

THE ROLE OF MEDICARE ADVANTAGE IN ADDRESSING BARRIERS TO CARE, IMPROVING HEALTH OUTCOMES FOR OLDER ADULTS IN RURAL AMERICA



INTRODUCTION

HEALTH NEEDS OF RURAL COMMUNITIES

More than 61 million Americans live in rural communities.¹ Due to a wide range of demographic, socioeconomic, and geographic factors, the health challenges and disparities that these Americans experience differ significantly from those faced by Americans living in urban and suburban regions.

When comparing the populations of those within urban and rural communities, individuals in rural areas tend to be older and manage more complex health conditions than those in more urban settings.² Research shows that compared to those living in urban settings, rural residents are more likely to live with one or more chronic condition, face higher burdens of preventable disease, injury, and suicide, and are more likely to engage in high-risk health behaviors.³

Further, these disparities and disproportionate rates of adverse health outcomes are often magnified and exacerbated as rural residents reach older age, and retrospective studies show that the gap in health outcomes between older adults in rural settings and older adults in urban settings has widened significantly over the past several decades.⁴ While health outcomes observed across urban and rural older adults in the 1980s were largely similar, today, older rural adults see notably higher all-cause mortality rates, an average life expectancy that is shorter than their urban counterparts, and higher rates of a wide range of serious and chronic illnesses.⁵

Given that the health disparity gaps seen across rural areas of the country continue to widen and disproportionately impact vulnerable groups, ensuring that the coverage options available to older adults can address these barriers is critical. The research brief that follows analyzes the key elements and differences between the two Medicare options available for eligible Americans—traditional fee-for-service (FFS) Medicare and Medicare Advantage (MA)—and examines the ways in which Medicare Advantage may be particularly well-suited to meet the unique profile and needs of older adults and those with disabilities living in rural regions of the country.

BACKGROUND ON MEDICARE

Today, nearly 66 million Americans, including 57 million older adults and 8 million individuals with disabilities, are enrolled in Medicare.⁶ Medicare-eligible adults have two main coverage options; they can either choose the federally run traditional Medicare program or they can opt to receive coverage through Medicare Advantage (MA), which provides comprehensive Medicare coverage through private health plans.⁷

While traditional Medicare has been in place since 1965, Medicare Advantage was not established until 1997. Since the introduction of MA over 25 years ago, the program's popularity has steadily grown. In 2023, more than half (51 percent) of all Medicare beneficiaries received coverage through MA plans.⁸

Medicare Advantage has become an increasingly popular and prevalent coverage option for older adults in rural communities over the past several years. MA enrollment among rural beneficiaries has quadrupled over the last decade, and in recent years, growth of MA enrollment in rural areas has outpaced growth in urban areas, with rural enrollment increasing by 13 percent in 2022 versus just 7 percent in urban regions during the same year.^{9,10}

The factors driving this growth are worth examining closely to better understand why and how these plans are supporting older rural Americans, and how potential changes to the program could stand to impact beneficiaries living in these communities.

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OVERVIEW OF THE UNIQUE PROFILE AND NEEDS OF OLDER RURAL AMERICANS

A critical starting point for assessing the increasing popularity of MA plans among rural beneficiaries is first recognizing and understanding the unique social, economic, geographic, and demographic factors that impact rural populations. Key factors and considerations include:

HEALTH STATUS AND OUTCOMES IN RURAL COMMUNITIES

While the U.S. population, on the whole, has grown increasingly older in recent decades, population aging has been more pronounced in rural communities than in urban areas.¹¹ In 2021, for the first time in Census Bureau history, residents 65 years and older made up over 20 percent of the rural population.¹² In urban regions, by comparison, older adults made up just 16 percent of the population.¹³ Further, many of the older Americans living in rural areas are concentrated in states where more than half of the older population resides in rural communities.¹⁴

In addition to a population that is comparatively older, rural communities also face higher rates of disparities in health and mortality and tend to have shorter life expectancies than urban populations. Compared to their urban counterparts, rural adults are more likely to live with chronic or serious conditions, with 11 percent higher rates of hypertension, 40 percent higher rates of diabetes, 40 percent higher rates of heart disease, 30 percent higher rates of stroke, and 100 percent higher rate of chronic obstructive pulmonary disease.¹⁵ Those living in rural counties also have higher rates of disability, with rural residents 9 percent more likely than urban residents to report living with a single disability and 24 percent more likely to report living with multiple disabilities.¹⁶ Additionally, compared to adults living in urban settings, rural residents are more likely to present with health risk factors such as substance use, depression, obesity, high blood pressure, food insecurity, and exposure to environmental and occupational hazards.¹⁷

