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One Child Town: The Health Care Exceptionalism Case Against Agglomeration Economies

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ONE CHILD TOWN: THE HEALTH CARE EXCEPTIONALISM CASE AGAINST AGGLOMERATION ECONOMIES

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Abstract

This Article offers an extended rebuttal to the suggestion to move residents away from dying communities to places with greater economic promise. Rural America, arguably, is one of those dying places. A host of strategies aim to shore up those communities and make them more economically viable. But one might ask, "Why bother?" In a similar vein, David Schleicher's provocative 2017 Yale Law Journal *article,* Stuck! The Law and Economics of Residential Stagnation*, recommended dismantling a host of state and local government laws that operate as barriers to migration by Americans from failing economies to robust agglomeration economies. But Schleicher said little about the fate of the places left behind. Schleicher's article drew a number of pointed responses, urging the value and preservation of Small Town America. But those arguments failed fully to meet the rational economic thesis, countering instead with more sentimental or humanitarian concerns. This Article offers a way to reconcile the two views, refracted through a health care lens. Health care is a particularly apt perspective for considering the question of whether America's rural places are worth saving because it necessarily, under longstanding U.S. policy preferences, walks the line between economic principles and human rights; individual responsibility and communitarian values; the rational actor and the deserving recipient of aid. The health care exceptionalism case against agglomeration economies urges consideration of the real, quantifiable costs of migration and, correlatively, the value of home, as well as the market imperfections inherent in health care and, even more so, in rural health care.*

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Well there's a young man in a T-shirt
Listenin' to a rock 'n' roll station
He's got a greasy hair, greasy smile
He says: "Lord, this must be my destination"
'Cause they told me, when I was younger
Sayin' "Boy, you're gonna be president"
But just like everything else, those old crazy dreams
Just kinda came and went

Oh but ain't that America, for you and me
Ain't that America, we're something to see baby
Ain't that America, home of the free, yeah
Little pink houses, for you and me, oh baby for you and me

–John Mellencamp, *Pink Houses*[1]

INTRODUCTION

The epigraph above highlights a romanticized version of rural America—one that is worth saving. It depicts contentment with place, even if that place is far from perfect, even if the American Dream of unlimited success, fame, glamor, or prestige is unachievable. Indeed, the lyrics go on to eschew the desires and temptations associated with Big City life.

[1] JOHN MELLENCAMP, *Pink Houses*, *on* UH-HUH (Riva Records 1983).

Well there's people and more people
What do they know, know, know
Go to work in some high rise
And vacation down at the Gulf of Mexico
Ooo yeah

And there's winners, and there's losers
But they ain't no big deal
'Cause the simple man baby pays the thrills,
The bills and the pills that kill

The upshot is that small-town residents are happy where they are; they do not want or need the trappings of urban life. Indeed, they are better off without those temptations and vices. For many folks living in rural America, that imagery and sentiment are their reality and their preference.[2]

But there is a counternarrative: Small town America is dying and, some say, not worth saving.[3] This is not a new sentiment but was similarly expressed in Arthur Morgan's 1942 book, *The Small Community: Foundation of Democratic Life*.[4] Morgan's work remains relevant today, "[a]t a time when many small towns are in crisis—facing economic decline, drug addiction despair—when economists and pundits recommend giving up on small towns, telling their populations to abandon their homes to find economic opportunity elsewhere . . . ."[5] Morgan's book is an extended rebuttal, a counterargument for saving rural America. But the suggestion to let those places die remains. As described with particular focus in recent academic literature, Professor David Schleicher suggests that people may not be choosing to stay in dying communities but rather are "stuck" there.[6] Schleicher details various institutional structures and legal impediments to interstate mobility of individuals away from dying economies to places of more promising economic opportunity. Breaking down those barriers would allow the United States and its residents to enjoy the benefits of "agglomeration economies," meaning the clustering of

[2] *See* Lisa R. Pruitt, *Rural Rhetoric*, 39 CONN. L. REV. 159, 168–72 (2006) (describing a somewhat cheerful portrayal of stereotypes associated with rural communities and areas).

[3] *See, e.g.*, Allan Golombek, *Sorry New York Times, Rural America Cannot Be Saved*, REALCLEAR MARKETS (Dec. 18, 2018), https://www.realclearmarkets.com/articles/2018/12/18/sorry_new_york_times_rural_america_cannot_be_saved_103542.html [https://perma.cc/6RH5-V7BJ]; Nick Gillespie, *If Rural Americans Are Being 'Left Behind,' Why Don't They Just Move?*, REASON (Jan. 9, 2018, 4:45 PM), https://reason.com/2018/01/09/if-rural-americans-are-being-left-behind/ [https://perma.cc/ADZ4-LCRT].

[4] ARTHUR E. MORGAN, THE SMALL COMMUNITY: FOUNDATION OF DEMOCRATIC LIFE (1942).

[5] Brian Alexander, *What America Is Losing as Its Small Towns Struggle*, ATLANTIC (Oct. 18, 2017), https://www.theatlantic.com/business/archive/2017/10/small-town-economies-culture/543138/ [https://perma.cc/7MWY-TJAU].

[6] *See generally* David Schleicher, *Stuck! The Law and Economics of Residential Stagnation*, 127 YALE L.J. 78 (2017).

economic activities to facilitate network effects and economies of scale, including deep labor markets, low transport costs, robust local markets, and knowledge spillover among firms.[7] As just one example, Schleicher queries why technologists and financiers moved to take advantage of opportunities in Silicon Valley, but custodians and other service workers did not, despite higher nominal wages.[8] His answer: Because they are stuck, and the solution is to reconsider a host of state and local laws that erect barriers to migration, ranging from building codes to homeowners' tax credits to public benefits enrollment processes.[9]

To paint the picture of dying rural America, consider Wiota, Iowa,[10] population 107 people, halfway between Omaha and Des Moines.[11] At the time of a 2017 news story featuring the town, Wiota counted only one family with children (which happened to be the town mayor's, with two children).[12] Horses outnumbered children by a ratio of seven to two.[13] Wiota represents the demographic trend of shrinking and aging rural America, as young people leave and do not return, leaving only long-time residents, many of whom are past working age and increasingly in need of medical and social services.[14] Those dynamics make sustaining basic public services—schools, hospitals, mental health counselors, employers, and public safety—even more difficult.[15] Imagine trying to keep a full-service acute care hospital afloat, much less retain pediatricians and obstetrical-gynecological specialists, in such locales.[16]

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[7] *Id.* at 97–101; *see also* Marion Drut & Auréli Mahieux, *Correcting Agglomeration Economies: How Air Pollution Matters*, 96 PAPERS OF REG'L SCI. 381, 383 (2015); Carol Newman, *Industrial Clusters: Who Benefits?*, BROOKINGS (Nov. 19, 2015), https://www.brookings.edu/blog/africa-in-focus/2015/11/19/industrial-clusters-who-benefits/#cancel [https://perma.cc/5EU8-N4AB].

[8] Schleicher, *supra* note 6, at 83.

[9] *See id.* at 111–12, 149–54.

[10] Kyle Munson, *Childless Iowa: More Communities Left with Few, If Any, Kids*, DES MOINES REG. (Dec. 27, 2017, 12:33 PM), https://www.desmoinesregister.com/story/news/local/columnists/kyle-munson/2017/12/27/childless-small-towns-iowa-struggle-aging-population/909256001/ [https://perma.cc/Q7L7-5ZL8].

[11] *Id.*; *Wiota, Iowa Population 2020,* WORLD POPULATION REV., http://worldpopulationreview.com/us-cities/wiota-ia-population/ [https://perma.cc/9GWP-ZD4R] (last visited Oct. 22, 2020).

[12] Munson, *supra* note 10.

[13] *Id.*

[14] *Id.*

[15] *See, e.g.*, Eli Saslow, *Who's Going to Take Care of These People?*, WASH. POST (May 11, 2019), https://www.washingtonpost.com/news/national/wp/2019/05/11/feature/whos-going-to-take-care-of-these-people/ [https://perma.cc/9ERN-P9WH]; Faimon A. Roberts III, *Why, Like Other Small Louisiana Towns, Bogalusa Is Slowly Dying*, NOLA (July 5, 2019, 11:30 AM), https://www.nola.com/news/article6ca32bac-98f8-11e9-9db5-57e742387089.html [https://perma.cc/N44S-WKSP].

