaid beneficiaries have been subjected to what Jessica Roberts and I have called "self-reliance scrutiny" to determine if they are worthy of governmental assis-

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[179] Megan Thielking, *Trump wants to cut $800 billion from Medicaid. Where does all the program's money go?*, STAT (May 22, 2017), https://www.statnews.com/2017/05/22/medicaid-spending-breakdown/ [https://perma.cc/R9EH-FX6C].

[180] *See* Huberfeld, *Universality, supra* note 1 (exploring Medicaid's universality on its fiftieth anniversary).

[181] *Id.* at 3–4 (describing the intended interplay between Medicaid and private insurance in the ACA).

[182] David Weigel, *Left out of AHCA fight, Democrats let their grass roots lead — and win*, WASH. POST (Mar. 24, 2017), https://www.washingtonpost.com/news/powerpost/wp/2017/03/24/left-out-of-ahca-fight-democrats-let-their-grass-roots-lead-and-win/?utm_term=.B8296da38aa7 [https://perma.cc/V6EE-79DQ] (reporting on the grassroots opposition to repeal-and-replace efforts in 2017).

[183] *See* Nicole Huberfeld, *Can Work Be Required in the Medicaid Program?*, 378 NEW ENG. J. MED. 788, 788–791 (2018) (discussing how work requirements thwart the universal coverage goal of the ACA); *see also Medicaid Waiver Tracker: Which States Have Approved and Pending Section 1115 Medicaid Waivers?* KAISER FAMILY FOUND. (Mar. 5, 2018), https://www.kff.org/medicaid/issue-brief/which-states-have-approved-and-pending-section-1115-medicaid-waivers/ [https://perma.cc/B7U5-4VNX].

tance,[184] especially the newly eligible population, on which some states are imposing work requirements as a condition of enrollment.[185] So far, rural states that expanded Medicaid eligibility have won approval for work requirements: Kentucky, Indiana, Arkansas, and New Hampshire have had demonstration waivers approved as this Article goes to print.[186] Yet these states' populations struggle with finding jobs that offer employer sponsored health insurance and suffer the other health disparities explored in Section I.

This targeting of the "able bodied" within Medicaid's new universalism is not the kind of "targeting within universalism" Skocpol imagined, as it seems highly likely to decrease access to care and to thwart the intentional universalism of the ACA. Work requirements are not only theoretically inconsistent with the universalism of the ACA, but also such requirements could reverse the gains in coverage and health that Medicaid expansion has witnessed thus far, potentially increasing rural health disparities in states that would otherwise be benefiting from Medicaid expansion. This phenomenon calls for further study.

Whether rural legislators' efforts at targeted legislation will alleviate the burdens of rural health disparities remains to be seen. Targeted legislation may have the effect of buffering rural disparities, but targeting *without* universalism holds limited promise both in theory and in practice. Rural communities may need special legislative attention for the reasons described in Section I: they experience demonstrable vulnerabilities tied to the unique features of geography and population.[187] These vulnerabilities exist for everyone living in rural areas, regardless of their income, because fixed features of rural areas may necessitate more targeted assistance than a universal program

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[184] *See generally* Nicole Huberfeld & Jessica Roberts, *Health Care and the Myth of Self-Reliance*, 57 B.C. L. REV. 1 (2016).

[185] *See* Yasmeen Abutaleb, *Arkansas becomes third U.S. state to add Medicaid work requirements*, REUTERS (Mar. 5, 2018), https://www.reuters.com/article/us-usa-healthcare-arkansas/arkansas-becomes-third-u-s-state-to-add-medicaid-work-requirements-idUSKBN1GH2PN [https://perma.cc/WB3V-L9Z2].

[186] *See* Nathaniel Weixel, *New Hampshire wins approval for Medicaid work requirements*, THE HILL (May 7, 2018), http://thehill.com/policy/healthcare/medicaid/386566-new-hampshire-wins-approval-to-imose-medicaid-work-requirements [https://perma.cc/WYS9-89CX] (reporting on the fourth CMS approval of Medicaid work requirements); *see also* MARYBETH MUSUMECI ET AL., KAISER FAMILY FOUND., SECTION 1115 MEDICAID DEMONSTRATION WAIVERS: THE CURRENT LANDSCAPE OF APPROVED AND PENDING WAIVERS (Mar. 2018), http://files.kff.org/attachment/Issue-Brief-Section-1115-Medicaid-Demonstration-Waivers-The-Current-Landscape-of-Approved-and-Pending-Waivers [https://perma.cc/9N9B-X8ND] (detailing the major features of approved section 1115 waivers and pending waivers in early 2018, including work requirements and other hurdles to enrollment).

[187] John Jacobi has argued that Medicaid's crucial role is to target care for the most medically vulnerable populations, a role that he sees as uniquely promising because the program was designed to protect people who could not otherwise obtain medical care. *See generally* Jacobi, *supra* note 16; *see also* John V. Jacobi, *Medicaid, Managed Care, and the Mission for the Poor*, 9 ST. LOUIS U. J. HEALTH L. & POL'Y 187 (2016). Jacobi notes that the poor face particular barriers to care, such as "exposure to determinants of ill-health, including insecure housing, environmental insult, underemployment, and inadequate access to wholesome food and recreational facilities; and physical, intellectual, or behavioral disabilities that engender social isolation." *Id.* at 188.

provides. This helps to account for a representative from a Medicaid expansion state like Iowa co-sponsoring the "Save Rural Hospitals" bill. The ACA and its intentional universalism facilitate access to care by getting patients through the payment gateway, but patients in rural areas could enter a gateway to nowhere without the additional support such targeted legislation could provide.

Conclusion

Many questions remain that need to be answered, such as: Does targeted legislation at the state level demonstrate any greater success than at the federal level? Can the success of targeting within universal legislation be empirically measured? What has been the impact of targeting rural areas within the ACA, and do Medicaid waivers play any role in the success or failure of the ACA's intentional universalism? Would federalizing Medicaid eliminate these questions?[188] Will targeted legislation improve maternal and infant health in rural areas? The list goes on.

In the meantime, it appears that because American health care has long been addressed through a legislative and policy patchwork, it is easy for populations or geographic regions to be excluded and to fall behind. The web of law and policy issues that connects through rural health may be a symptom of the larger fragmentation that persists in American health care, in part because the universality principle embraced by the ACA was not accompanied by a uniform program and has not been implemented or politically supported in some corners.

Addressing rural health disparities with targeted, narrowly drawn legislation may offer some relief, but a legislative effort with no universal baseline, which is the case in non-expansion states today, will only address small pieces of the root causes of rural communities' circle of health disparities. The ACA provides a form of intentional universalism that has demonstrably improved health in expansion states and could advance rural legislators' efforts at targeting rural needs by addressing health disparities more broadly. All people living in rural areas face the fixed rural features of geography and population that may render rural areas enduringly needful of special legislative policies. Targeted legislation may see some limited success in decreasing health disparities, but if it does not occur within a universalism that offers a more widespread approach to solving health-care problems, rural health disparities are likely to persist.

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[188] *See* Huberfeld, *Federalizing Medicaid*, *supra* note 89 (urging the full federalization of Medicaid).