This overall health profile and increased likelihood of being impacted by health disparities contributes to what is commonly

referred to as the “rural mortality penalty,” which refers to a widespread mortality disadvantage among rural populations that was first observed in 1980 and has only widened in recent decades, as the urban mortality rate continues to decline at a comparatively faster rate.¹⁸ Today, rural Americans have higher all-cause mortality rates and are more likely than their urban counterparts to die from all five of the leading causes of death in the United States: cancer, heart disease, unintentional injury, chronic lower respiratory disease, and stroke.¹⁹ Additionally, recent data show that rural COVID-19 mortality rates are more than twice the rates found in urban areas.²⁰ Those living in rural settings are also at greater risk of dying from motor vehicle accidents, suicide, and drug overdose.²¹ As a result of these disparate mortality rates, the average life expectancy for rural residents (77.4 years) is over two years shorter than that of urban residents (79.8 years).²²

The disproportionate burden of disease and mortality impacts rural residents of all ages but can be especially detrimental to older adults living in these settings, who are often more vulnerable, less mobile, and more likely to live with and experience potentially life-threatening complications related to both chronic and acute conditions than younger demographics. A national survey of Medicare beneficiaries found that rural residence was associated with a 40 percent higher rate of preventable hospitalization and 23 percent higher mortality rate as compared with urban residence.²³ Further, another recent study aimed at examining outcomes among Medicare beneficiaries hospitalized after presenting with a wide range of serious conditions found that rural beneficiaries were more likely than their urban counterparts to die within 30, 90, and 180 days of discharge.²⁴

ACCESS CHALLENGES

One of the primary factors driving the disproportionately high rates of morbidity and mortality among older rural Americans, as compared with older adults in urban areas, is related to a disparity in access to timely, high-quality healthcare. There are many barriers that can make accessing the right care at the right time more difficult for older adults living in rural settings, including:

- **Location and transportation barriers.** Compared to more urban settings, rural areas are less dense and more geographically remote, which in turn often means rural residents must travel long distances to access necessary medical care. These distances can be exacerbated by the fact that in some rural settings, there is limited infrastructure and/or poor-quality roads. Rural residents, on average, must travel twice as far as urban residents to access medical or dental care.²⁵ This rural-urban travel disparity is even more pronounced when looking at specialized services. For example, compared to their urban counterparts, rural residents, on average, must travel nearly three times as far to access skilled nursing services, more than three times as far to access cancer screening and treatment, and nearly four times as far to access cardiac care.²⁶ This barrier is especially onerous for older adults who typically require more medical care than younger populations, necessitating more frequent trips to healthcare providers.
- **Workforce shortages.** While the COVID-19 pandemic caused broad disruptions in the healthcare workforce market, rural communities have long faced chronic shortages and challenges recruiting and retaining medical staff. In 2023, 91.4 percent of all rural counties were found to have healthcare workforce shortages.²⁷ Further, according to the most recently collected data from the Health Resources & Services Administration (HRSA), rural areas only have 10.9 physicians per 10,000 residents, compared with 31.7 per 10,000 in urban areas.²⁸ Additionally, for rural older adults that want to age at home, finding skilled home nursing staff can be incredibly challenging—rural adults are 78 percent less likely than those in the largest metropolitan counties to

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receive home-based medical care.²⁹ This makes it much more likely for rural older adults to end up in skilled nursing facilities.³⁰ Even then, these facilities face similar shortages, and as a result, nearly 450 skilled rural long-term care facilities have closed over the past decade.³¹

- **Health literacy disparities.** Due in large part to a variety of systemic disadvantages, rural residents are more likely than their urban counterparts to have insufficient health literacy levels. Further, research has demonstrated that the strongest predictor for insufficient health literacy is older age, as many older adults experience as decline in cognition and difficulties adopting newer health practices, resources, and treatments.³² This puts rural older adults at highest risk for experiencing health literacy disparities, which in turn can jeopardize treatment management, likelihood of seeking out medical care, and overall health and wellbeing.³³
- **Financial challenges.** While many older adults report concerns about the cost of healthcare, cost of care can be particularly burdensome for older adults in rural communities. In addition to higher likelihood of managing multiple chronic conditions—which can drive up healthcare utilization and therefore make costs more difficult to manage—rural older adults are also more likely to have lower income status and experience higher rates of poverty. Despite the financial protections offered to older Americans by Medicare, rural adults 65 years and older are more likely than their urban counterparts to forgo medical care because of costs.³⁴ A survey conducted in 2022 found that while nationally 1 in 4 older adults report delaying or skipping medical care due to costs, this number jumps up to more than 1 in 3 for older adults living in rural settings.³⁵