[16] *See, e.g.*, Saslow, *supra* note 15; Shelby Livingston, *'The Hospital Was a Force Holding the Community Together. Without It, I Think this Community Probably Will Disintegrate*,*'* MOD. HEALTHCARE, https://www.modernhealthcare.com/indepth/rural-

A number of strategies and policies have been deployed to try to maintain the economic viability of and essential services in towns like Wiota.[17] But Schleicher's response might be, "Why bother?" Rather than throw good money after bad by trying to shore up these communities, instead we should facilitate their residents' movement elsewhere, to economies that are robust, and where human capital is concentrated and services can be provided efficiently.[18] Any arguments for keeping residents in place and saving places like Wiota are intangible and economically irrational, the stuff of sentimental classic rock or modern country lyrics.[19] Responses

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hospital-closure-tennessee-leaves-town-scrambling/ [https://perma.cc/S5RF-GNU5] (last visited Oct. 22, 2020).

[17] *See, e.g.*, Charles W. Fluharty, *Why Rural Policy Now Matters to Agriculture: Rural Development, Regional Innovation, and the Next Farm Bill*, 16 DRAKE J. AGRIC. L. 31, 34–35 (2011); Scott Lindstrom, *Health Care Reform and Rural America: The Effect of the Patient Protection and Affordable Care Act on the Rural Economy and Rural Health*, 47 IDAHO L. REV. 639, 646–54 (2011); *Rural Economic Development Loan & Grant Program*, U.S. DEP'T OF AGRIC., https://www.rd.usda.gov/programs-services/rural-economic-development-loan-grant-program [https://perma.cc/XX4W-PCZ8] (last visited Oct. 22, 2020); Michael Tomberlin, *Rural Alabama Is Getting Much-Needed Attention from Economic Developers*, ALA. NEWSCENTER (Jan. 29, 2020), https://www.alabamanewscenter.com/2020/01/29/rural-alabama-is-getting-much-needed-attention-from-economic-developers/ [https://perma.cc/9MFG-LBZS]; Charles Ashby, *House Panel OKs Changes to Rural Economic Development Program*, DAILY SENTINEL (Jan. 28, 2020), https://www.gjsentinel.com/news/western_colorado/house-panel-oks-changes-to-rural-economic-development-program/article_ad0f8f64-4127-11ea-89ce-8b58e6536529.html [https://perma.cc/PS5B-9ETJ]; *Best Practices for Rural Economic Development*, MORNING AG CLIPS (Apr. 26, 2018), https://www.morningagclips.com/best-practices-for-rural-economic-development/ [https://perma.cc/R7JE-7YQ3].

[18] *See generally* Schleicher, *supra* note 6.

[19] For a somewhat less rosy portrayal of rural American life, see BRUCE SPRINGSTEEN, *Born in the U.S.A.*, *on* BORN IN THE U.S.A. (Columbia 1984):

> Born down in a dead man's town
> The first kick I took was when I hit the ground
> End up like a dog that's been beat too much
> 'Til you spend half your life just covering up
>
> Born in the U.S.A
> I was born in the U.S.A
> I was born in the U.S.A
> Born in the U.S.A
> ….
> Down in the shadow of the penitentiary
> Out by the gas fires of the refinery
> I'm ten years burning down the road
> Nowhere to run ain't got nowhere to go

to Schleicher's provocative argument exposes a tension in the literature between rational economic arguments explaining rural decline and seeking to boost the nation's economy, and more sentimental arguments about the value of place, home, heritage, and relationships—apples to oranges arguments talking past each other.[20]

This Article posits that rural America should be saved, not just for intangible reasons, but in the name of health. Health is a uniquely helpful lens for navigating the apparent divide between the two views because health law and policy regularly must engage core economic principles and market theory as well as humanitarian and communitarian concerns. Thus, this Article provides a robust counterargument to Schleicher's agglomeration economies thesis and justifies continuing to direct resources toward sustaining rural places across the country. First, the argument highlights the negative health impacts of migration and agglomeration on both

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Born in the U.S.A
I was born in the U.S.A
Born in the U.S.A
I'm a long gone Daddy in the U.S.A

See also, e.g., JOHN MELLENCAMP, *Small Town*, *on* SCARECROW (Riva Records 1985); JOHN MELLENCAMP, *Jack and Diane*, *on* AMERICAN FOOL (Riva Records 1982); BRUCE SPRINGSTEEN, *My Hometown*, *on* BORN IN THE U.S.A. (Columbia 1985); BOB SEGER, *Mainstreet*, *on* NIGHT MOVES (Capitol 1977); JUSTIN MOORE, *Small Town U.S.A.*, *on* JUSTIN MOORE (Valory Music Group 2009); CARRIE UNDERWOOD, *Thank God for Hometowns*, *on* BLOWN AWAY (Arista Nashville 2012); MONTGOMERY GENTRY, *My Town*, *on* MY TOWN (Columbia Nashville 2002); JASON ALDEAN, *Hicktown*, *on* JASON ALDEAN (BBR Music Group 2005); LUKE BRYAN, *We Rode in Trucks*, *on* I'LL STAY ME (Capitol Nashville 2007); RASCAL FLATS, *Mayberry*, *on* MELT (Lyric Street 2002); KENNY CHESNEY, *American Kids*, *on* THE BIG REVIVAL (Blue Chair & Columbia Nashville 2014); ALAN JACKSON, *Small Town Southern Man*, *on* GOOD TIME (Arista Nashville 2007); BILLY CURRINGTON, *Drinking Town with a Football Problem*, *on* SUMMER FOREVER (Mercury Nashville 2015); *see generally* Casey Quinlan, *When Country Music Goes to the Dark Side of Small-Town Life*, ATLANTIC (Nov. 19, 2013), https://www.theatlantic.com/entertainment/archive/2013/11/when-country-music-goes-to-the-dark-side-of-small-town-life/281544/ [https://perma.cc/UJ7B-8M3Q].

[20] *Compare*, Schleicher, *supra* note 6, *with* Naomi Schoenbaum, *Stuck or Rooted? The Costs of Mobility and Value of Place*, 127 YALE L.J. FORUM 458 (2017) (considering Schleicher's omission of "the costs of mobility for productivity, welfare, and sex equality[,]" and addressing place as a market), *and* Sheila R. Foster, *The Limits of Mobility and the Persistence of Urban Inequality*, 127 YALE L.J. FORUM 480 (2017) (arguing that understanding "the economic and racial stratification of disadvantaged populations within the successful metro regions" in which these migrants live helps explain the deficiency in Schleicher's policy prescriptions), *and* Sara Pratt, *Civil Rights Strategies to Increase Mobility*, 127 YALE L.J. FORUM 498 (2017) (arguing that "federal leadership, changes to the Fair Housing Act, and different approaches to state and local planning" may improve mobility across state and regional lines), *and* Michelle Wilde Anderson, *Losing the War of Attrition: Mobility, Chronic Decline and Infrastructure*, 127 YALE L.J. FORUM 522, 522–24 (2017) (arguing that a new "antipoverty agenda" is needed to effect meaningful improvements to mobility in economically declining regions).

migrants and those left behind, as well as the positive health benefits of home and being treated close to home. Neither Schleicher nor responses to his provocative thesis fully considered those well-documented health effects. In short, there are health care costs to mobility and health care benefits to familiar places.

A deeper, more theoretical argument recognizes what we might term rural health care exceptionalism, consistent with prior recognition of health care exceptionalism.[21] U.S. economic and social welfare policy has long recognized that health care is different: While not a cognizable "right" under our laws,[22] health care is something that merits special treatment outside of normal market economic principles.[23] This is a theme explored repeatedly in my prior scholarship.[24] U.S. health policy continually—perhaps stubbornly—continues to push market-based

[21] *See* Peter Neumann, *American Exceptionalism and American Health Care: Implications for the US Debate on Cost-Effectiveness Analysis*, 47 OFF. HEALTH ECON. 1, 2–4 (March 2009); Neomi Rao, *American Dignity and Healthcare Reform*, 35 HARV. J.L. & PUB. POL'Y 171, 180–84 (2012); Amitabh Chandra, Amy Finkelstein, Adam Sacarny & Chad Syverson, *Healthcare Exceptionalism? Performance and Allocation in the US Health Care Sector*, 106 AM. ECON. REV. 2110, 2111 (2016); *cf.* Ishaan Tharoor, *American Health Care Is a Bad Case of American Exceptionalism*, WASH. POST (June 27, 2017, 11:00 PM MDT), https://www.washingtonpost.com/news/worldviews/wp/2017/06/28/american-health-care-is-a-bad-case-of-american-exceptionalism/ [https://perma.cc/SUK5-PSFN].

[22] Elizabeth Weeks, *State Constitutionalism and the Right to Health Care*, 12 U. PA. J. CONST. L. 1325, 1328 (2010) [hereinafter Weeks, *State Constitutionalism*]; David Orentlicher, *Rights to Healthcare in the United States: Inherently Unstable*, 38 AM. J.L. & MED. 326 (2012); Jennifer Prah Ruger, Theodore W. Ruger & George J. Annas, *The Elusive Right to Healthcare Under U.S. Law*, 372 NEW ENG. J. MED. 2558 (2015); Erin C. Fuse Brown, *Developing a Durable Right to Health Care*, 14 MINN. J.L. SCI. & TECH. 439, 448 (2013); Jennifer Fahnestock, *Renegotiating the Social Contract: Healthcare as a Natural Right*, 72 U. PITT. L. REV. 549, 549–50 (2011).

[23] *See, e.g.*, Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963); Victor R. Fuchs, *Health Care Is Different—That's Why Expenditures Matter*, 303 JAMA 1859 (2010); VICTOR R. FUCHS, WHO SHALL LIVE? HEALTH, ECONOMICS, AND SOCIAL CHOICE 11–12 (1974); David A. Hyman, *Health Insurance: Market Failure or Government Failure?*, 14 CONN. INS. L.J. 307, 307–08 (2007); Martin Gaynor, Farzad Mostashari & Paul B. Ginsburg, *Making Health Care Markets Work: Competition Policy for Health Care*, 317 JAMA 1313 (2017).

[24] *See, e.g.*, Weeks, *State Constitutionalism*, *supra* note 22; Elizabeth Weeks, *Death Panels and the Rhetoric of Rationing*, 13 NEV. L.J. 872 (2013) [hereinafter Weeks, *Death Panels*]; Elizabeth A. Weeks, *Loopholes: Opportunity, Responsibility, or Liability?*, 35 J.L. MED. & ETHICS 320 (2007); Elizabeth A. Weeks, *Gauging the Cost of Loopholes: Health Care Pricing and Medicare Regulation in the Post-Enron Era*, 40 WAKE FOREST L. REV. 1215 (2005) [hereinafter Weeks, *Gauging the Cost of Loopholes*]; Elizabeth Weeks, *The Public's Right to Health: When Patient Rights Threaten the Commons*, 86 WASH. U. L. REV. 1335 (2009); Elizabeth Weeks, *The Fragility of the Affordable Care Act's Universal Coverage Strategy*, 46 U. TOL. L. REV. 559 (2015); Elizabeth Weeks, *Medicalization of Rural Poverty: Challenges for Access*, 46 J.L. MED. & ETHICS 651 (2018).

delivery models.[25] At the same time, individuals who are unable to provide for themselves are not left to die in the streets without care, treatment, and comfort.[26] At least some members of our society historically have been deemed deserving of government assistance, rather than having to fend for themselves in the health care marketplace.[27] Lacking a universal health care system, the United States persists in awkwardly marrying a market-driven approach with a government-entitlement approach to health care delivery.[28]

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[25] *See, e.g.*, Thomas R. Oliver, Philip R. Lee & Helene L. Lipton, *A Political History of Medicare and Prescription Drug Coverage*, 82 MILBANK Q. 283, 341 (2004); Thomas G. McGuire, Joseph P. Newhouse & Anna D. Sinaiko, *An Economic History of Medicare Part C*, 82 MILBANK Q. 283 (2004); Bethany Maylone & Benjamin D. Sommers, *Evidence from the Private Option: The Arkansas Experience*, COMMONWEALTH FUND (Feb. 22, 2017), https://www.commonwealthfund.org/publications/issue-briefs/2017/feb/evidence-private-option-arkansas-experience [https://perma.cc/WQ49-5PP8]; Matthew Glans, *Research & Commentary: Medicaid Expansion Is Not the Only Way to Improve Medicaid in Kansas*, HEARTLAND INST. (Jan. 10, 2020), https://www.heartland.org/publications-resources/publications/research--commentary-medicaid-expansion-is-not-the-only-way-to-improve-medicaid-in-kansas [https://perma.cc/673L-5WH5]; Kelsey Waddill, *IN 1115 Waiver Amendment Helps Members Transition to Commercial Plans*, HEALTHPAYER INTEL. (Aug. 9, 2019); *see generally* Kristin M. Madison & Peter D. Jacobson, *Consumer-Directed Health Care*, 156 U. PA. L. REV. PENNUMBRA 107 (2007); M. Kate Bundorf, *Consumer-Directed Health Plans: A Review of the Evidence*, 83 J. RISK & INS. 9 (2016); NAT'L ASS'N MEDICAID DIR., MEDICAID SECTION 1115 WAIVER TRENDS IN AN ERA OF STATE FLEXIBILITY 1, 4 (Mar. 2018), https://medicaiddirectors.org/wp-content/uploads/2018/03/Section-1115-Waiver-Trends-NAMD-Whitepaper-1.pdf [https://perma.cc/4J5Z-BSQF] (last visited Oct. 22, 2020); Nathan Cortez, *The Elusive Ideal of Market Competition in United States' Health Care*, *in* HEALTH CARE AND EU LAW 359–83 (J.W. van de Gronden et al. eds., 2011).

[26] *See* EMTALA Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), 42 U.S.C. § 1395dd; *see infra,* Part III.B (describing historical context of enactment).

[27] *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 368–74 (1982) (outlining the history of the enactment of Medicare and Medicaid); David Orentlicher, *Medicaid at 50: No Longer Limited to the "Deserving" Poor?*, 15 YALE J. HEALTH POL'Y, L. & ETHICS 185, 189–90 (2015); Nicole Huberfeld, *The Universality of Medicaid at Fifty*, 15 YALE J. HEALTH POL'Y, L. & ETHICS 67, 70–71 (2015) [hereinafter Huberfeld, *Universality of Medicaid*]; Laura D. Hermer, *On the Expansion of "Welfare" and "Health" Under Medicaid*, 9 ST. LOUIS U. J. HEALTH L. & POL'Y 235, 235–36 (2016); Nicole Huberfeld & Jessica L. Roberts, *Medicaid Expansion as Completion of the Great Society*, 1 ILL. L. REV. SLIP OPS. 1, 2–3 (2014); Jonathan Oberlander, *The Political History of Medicare*, 39 J. AM. SOC'Y ON AGING 119, 120–21 (Summer 2015); Onyinyechi Jeremiah, *A Thin Line Between Inpatient and Outpatient: Observation Status and Its Impact on the Elderly*, 20 GEO. J. POVERTY L. & POL'Y 141, 144 (2012).

[28] Huberfeld, *Universality of Medicaid*, *supra* note 27, at 69; Timothy Jost, *Neither Public Nor Private: A Health-Care System Muddling Through*, ATLANTIC (May 18, 2012), https://www.theatlantic.com/health/archive/2012/05/neither-public-nor-private-a-health-care-system-muddling-through/257123/ [https://perma.cc/X442-C368]; NICOLE HUBERFELD, ELIZABETH WEEKS LEONARD & KEVIN OUTTERSON, THE LAW OF AMERICAN HEALTH CARE 1 (Wolters Kluwer eds., 2018).

Simultaneously, U.S. health policy has long recognized that rural health care is different,[29] as demonstrated by a host of special designations, reimbursement models, and subsidies that sustain rural health care providers, ensuring access to essential services for residents in those areas.[30] Moreover, the unique challenges facing rural health care delivery drive innovation and operate as laboratories for developing more efficient and effective health care delivery nationwide. Navigating the apparent divide between Schleicher's rational economic arguments and the more humanitarian responses, thus, is familiar to health law and policy scholarship. Features of the hybrid private-public approach to health care in the U.S. inform perspectives on the future of rural America and call for examining the question through a health care lens.

Following this Introduction, Part II of the Article provides a snapshot of rural demographics in the United States, with particular attention to the health care impacts of those demographics. Part III presents Schleicher's argument for facilitating migration away from dying places to places of greater economic opportunity and existing counterarguments to his thesis. Part IV makes the rural health care exceptionalism case for saving rural America. Part V concludes.