INCOME AND POVERTY

It is important to note that despite comparatively higher rates of individuals with lower incomes within rural communities, there are distinct cultural aspects that influence how rural residents perceive and identify their financial status. In short, these income statistics do not necessarily capture the resilience and pride that is characteristic in many rural areas—a perspective that is rooted in a strong sense of community, perseverance, and an understanding of economic stability that transcends financial metrics.

That said, historically, poverty rates have been comparatively higher in rural regions than in urban areas. Over the last several decades, economic activity has become more concentrated in a smaller number of large urban markets, and the geographic inequality gap has widened significantly.³⁶ According to the most recent Census Bureau data, the rate of urban poverty was 11 percent, while the poverty rate among rural communities was 4 percentage points higher at 15 percent.³⁷ In some regions this gap is even more pronounced—in the southern United States, for example, the rural poverty rate reaches nearly 20 percent.³⁸ In addition to being more prevalent, rural poverty is also far more persistent than urban poverty in the United States. Of the 318 counties designated as counties experiencing long-term, persistent poverty, 85 percent are rural.³⁹

The rates of income insecurity within rural communities persist as rural residents age. Although the gap is narrower, older adults in rural settings still experience higher rates of income insecurity than older adults in urban areas (10.3 percent vs. 9.3 percent among adults 65 years and older), and about 1 in 4 low-income older Americans live in rural areas.^{40,41} Older adults in rural settings also tend to be less financially secure in retirement. According to recent research published by the Employee Benefit Research Institute (EBRI), rural residents are less likely than urban residents to own retirement accounts, mutual funds, or other investment holdings that can support financial security as individuals reach older age.⁴² Additionally, compared to their urban counterparts, older adults in rural settings have—on average—significantly lower total wealth and asset values. Among rural older adults, average household wealth and assets total \$264,573, compared to an average of \$471,390 among older adults in urban areas.⁴³

The higher rates of income disparities found among rural populations are significant and important to consider as part of efforts to understand the health outcomes and healthcare preferences of older rural adults, as a large body of research demonstrates that lower income status is associated with reduced access to timely medical care, increased risk of presenting with health risk factors (e.g. obesity, nutrient poor diet, sedentary lifestyle), poorer health outcomes, and increased morbidity and mortality as individuals age.⁴⁴

While many older adults report concerns about the cost of healthcare, cost of care can be particularly burdensome for older adults in rural communities. In addition to higher likelihood of managing multiple chronic conditions—which can drive up healthcare utilization and therefore make costs more difficult to manage—rural older adults are also more likely to have lower income status.

THE ROLE OF MEDICARE ADVANTAGE IN SUPPORTING OLDER AMERICANS IN RURAL COMMUNITIES

As detailed in previous sections, enrollment in Medicare Advantage has become increasingly popular among older adults living in rural settings. Whereas in 2010 only 11 percent of rural beneficiaries chose to enroll in MA, recent data on enrollment trends show that today that number is upwards of 40 percent, with projections showing continued growth over the next several years.⁴⁵

Notably, both traditional fee-for-service Medicare and MA provide millions of older adults in rural settings with important health benefits.⁴⁶ That said, as rural beneficiaries increasingly opt for MA coverage, many of the core elements unique to the MA program may be driving increased enrollment and improved health outcomes among rural beneficiaries.