I. A PORTRAIT OF RURAL AMERICA

Demographic trends in population decline, age, educational attainment, and poverty, combined with loss of economic opportunity, challenge rural America's survival. Moreover, these trends produce an array of particular health effects for rural residents that are difficult to prevent and treat, which poses yet another set of challenges for rural health care access and sustainability.

A. Rural Demographics

What are the numbers? Is rural America really dying? According to the first U.S. census in 1790, 95 percent of the United States population lived in rural areas.[31]

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[29] *See, e.g.*, Nicole Huberfeld, *Rural Health, Universality, and Legislative Targeting*, 13 HARV. L. & POL'Y REV. 241, 242–43 (2018) [hereinafter Huberfeld, *Rural Health*]; Sheldon Weisgrau, *Issues in Rural Health: Access, Hospitals, and Reform*, 17 HEALTH CARE FIN. REV. 1 (1995); *Healthcare Access in Rural Communities*, RURAL HEALTH INFO. HUB, https://www.ruralhealthinfo.org/topics/healthcare-access [https://perma.cc/P22C-ELET] (last updated Jan. 18, 2019); Jane van Dis, *Where We Live: Health Care in Rural vs. Urban America*, 287 MED. STUDENT JAMA 108 (2002); Robin Warshaw, *Health Disparities Affect Millions in Rural U.S. Communities*, ASS'N AM. MED. COLLEGES (Oct. 31, 2017), https://www.aamc.org/news-insights/health-disparities-affect-millions-rural-us-communities [https://perma.cc/Z8FE-TWRV].

[30] *See infra* Part III.C.

[31] HOUS. ASSISTANCE COUNCIL, RURALITY IN THE UNITED STATES 1 (2011), http://www.ruralhome.org/storage/research_notes/Rural_Research_Note_Rurality_web.pdf [https://perma.cc/46JW-93J9].

By 1920, just over half of the population lived in urban areas.[32] By 1970, close to three-quarters of the population was urban.[33] The most recent 2016 census reported that just under 20 percent of the population was considered rural.[34] In sum, we have shifted from a predominantly rural to a predominantly urban country. With 97 percent of the nation's land considered rural, that means that the remaining 80 percent of the population is crowded into just 3 percent of the land in metropolitan areas.[35] "Population decline . . . is especially concentrated in the rural West."[36] In Oregon, for example, 50 percent of jobs in the state are in the three-county area in and around the Portland metropolitan area.[37]

Of course, a great deal has happened over the past two-plus centuries—immigration, migration, slavery, industrialization, infectious disease epidemics, highway construction, economic recession, the Great Depression, the rise of the administrative state, globalization—to crudely capture just a few dynamics of U.S. history affecting population trends. Moreover, the United States' urbanization trend is not unique but tracks a global pattern. World population similarly has shifted "from predominantly rural to predominantly urban."[38] As of 2012, more than half of the world's population lived in an urban area, and the trend shows no signs of abatement.[39] The shift is all but complete for developed countries and nearly complete for developing countries. Projections are for the global population to be two-thirds urban by 2050.[40]

Shifts in U.S. demographics were particularly stark over the past two decades. "Since 2010, for what appears to be the first time ever, rural America has been losing population."[41] That is, for the first time, those areas have lost *people* overall, not just

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[32] *Urban and Rural Areas*, U.S. CENSUS BUREAU https://www.census.gov/history/www/programs/geography/urban_and_rural_areas.html [https://perma.cc/ZLB3-977M] (last updated Dec. 17, 2019).

[33] U.S. DEP'T COMMERCE, UNITED STATES SUMMARY: 2010 CENSUS OF POPULATION AND HOUSING 20 (Sept. 2012), https://www.census.gov/prod/cen2010/cph-2-1.pdf [https://perma.cc/7XLX-SD5N].

[34] *New Census Data Show Differences Between Urban and Rural Populations*, U.S. CENSUS BUREAU (Dec. 8, 2016), https://www.census.gov/newsroom/press-releases/2016/cb16-210.html [https://perma.cc/Y77U-6CAR].

[35] *Id.*

[36] Alana Semuels, *The Graying of Rural America*, ATLANTIC (June 2, 2016), https://www.theatlantic.com/business/archive/2016/06/the-graying-of-rural-america/485159/ [https://perma.cc/KTE7-4TAS].

[37] *Id.*

[38] Elizabeth Nauman, Mark VanLandingham, Philip Anglewicz, Umaporn Patthavanit & Sureeporn Punpuing, *Rural-to-Urban Migration and Changes in Health Among Young Adults in Thailand*, 52 DEMOGRAPHY 233, 234 (2015).

[39] *Id.*

[40] *Id.*

[41] Justin Fox, *Rural America Is Aging and Shrinking*, BLOOMBERG (June 20, 2017), https://www.bloomberg.com/view/articles/2017-06-20/rural-america-is-aging-and-shrinking [https://perma.cc/WB5Y-H9S4].

a percentage of the population.[42] More precisely, from 2010 to 2018, 1,350 nonmetro counties in the United States lost population.[43] The only nonmetro areas experiencing population growth during that time were those with oil and natural gas reserves.[44] The rural population decline is the product of three interrelated processes: (1) natural decrease; (2) rural to urban migration; and (3) reclassification.[45] For rural America, a significant portion of the population loss is due to natural decrease—births minus deaths—as rural America ages and rural birth rates decline.[46] In a growing number of rural areas, deaths exceed births, resulting in a natural decrease.[47] Out-migration is another significant component.[48] Working-age adults (who are not dying prematurely from opioids and other causes discussed *infra*), especially those with high school or greater education, are leaving their hometowns for educational, employment, and other opportunities in urban areas. Although the number of people leaving rural areas is not as great as in other recent eras, the urban migration trend, combined with the steady natural decrease in population resulted in sub-zero growth in rural areas.[49]

A third factor is reclassification. With every decennial census, new counties are added to the list of urban areas, thus pulling rural areas in the fastest growing regions out of the classification.[50] The U.S. census defines rural as everything that is not urban.[51] But the definition varies from one census to the next and is not consistent

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[42] Lydia DePillis, *Drier than the Dust Bowl: Waiting for Relief in Rural America*, WASH. POST (July 21, 2014), https://www.washingtonpost.com/news/storyline/wp/2014/07/17/lydias-drought-narrative-tk/?noredirect=on&utm_term=.1f4a87a867ac [https://perma.cc/MT4D-MZW6].

[43] Dipak Kumar, *Rural America Is Losing Young People—Consequences and Solutions*, WHARTON PUB. POL'Y INITIATIVE (Mar. 23, 2018), https://publicpolicy.wharton.upenn.edu/live/news/2393-rural-america-is-losing-young-people- [https://perma.cc/A9YA-BGAU].

[44] HOUS. ASSISTANCE COUNCIL, *supra* note 31.

[45] Nauman et al., *supra* note 38.

[46] John Cromartie, *Rural Areas Show Overall Population Decline and Shifting Regional Patterns of Population Change*, U.S. DEP'T OF AGRIC. (Sept. 05, 2017), https://www.ers.usda.gov/amber-waves/2017/september/rural-areas-show-overall-population-decline-and-shifting-regional-patterns-of-population-change/ [https://perma.cc/ESP2-AZZ2]; Fox, *supra* note 41 (stating that deaths are outpacing births in hundreds of rural counties, including large areas of Appalachia, from Pennsylvania through northern Alabama).

[47] Cromartie, *supra* note 46.

[48] *Id.*

[49] *Id.*

[50] *Urban and Rural,* U.S. CENSUS BUREAU, https://www.census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural.html [https://perma.cc/KW2U-SJBA] (last updated Feb. 24, 2020).

[51] MICHAEL RATCLIFFE, CHARLYNN BURD, KELLY HOLDER & ALISON FIELDS, U.S. DEP'T OF COM., DEFINING RURAL AT THE U.S. CENSUS BUREAU 1 (Dec. 2016), https://www2.census.gov/geo/pdfs/reference/ua/Defining_Rural.pdf [https://perma.cc/FQ4C-JL6C].

across federal agencies.[52] Since 2000, the Census Bureau has numerically defined "urban" as those areas with 50,000 or more people, and "urban clusters" as areas with between 2,500 and 50,000 people.[53] The definition is not just a matter of numbers. Other factors, including density, land use, and distance, factor into the classification.[54] After those factors are applied to designate the urban and urban clusters, everything else is deemed "rural."[55] "Rural counties . . . closer to cities actually grew slightly from 2015" to 2016, a trend that was not evident since the Great Recession until very recently.[56] The result is that the population loss is concentrated in more remote rural counties.[57]

As the foregoing discussion flagged, the demographics of rural America also are shifting. Those who remain are elderly. Those young enough to move and gain employment are leaving rather than working and raising families in their hometowns. According to a café owner in Mitchell, Oregon (population 124, down from 130 in the 2010 census): "The young people have no chance whatsoever of making it here."—"That's why the smart ones, when they finish high school, they leave."[58] Another commentator observed that rural job markets do not appeal to young people, who want "hip" careers and lifestyles that older communities do not provide.[59] For high school graduates who do not go on to college, which is the majority, options for decent paying jobs with benefits are limited.[60]

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[52] *Id.* ("Other federal agencies and researchers may use a different definition of rural."); *see* Cromartie, *supra* note 46 (defining rural as "counties outside the commuting zones of cities of 50,000 or more"); *see also* Nauman et al., *supra* note 38 (explaining that reclassification is an administrative mechanism conferring urban status on formerly rural or "peri-urban" territory when absolute population size or population density exceeds a certain threshold); Huberfeld, *Rural Health*, *supra* note 29, at 245.

[53] RATCLIFFE ET AL., *supra* note 51, at 3.

[54] *Id.*

[55] *Id.*

[56] Tim Marema & Bill Bishop, *Rural Population Drops for Fifth Straight Year, but Other Patterns Are Changing*, DAILY YONDER (Apr. 14, 2017), https://dailyyonder.com/rural-population-drops-fifth-straight-year/2017/04/14/ [https://perma.cc/56TE-AF5S].

[57] David McGranahan & Calvin L Beale, *The Roots of Rural Population Loss*, U.S. DEP'T OF AGRIC. (Feb. 3, 2003), https://www.ers.usda.gov/amber-waves/2003/february/the-roots-of-rural-population-loss/ [https://perma.cc/KM4R-MX9E].

[58] Semuels, *supra* note 36.

[59] Melody Martinsen, *Can Rural Towns Stem the Trend of Population Decline?*, HIGH COUNTRY NEWS (Jan. 11, 2018), https://www.hcn.org/articles/the-montana-gap-can-rural-towns-stem-the-trend-of-population-decline [https://perma.cc/V7AP-DRGE].

[60] Paul C. Erwin, *Despair in the American Heartland? A Focus on Rural Health*, 107 AM. J. PUBLIC HEALTH 1533 (2017); *see, e.g.*, PATRICK CARR & MARIA KEFALAS, HOLLOWING OUT THE MIDDLE: THE RURAL BRAIN DRAIN AND WHAT IT MEANS FOR AMERICA 1, 85 (2009) (stating that high school graduates who leave Iowa do not advance far without first enlisting in the military); Alexander, *supra* note 5 (communities must adapt or die; various rejuvenation tactics like Tennessee Valley Authority and rural electrification were largely successful); *see also* Semuels, *supra* note 36 (describing a short-staffed assisted living facility where young people who are qualified, can pass a drug test, and want to work

As young people and families with children leave, those communities have fewer services and support and, accordingly, become less attractive to other residents.[61] Rather than pink houses sporting American flags, the iconic image of small-town America has become a Main Street with abandoned store fronts and social service agencies on the brink of closing.[62] Rural population decline means "fewer people working, fewer kids in school, fewer people shopping and doing the other things that contribute to the local economy."[63] As a result, rural America is graying.[64] "Roughly one-quarter of [all] seniors live in rural areas."[65] Twenty-one of the twenty-five oldest counties in the United States are rural.[66] The elderly, by contrast, generally are no longer seeking employment and are not as mobile as their younger peers. Among other reasons, rural real estate prices have dropped, meaning that elderly people cannot afford to leave because they cannot pay urban rents or mortgages, much less afford assisted living in those locations.[67]

Anecdotes tell the story of these shifting demographics. Recall Wiota, Iowa, with the mayor's two children as the only kids in town. Iowa's five smallest towns have zero children.[68] With the exception of the 1990s, Iowa's rural population declined in every census over the last 110 years.[69] By 2010, only 36 percent of Iowans remained in rural areas.[70] Shifting Westward, Teton County, Montana (population 6085, over 2293 square miles), has experienced a 20.44 percent drop in the number of children ages five to nineteen, from 1536 in 2000, to 1222 in 2016.[71] In the same county, the twenty-five to forty-four-year-old age group—the group most likely to be raising families and working—decreased 41.59 percent from 2000 to 2016.[72]

Another feature of rural America is poverty. Whether measured by per capita or median income, the poorest places in the nation are rural.[73] During the 1950s and

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with the infirm for the pay offered are hard to find, few workers are certified and the nearest training facility is 90 miles away).

[61] Munson, *supra* note 10.

[62] Martinsen, *supra* note 59.

[63] Marema & Bishop, *supra* note 56.

[64] *See* Semuels, *supra* note 36.

[65] *Id.*

[66] *Id.*

[67] *Id.*

[68] *See* Munson, *supra* note 10.

[69] Georgeanne Artz, Younjun Kim & Peter Orazem, *Can the Trend of Rural Population Decline Be Reversed?*, CARD AGRIC. POL'Y REV. (Apr. 2014), https://www.card.iastate.edu/ag_policy_review/display.aspx?id=23 [https://perma.cc/K8QH-264L].

[70] *Id.*

[71] *See* Martinsen, *supra* note 59.

[72] *Id.*

[73] Steven Conn, *Is Rural America the New Inner City?*, HUFFINGTON POST (Apr. 18, 2017), https://www.huffingtonpost.com/entry/rural-american-the-new-inner-city_us_58c5961ce4b0a797c1d39e24 [https://perma.cc/NF26-GZUG].

1960s, rural poverty rates often were twice as high as rates in urban areas.[74] The gap has narrowed over time but remains noteworthy. In 2015, 16.7 percent of the rural population was poor, compared to 13 percent in urban areas and 10.8 percent in suburban areas.[75] The rural-urban poverty rate gap also varies by region. Historically, the gap has been the greatest in the South. Between 2014 to 2018, the South's rural poverty rate was 20.5 percent, 6 percent higher than in the region's urban areas.[76]

Rural poverty is not only greater but has deeper roots than urban poverty. Rural counties comprise the vast majority (85 percent) of counties nationwide that are deemed "persistently poor."[77] Persistently poor means counties in which 20 percent or more of the population was living in poverty in three consecutive decennial censuses.[78] Fifteen percent of all nonmetro counties fall in that category.[79]

The working poor are a feature of both rural and urban poverty, but the rates are higher for rural households, with close to 10 percent of rural prime-age working households considered poor, compared to 6.8 percent in urban areas.[80] Across all age groups, nonmetro residents have higher poverty rates than their urban counterparts.[81] The rural-urban income disparity is greatest for children under age five while seniors over age sixty-five are closest in terms of poverty rates, when rural and urban residents are compared.[82] Rural poverty rates for children are higher than urban areas for every racial and ethnic group.[83] In sum, rural poverty runs deep and long.

Small towns are challenged by myriad of shifts in employment and economic development. Rural America was once the nation's breadbasket. Farming is just one of the industries in rural America that has changed dramatically over the past fifty years. In 1900, 40 percent of the nation's population worked in agriculture, compared to only 2 percent by 2000.[84] In particular, rural family farms are disappearing. In 1964, America had 3.5 million separate farms, compared with just

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[74] Brian Thiede, Lillie Greiman, Stephan Weiler, Steven Beda & Tessa Conroy, *6 Charts that Illustrate the Divide Between Rural and Urban America*, PBS (Mar. 17, 2017), https://www.pbs.org/newshour/nation/six-charts-illustrate-divide-rural-urban-america [https://perma.cc/K3JC-4UHW].

[75] *Id.*

[76] *Rural Poverty & Well-Being*, U.S. DEP'T OF AGRIC., https://www.ers.usda.gov/topics/rural-economy-population/rural-poverty-well-being/ [https://perma.cc/B6PN-FKME] (last updated Aug. 20, 2019).

[77] *Id.*

[78] *Id.*

[79] *Id.*

[80] *See* Thiede et al., *supra* note 74.