LOWER COSTS AND HIGHER SAVINGS

A substantial body of research has demonstrated that MA plans play a key role in shielding financially vulnerable populations from high out-of-pocket (OOP) medical costs.⁴⁷ According to a 2023 ATI analysis, beneficiaries enrolled in MA plans save an average of \$2,400 annually on out-of-pocket costs and premiums, compared to their counterparts in traditional Medicare.⁴⁸

Further, a 2023 Avalere study analyzing health spending and outcomes among Medicare beneficiaries with one or more chronic conditions found that across conditions, overall spending was lower among MA beneficiaries than among traditional beneficiaries.⁴⁹ For example, average monthly spending for patients with diabetes enrolled in MA was 69 percent lower than the spending for diabetes patients in traditional Medicare.⁵⁰ According to another study, Part D drug costs were found to be up to 44 percent lower among MA plan enrollees compared to costs for those enrolled in traditional Medicare.⁵¹

Two components that are unique to Medicare Advantage help drive the cost savings associated with the program. First, MA plans are able to offer more flexible cost and coverage policies, compared to traditional Medicare, and may also offer

deductible and cost sharing policies that are more beneficial to enrollees. For example, when looking at rural populations specifically, 2023 enrollment data shows that more than two-thirds (69 percent) of rural MA beneficiaries are enrolled in plans with no additional premiums (outside of what they would otherwise pay for traditional Medicare), despite having coverage of supplemental benefits not covered by the traditional program.⁵² Second, unlike traditional Medicare, MA plans are required to place limits on annual out-of-pocket spending, which guarantees that MA beneficiaries will not spend over a certain amount annually on OOP expenses.⁵³

Considering that compared to their urban counterparts, rural beneficiaries are more likely to experience poverty, have lower income status, live with higher rates of costly chronic conditions, and report higher rates of forgoing medical care due to financial burden, the cost savings associated with Medicare Advantage may well play an important role in the growing reliance on MA plans over traditional Medicare.

COVERAGE OF SUPPLEMENTAL BENEFITS

One mechanism by which Medicare Advantage is able to provide more comprehensive care is through coverage of supplemental benefits, such as vision and dental benefits.

Unlike traditional Medicare, which provides no coverage of such benefits, nearly all MA plans (99 percent) provide coverage of supplemental benefits such as dental, vision, hearing, and/or telehealth.⁵⁴ Coverage of supplemental benefits has proven to be a key differentiator for MA plans—in fact, data show that compared to MA enrollees, traditional beneficiaries without supplemental coverage face higher rates of cost-related healthcare challenges and are more likely to skip dental care or visits to a specialist due to financial burden.⁵⁵

Increasingly, MA plans are also expanding their coverage of non-medical benefits to help address social determinants of health, many of which disproportionately impact older Americans living in rural communities.⁵⁶ For example, compared to most other demographic groups, rural older Americans are:

- More likely to experience food insecurity^{57,58}
- More isolated and face greater transportation-related challenges, with limited access to public transit⁵⁹
- More likely to face limitations to leisure time physical activity and exercise⁶⁰
- More likely to present with health risk factors like tobacco and substance use and obesity⁶¹

Examples of the expanded benefits offered by many MA plans include grocery and meal delivery services, ride share services that provide transportation to medical appointments, gym, and fitness class memberships, and coverage for expanded mental health and substance use interventions—all of which aim to address non-medical health factors that can be particularly burdensome to rural beneficiaries.⁶²

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PLANS DESIGNED TO SUPPORT CONSISTENT ACCESS & PATIENT-CENTRIC CARE

In addition to coverage of supplemental benefits, there are several other aspects of Medicare Advantage that incentivize, support, and make patient-centered care possible in a way that is fundamentally different from traditional Medicare. Notable unique-to-MA components that help support more streamlined and comprehensive care include:

- **A payment structure that encourages “whole patient” health.** Unlike traditional Medicare’s traditional model, which reimburses providers based on the cost of individual services provided, MA receives monthly payments from the Centers for Medicare & Medicaid Services (CMS) that are based on projections that account for: 1) estimated costs of a wide range of medical services; and 2) the health of the beneficiary population to ensure plans have enough resources to cover patients with high health needs.⁶³ Accordingly, MA plans must account for and consider beneficiaries’ health needs comprehensively and provide care management interventions that help meet the complex care needs of vulnerable beneficiaries to drive improvements in health outcomes.⁶⁴
 - **The availability of tailored Special Needs Plans (SNPs).** SNPs—a part of Medicare Advantage—are customized MA plans designed to meet the unique health needs of some of Medicare’s most vulnerable beneficiaries, including those that are dual-eligible for Medicare and Medicaid, have certain conditions, or live in institutionalized settings.⁶⁵ SNPs tailor their benefits, provider choices, and drug formularies to best meet the specific needs of the groups they serve, which can make it much easier for beneficiaries to navigate care and access specialized medical services and providers.⁶⁶ In addition to offering specialized benefits, many of these plans also offer extra condition-specific programs or services, such as care coordinators that can support beneficiaries in managing their conditions.⁶⁷
- SNPs have shown to be particularly important among low-income beneficiaries and vulnerable populations,