[81] *See Rural Poverty & Well-Being*, *supra* note 76.

[82] *Id.*

[83] KENNETH JOHNSON, DEMOGRAPHIC TRENDS IN RURAL AND SMALL TOWN AMERICA 1, 29 (2006), https://scholars.unh.edu/cgi/viewcontent.cgi?article=1004&context=carsey [https://perma.cc/8WXN-LD67].

[84] *See* Semuels, *supra* note 36.

2.1 million in 2013, as automation and consolidation decreased the need for labor.[85] The Pointon family of Las Animas, Colorado, provides one example: As young adults, the couple left for Denver, seeking employment and excitement of urban life.[86] Eventually, they were drawn back home by the familiar and their desire to tend the family farm, only to scrape by amid drought and other challenges.[87] Now, decades later, they remain mostly because they cannot afford to move elsewhere.[88]

Similarly, rural areas that historically relied on logging, mining, or other resource-extraction industries saw the wealth that they generated leave, and it does not seem to be coming back.[89] Especially in the West, shifting management of federal lands also changes the mix of jobs available. The federal government owns 53 percent of land in Oregon and "has reduced the amount of timber harvesting and grazing allowed . . . in the past few decades."[90] At the same time, "fewer other opportunities materialize to replace the jobs the machines take."[91] The dynamics are interrelated: With the population shifts described above, essential services may not be sustainable in small towns. Without essential services, manufacturing facilities or other potential employers are less likely to locate in rural areas.[92] Rural America's slower paced, more affordable lifestyle and natural resource recreation opportunities may make them attractive retirement communities, but, again, not without a hospital or other essential services.[93] Adding insult to injury, rural America has never recovered from the 2007–2009 recession, with the rural job market 4.26% smaller

[85] *See* DePillis, *supra* note 42.

[86] *Id.*

[87] *Id.*

[88] *Id*.

[89] *See* Conn, *supra* note 73; Ann M. Eisenberg, *Rural Blight*, 13 HARV. L. & POL'Y REV. 187, 208 (2018); Sidney D. Watson, *Mending the Fabric of Small Town America: Health Reform & Rural Economies*, 113 W. VA. L. REV. 1, 10 (2010).

[90] *See* Semuels, *supra* note 36.

[91] *Id.*

[92] *See, e.g.*, Lauren Weber & Andy Miller, *A Hospital Crisis Is Killing Rural Communities. This State Is "Ground Zero,"* GA. HEALTH NEWS (Sept. 22, 2017), http://www.georgiahealthnews.com/2017/09/hospital-crisis-killing-rural-communities-state-ground-zero/ [https://perma.cc/WL64-HTXD] (Candler County, Georgia "got a financial boost when Linzer Products Corporation opened up a paint manufacturing and distribution center in Metter [the county seat] last year, creating 200 jobs. It would be a lot harder to attract that kind of new business without a hospital, [Carvy] Snell [publisher of the city's 104-year-old local newspaper] said.").

[93] *See, e.g.*, Blake Farmer, *Economic Ripples: Hospital Closure Hurts a Town's Ability to Attract Retirees*, NPR (Apr. 7, 2019), https://www.kcur.org/post/economic-ripples-hospital-closure-hurts-towns-ability-attract-retirees#stream/0 [https://perma.cc/BJH8-27Y2].

in 2017, compared to 2008.[94] By contrast, urban job growth steadily increased until the onset of the 2020 COVID-19 job crisis.[95]

B. Rural Health Impacts

Those rural demographics—aging, poverty, outmigration, and lack of economic opportunity—produce a particular constellation of health impacts for rural America. Such impacts are illustrated in the devastating effect of the coronavirus (COVID-19) on rural areas. Rural demographics, combined with a dearth of local healthcare resources, likely facilitated COVID-19's rapid spread and high death rates among rural populations.[96] A study by David Peters, a professor of rural sociology, found that rural demographics and limited resources made one third of all rural counties in the United States highly susceptible to COVID-19.[97] In Albany, Georgia, for example, the local hospital lacked basic equipment and personnel to adequately respond to COVID-19's rapid spread in the small town.[98] Within just seven days, Albany's local hospital used up its six-month stockpile of personal protective equipment and was so low on staff that staff who were COVID-positive, but without symptoms, were asked to work.[99] Rural areas across the nation faced similar challenges, as they tend to have a higher percentage of the aging population and uninsured persons than urban areas.[100] Rural regions also tend to have more

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[94] *See* Thiede et al., *supra* note 74; *see also* John Casey, *With a Shortage of Manufacturing Jobs, Citizens of Rural Areas Aren't Benefiting from Economic Growth*, TENNESSEAN (July 10, 2019), https://www.tennessean.com/story/opinion/2019/07/10/rural-communities-suffer-while-urban-areas-flourish/1630703001/ [https://perma.cc/WC93-JQGB].

[95] *See* Thiede et al., *supra* note 74; *see, e.g.*, Chuck Jones, *One Chart Shows Coronavirus' Stunning Job Losses*, FORBES (Apr. 18, 2020), https://www.forbes.com/sites/chuckjones/2020/04/18/one-chart-shows-coronavirus-stunning-job-losses/#60150e387fb0 [https://perma.cc/RHW9-997R].

[96] Sari Boren, *Rural Health Care and COVID-19: A Research Roundup*, JOURNALIST'S RES. (June 10, 2020), https://journalistsresource.org/studies/government/health-care/rural-health-care-covid-19-research/ [https://perma.cc/99T4-YNXT]; *COVID-19 in Metropolitan and Non-Metropolitan Counties*, KFF (May 21, 2020), https://www.kff.org/slideshow/covid-19-in-metropolitan-and-non-metropolitan-counties/ [https://perma.cc/828R-H3HN]; David J. Peters, *Rural America Is More Vulnerable to COVID-19 than Cities Are, and It's Starting to Show*, CONVERSATION (Jun. 19, 2020, 3:16 PM), https://theconversation.com/rural-america-is-more-vulnerable-to-covid-19-than-cities-are-and-its-starting-to-show-140532 [https://perma.cc/KYM6-HZAB].

[97] Peters, *supra* note 96; *see also* Ian F. Miller, Alexander D. Becker, Bryan T. Grenfell & C. Jessica E. Metcalf, *Disease and Healthcare Burden of COVID-19 in the United States*, NATURE MED. (June 16, 2020), https://www.nature.com/articles/s41591-020-0952-y [https://perma.cc/ADG3-NQW8].

[98] Ellen Barry, *Days After a Funeral in a Georgia Town, Coronavirus 'Hit Like a Bomb,'* N.Y. TIMES (Mar. 30, 2020), https://www.nytimes.com/2020/03/30/us/coronavirus-funeral-albany-georgia.html [https://perma.cc/2AGU-J63A].

[99] *Id.*

[100] Peters, *supra* note 96.

group facilities such as plants, prisons, and nursing homes, where COVID-19 could easily spread among large groups of people.[101] In sum, rural America's unique demographics and healthcare systems made it uniquely susceptible to COVID-19 outbreaks and poorly equipped to respond adequately when outbreaks did occur.

Rural-to-urban health disparities are well documented, with a recent study from the U.S. Centers for Disease Control and Prevention (CDC) revealing that rural Americans are more likely than their urban counterparts to die from five leading, potentially preventable, causes including heart disease, stroke, chronic lower respiratory disease, cancer, and unintentional injury.[102] According to the CDC, drug overdose is the leading cause of unintentional injury death in the United States, and despite the higher percentage of reported illicit drug use in urban areas, drug overdose rates in rural areas have surpassed those of urban areas.[103] In fact, rural areas experience higher age-adjusted death rates and higher numbers of potentially excess deaths from all five leading causes of death, compared to urban areas.[104] Those results suggest a public health policy prescription for rural communities focused on smoking cessation, diet and exercise, screening and early detection, motor vehicle safety, and opioid prescribing and addiction recovery. To be sure, improving access to health care, including both routine and emergency care, also needs to be addressed.[105]

The CDC report somewhat echoes the headline-grabbing findings in Anne Case and Angus Deaton's 2015 "deaths of despair" study. They reported that since the 1990s, midlife mortality rates in the United States have been declining among all education classes.[106] Case and Deaton's surprising finding was a notable exception

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[101] Peters, *supra* note 96; Boren, *supra* note 96.

[102] *Leading Causes of Death in Rural America*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/ruralhealth/cause-of-death.html [https://perma.cc/4G55-PF4U] (last visited Oct. 22, 2020).

[103] *Drug Overdose in Rural America,* CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/ruralhealth/drug-overdose/index.html [https://perma.cc/W8KJ-X359] (last visited Apr. 12, 2021).

[104] Ernest Moy, Macarena C. Garcia, Brigham Bastian, Lauren M. Rossen, Deborah D. Ingram, Mark Faul, Greta M. Massetti, Cheryll C. Thomas, Yuling Hong, Paula W. Yoon & Michael F. Iademarco, *Leading Causes of Death in Nonmetropolitan and Metropolitan Areas—United States, 1999–2014*, 66 MORBIDITY & MORTALITY WKLY. REP. 1, 3 (2017).

[105] Macarena C. Garcia, Mark Faul, Greta Massetti, Cheryll C. Thomas, Yuling Hong, Ursula E. Bauer & Michael F. Iademarco, *Reducing Potentially Excess Deaths from the Five Leading Causes of Death in the Rural United States*, 66 MORBIDITY & MORTALITY WKLY. REP. SURVEILLANCE SUMMARIES 1, 1 (2017); *see also* Di Zeng, Wen You, Bradford Mills, Jeffrey Alwang, Michael Royster & Rexford Anson-Dwamena, *A Closer Look at the Rural-Urban Health Disparities: Insights from Four Major Diseases in the Commonwealth of Virginia,* 140 SOC. SCI. & MED. 62, 63 (2015); Warshaw, *supra* note 29; *Rural Health Disparities*, RURAL HEALTH INFO. HUB, https://www.ruralhealthinfo.org/topics/rural-health-disparities [https://perma.cc/5RX8-W3R7] (last visited Oct. 22, 2020).

[106] Anne Case & Angus Deaton, *Mortality and Morbidity in the 21st Century*, 2017 BROOKINGS PAPERS ON ECON. ACTIVITY 397, 415 fig. 10 [hereinafter Case & Deaton, *Mortality and Morbidity*].

to that trend: Middle-aged, non-Hispanic, whites in the United States with a high school diploma or less experienced *increasing* mortality rates.[107] The disparity was especially pronounced for residents living in the South and West, where many rural communities lie.[108] Case and Deaton, both Princeton economists, noted increased deaths particularly from drug and alcohol poisonings, suicide, chronic liver diseases, and cirrhosis.[109] Thus, they suggested that the increasing mortality could be attributed to reduced economic opportunity, leading to hopelessness and family dysfunction, leading to substance abuse, addiction, and mental health problems. The researchers coined the term "deaths of despair" to describe the patterns and findings among these middle-aged non-Hispanic, lower-educated whites.[110]

The deaths of despair narrative is especially apt for rural America. It suggests that white rural residents are doing worse than the generation before them and losing their foothold in the iconic American Heartland.[111] Case and Deaton's study is controversial and subject to criticism for overemphasizing mortality rates among whites.[112] To be sure, blacks have long suffered disproportionate rates of premature death from all causes,[113] a statistic that gets lost in Case and Deaton's story that emphasizes a relatively recent pattern among middle-aged whites. As a result, policy priorities may be misdirected to that identified subpopulation and away from longer-standing, intractable disparities.

The critiques notwithstanding, the deaths of despair narrative, combined with insights from the CDC study, portray a rural population suffering from unemployment and lack of economic opportunity; increasingly sedentary lifestyles; addictions to food, alcohol, tobacco, and drugs; mental illness; and self-inflicted injury, including overdose and suicide. At the same time that rural America is suffering various health disparities, it also is suffering across the board due to lack of access to emergency, routine, preventive, and specialty health care.

Since the Patient Protection and Affordable Care Act took effect in 2010, thirty states have seen at least one rural hospital close, with a total of 113 hospitals having closed as of August 2019.[114] Twenty hospitals closed in Texas, twelve in Tennessee,

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[107] 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. U.S. 15078, 15079 (2015) [hereinafter Case & Deaton, *Rising Morbidity and Mortality*].

[108] *Id.* at 15080.

[109] *Id.* at 15078.

[110] Case & Deaton, *Mortality and Morbidity*, *supra* note 106, at 398.

[111] Case & Deaton, *Rising Morbidity and Mortality*, *supra* note 107, at 15081; Case & Deaton, *Mortality and Morbidity*, *supra* note 106, at 429.

[112] *See, e.g.*, Malcolm Harris, *The Death of the White Working Class Has Been Greatly Exaggerated*, PAC. STANDARD (Mar. 28, 2017), https://psmag.com/news/the-death-of-the-white-working-class-has-been-greatly-exaggerated [https://perma.cc/NNM9-KTKG].

[113] Jeanine M. Buchanich, Shannon M. Doerfler, Michael F. Lann, Gary M. Marsh & Donald S. Burke, *Improvement in Racial Disparities in Years of Life Lost in the USA Since 1990*, 13 PLOS ONE 1, 2 (2018).

[114] Ayla Ellison, *State-by-State Breakdown of 113 Rural Hospital Closures*, BECKER'S HOSP. CFO REP. (Aug. 26, 2019), https://www.beckershospitalreview.com/finance/state-by-

and seven each in Georgia and Oklahoma.[115] Those closures were concentrated in the South and states that declined to expand Medicaid after the U.S. Supreme Court's decision in *NFIB v. Sebelius*.[116] As just one effect of rural hospital closures, women who experience complications during deliveries may face drastically adverse outcomes from conditions that could have been effectively managed in an urban medical center.[117] In addition, as hospitals close, rural communities often lose their major employers,[118] as well as the ability to attract other employers and economic development opportunities.[119]

Although Medicaid opt-out decisions partially explain the access to care challenges in rural America, the reliance on government payors is a long-standing challenge. With the rural patient population predominately elderly, poor, and unemployed,[120] rural health care providers' patient rolls typically include a significant number of government health care program beneficiaries. Medicare, which is tied to Social Security and operates similarly to a federal retirement benefit, covers the elderly, disabled, and those with end-stage renal disease (ESRD, or kidney failure) and amyotrophic lateral sclerosis (ALS, or Lou Gehrig's disease)

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state-breakdown-of-113-rural-hospital-closures-082619.html [https://perma.cc/SE7U-6AW6].

[115] *Id.*

[116] Diane Archer, *453 Rural Hospitals Are Failing—Medicare for All Would Save Them*, THE HILL (Mar. 11, 2020, 1:30 PM), https://thehill.com/blogs/congress-blog/healthcare/487026-453-rural-hospitals-are-failing-medicare-for-all-would-save [https://perma.cc/EN43-D9GD].

[117] 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/G58R-6LAX]; Jack Healy, *It's 4 A.M. The Baby's Coming. But the Hospital Is 100 Miles Away.*, N.Y. TIMES (July 17, 2018), https://www.nytimes.com/2018/07/17/us/hospital-closing-missouri-pregnant.html?emc=edit_th_180717&nl=todaysheadlines&nlid=334258010717 [https://perma.cc/XQ7P-6B2Z].

[118] *Rural Hospitals: The Beating Heart of a Local Economy*, NAT'L RURAL HEALTH ASS'N (June 18, 2018), https://www.ruralhealthweb.org/blogs/ruralhealthvoices/july-2018/rural-hospitals-the-beating-heart-of-a-local-econ [https://perma.cc/3AC6-JNFQ]; Thomas C. Rickets III & Paige R. Heaphy, *Hospitals in Rural America*, 173 CULTURE & MED. 418, 419 (2000) ("Rural hospitals are often the largest or second largest employer in the towns where they are located, and they are an important part of the social capital of any community.").

[119] Jane Wishner, Patricia Solleveld, Robin Rudoqitz, Julia Paradise & Larisa Antonisse, *A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies*, KAISER FAM. FOUND. (July 2016), https://www.kff.org/report-section/a-look-at-rural-hospital-closures-and-implications-for-access-to-care-three-case-studies-issue-brief/ [https://perma.cc/B6UR-GCSX].