including those in rural settings. For example, between 2021 and 2024, rural enrollment in I-SNPs—which include enrollees who rely on institutionalized care such as long-term care or skilled nursing facilities—grew by double digit percentages, outpacing urban enrollment.⁶⁸ Given that rural beneficiary populations are more likely than their urban counterparts to be managing multiple chronic conditions and face socioeconomic and geographic barriers that can make accessing care more challenging, SNPs stand to play a critical role in improving health outcomes among rural beneficiaries and may contribute to recent increases in rural MA enrollment.

- **A model built to support coordinated care.**

SNPs are only one example of coordinated care plans offered through MA. Beneficiaries receiving coverage through MA have the option of enrolling in a range of coordinated care plans that offer more integrated, streamlined, and often more cost-effective care. Coordinated care plans offer a more tailored way for patients to receive the care they need and can help patients more easily access the care that is relevant to their specific health status and conditions.⁶⁹

Notably, 92 percent of MA beneficiaries are enrolled in a plan that integrates their prescription drug coverage into one plan, enabling better coordination of care and management of costs across both medical and drug benefits.⁷⁰ This streamlined care has real world impacts: research shows that Medicare Advantage enrollees are more likely than beneficiaries in traditional Medicare to receive preventive care services, such as annual wellness visits and routine checkups, screenings, and vaccines.⁷¹

Care plans that provide better integration of benefits, financial protection, and higher levels of coordination can support all beneficiaries, but this MA differentiator may be particularly beneficial for rural older adults given the specific needs and disparities found in this population. Considering that rural adults are more likely than their urban counterparts to report barriers to care, the fact that MA's coordinated care plans are associated with greater access to preventive care services, more streamlined care for management of multiple conditions, and lower out-of-pocket costs, may very well factor into older rural adults' decisions to opt for MA plans over traditional Medicare.⁷²

DEMONSTRATED SUCCESS IN ADDRESSING GAPS IN CARE AND IMPROVING HEALTH OUTCOMES

In addition to—and likely because of—the cost, coverage, care, and accessibility benefits detailed above, research and large-scale comparative analyses have shown that Medicare Advantage outperforms traditional Medicare across a range of health outcome categories and quality metrics.⁷³

For example, an analysis of 62 studies comparing health outcomes and utilization associated with MA and traditional Medicare found that beneficiaries enrolled in MA plans were more likely to receive preventive services, report having a usual source of care, and saw lower hospital readmission rates.⁷⁴ Indeed, MA plans consistently outperform traditional Medicare across a diverse range of outcomes. Among patients with diabetes, for instance, those enrolled in MA experienced 73 percent fewer serious clinical complications than traditional beneficiaries.⁷⁵ Further, compared to traditional beneficiaries, beneficiaries enrolled in MA have a 43 percent lower rate of avoidable hospitalization across all conditions, and a 21 percent higher rate of seeing a physician within 14 days of hospital discharge.⁷⁶

CONCLUSION

While the unique benefits of Medicare Advantage could certainly be advantageous to beneficiaries across demographic groups and regional settings, the core elements that differentiate MA plans from traditional Medicare may be especially well positioned to support the needs of older adults living in rural communities for a wide range of reasons, include MA's ability to:

- Deliver more comprehensive and integrated healthcare and medical services to a population disproportionately exposed to health disparities, with higher rates of chronic conditions and greater barrier to access;
- Better shield beneficiaries from high out-of-pocket costs and provide cost-saving mechanisms for a group that, on average, faces greater risk of financial vulnerability, higher likelihood of low-income status, and reports higher rates of delaying or forgoing medical care due to financial burden;
- Provide innovative “non-medical” benefits that can help directly address some of the key social and geographics barriers that disparately impact access within rural communities; and
- Demonstrate improved health outcomes through a wide range of measurements and metrics, with higher rates of morbidity and mortality, and greater risks of experiencing complications related to acute and chronic conditions.

As rural older adults increasingly enroll in Medicare Advantage plans over traditional Medicare, it is critical that these factors are not overlooked and that the MA plans that nearly 66 million Americans—including many of the most vulnerable populations—rely on remain supported and protected.

ENDNOTES

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