[120] Sheldon Weisgrau, *Issues in Rural Health: Access, Hospitals, and Reform*, 17 HEALTH CARE FIN. REV. 1, 1 (1995).

regardless of income.[121] Medicaid provides medical insurance coverage for low-income individuals; it is explicitly the government's indigent care program.[122] Medicaid eligibility rules vary by state, and some require indigency plus another qualifying condition such as age, disability, pregnancy, or dependent-care responsibilities.[123] Rural residents, not surprisingly, quite often fall into one or more of those categories, thus becoming eligible for Medicare and/or Medicaid.[124] About twelve million people qualify for both programs,[125] and the percentage of dually eligible Medicare recipients is higher for rural residents.[126]

For rural health care providers, that means a payor-mix dominated by government health care programs, which typically pay lower rates than private insurers. In 2017, 56 percent of rural hospitals' revenue came from Medicare and Medicaid.[127] Twenty-three percent of Medicare beneficiaries live in rural areas, and rural primary care physicians are more likely to accept Medicare patients, compared to urban providers (81 percent rural, compared to 72 percent urban).[128] Medicaid covers 40 percent of nationwide long-term care (nursing home) costs, and significant numbers of nursing home beds are in rural areas.[129] That dependence makes rural

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[121] *Who Is Eligible for Medicare?*, U.S. DEP'T OF HEALTH & HUM. SERV., https://www.hhs.gov/answers/medicare-and-medicaid/who-is-elibible-for-medicare/index.html [https://perma.cc/3MFS-FEAJ] (last updated Sept. 11, 2014).

[122] *Eligibility*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/eligibility/index.html [https://perma.cc/4VHT-Q68S] (last visited Oct. 22, 2020).

[123] *Id.*

[124] *How Medicaid Work Requirements Will Harm Rural Residents and Communities*, CTR. ON BUDGET & POL'Y PRIORITIES, https://www.cbpp.org/research/health/how-medicaid-work-requirements-will-harm-rural-residents-and-communities [https://perma.cc/JG3J-AE3J] (last updated Mar. 14, 2019).

[125] *Seniors & Medicare and Medicaid Enrollees*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/eligibility/seniors-medicare-and-medicaid-enrollees/index.html#:~:text=In%20total%2C%2012%20million%20people,both%20optional%20and%20mandatory%20categories [https://perma.cc/U3AN-HYVW] (last visited Oct. 22, 2020).

[126] Kevin J. Bennett, Ashley S. Robertson & Janice C. Probst, *Characteristics, Utilization Patterns, and Expenditures of Rural Dual Eligible Medicare Beneficiaries*, S.C. RURAL HEALTH RES. CTR. 1 (Nov. 2014), https://sc.edu/study/colleges_schools/public_health/research/research_centers/sc_rural_health_research_center/documents/133characteristicsutilizationpatterns2014.pdf [https://perma.cc/YT2E-UDGC].

[127] AM. HOSP. ASS'N, RURAL REPORT 1, 4 (2019), https://www.aha.org/system/files/2019-02/rural-report-2019.pdf [https://perma.cc/SQ4Q-9VC8].

[128] MICHAEL E. GLUCK & KRISTINA W. HANSON, THE HENRY J. KAISER FAMILY FOUND., MEDICARE CHART BOOK 1, 13 (2d ed. 2001); Cristina Boccuti, *Primary Care Physicians Accepting Medicare: A Snapshot*, KFF (Oct. 30, 2015), https://www.kff.org/medicare/issue-brief/primary-care-physicians-accepting-medicare-a-snapshot/ [https://perma.cc/6P43-E59L].

[129] Anna Gorman, *Medicaid Safety Net Stretched to Pay for Seniors' Long-Term Care*, NPR (Aug. 3, 2016, 9:01 AM), https://www.npr.org/sections/health-shots/2016/08/03/488385286/medicaid-safety-net-stretched-to-pay-for-seniors-long-term-care [https://perma.cc/

providers especially vulnerable to policy changes around payment under those programs.[130] Moreover, as a general matter, Medicare reimbursement rates are significantly lower than private insurance reimbursement rates, and Medicaid reimbursement is even lower. Medicare pays around 80 percent of private rates.[131] Medicaid pays about 56 percent of private rates.[132]

Urban hospitals often are able to make up the difference from lower government health care program reimbursement through cost-shifting—charging higher rates to commercially insured patients (and, in some cases, uninsured but affluent self-pay patients who can pay list prices out of pocket).[133] Rural areas consistently have a higher percentage of uninsured residents, who decidedly are not in a position to self-pay for their health care. Among the population under age 65, 19 percent of rural residents are uninsured, compared to 16 percent of urban residents.[134] Moreover, rural residents have been uninsured for longer periods of time, with over one-third of rural residents uninsured for more than three years, compared to about one-quarter of urban residents uninsured for that duration.[135] Again, add to the picture the fact that rural patients tend to be older, sicker, and poorer,[136] thus often in greater need of health care services.

Historically, both Medicare and Medicaid have provided add-on payments to hospitals that serve a disproportionate share of government-insured and uninsured patients in order to address the reimbursement shortfall and the expectation that such

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U9PJ-DY7U]; Lisa C. Dubay, *Comparison of Rural and Urban Skilled Nursing Facility Benefit Use*, 14 HEALTH CARE FIN. REV. 25, 25 (1993) (noting that rural areas have a higher number of rural nursing beds per population than urban areas).

[130] Alex Kacik, *Rural Nursing Homes Face Closure as Occupancy Wanes*, MOD. HEALTHCARE (Mar. 14, 2019, 4:21 PM), https://www.modernhealthcare.com/operations/rural-nursing-homes-face-closure-occupancy-wanes [https://perma.cc/8TSE-L9CS].

[131] Trudy M. Krause, Maria Ulkhanova & Frances L. Revere, *Private Carriers' Physician Payment Rates Compared with Medicare and Medicaid*, 112 TEX. MED. e1 (2016), https://www.texmed.org/June16Journal/ [https://perma.cc/5EGR-AGHN]; Tami Luhby, *Medicare vs. Private Insurance: Which Costs Less*, CNN (Apr. 21, 2014, 8:19 AM), http://money.cnn.com/2014/04/21/news/economy/medicare-doctors/index.html [https://perma.cc/7ACJ-FD4K]; Mark E. Miller, Stephen Zuckerman & Michael Gates, *How Do Medicare Physician Fees Compare with Private Payers?*, 14 HEALTH CARE FIN. REV. 25, 25 (1993).

[132] Merrill Matthews, *Doctors Face a Huge Medicare and Medicaid Pay Cut in 2015*, FORBES (Jan. 5, 2015, 9:50 AM), https://www.forbes.com/sites/merrillmatthews/2015/01/05/doctors-face-a-huge-medicare-and-medicaid-pay-cut-in-2015/#69a0a4bc3173 [https://perma.cc/69CY-2H9V].

[133] Leyla Norman, *What Is Cost Shifting?*, CHRON, https://smallbusiness.chron.com/cost-shifting-23849.html [https://perma.cc/36AK-APPJ] (last visited Oct. 22, 2020).

[134] Lee Shirley & Laura Summer, *Rural and Urban Health*, GEO. UNIV. HEALTH POL'Y INST. (Jan. 2003), https://hpi.georgetown.edu/rural/ [https://perma.cc/SAH5-ZCPE].

[135] *Id.*

[136] AM. HOSP. ASS'N, *supra* note 127, at 5.

patients tend to be sicker and harder to treat.[137] The "disproportionate share hospital," or DSH, adjustment,[138] however, has tended to benefit urban hospitals to a much greater degree than rural hospitals.[139] Moreover, the Patient Protection and Affordable Care Act of 2010 (ACA) drastically cut Medicaid DSH payments,[140] with the idea that under that statute's near-universal coverage design, hospitals would treat significantly fewer un- and under-insured patients and, thus, would not need the supplemental payments.[141] That promise was not entirely realized for a variety of reasons, including several states' decisions not to expand Medicaid and other failures to reduce rates of uninsured in ACA implementation.[142]

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[137] Craig Caplan, *FYI: Medicare's Disproportionate Share Hospital Payments*, AARP (Aug. 1998), https://www.aarp.org/health/medicare-insurance/info-1998/aresearch-import-694-FYI.html [https://perma.cc/E7SP-3N92].

[138] 42 U.S.C. § 1396r-4.

[139] Janet P. Sutton, Jeffrey Stensland, Lan Zhao & Michael Cheng, *Achieving Equity in Medicare Disproportionate Share Payments to Rural Hospitals: An Assessment of the Financial Impact of Recent and Proposed Changes to the Disproportionate Share Hospital Payment Formula*, 18 J. RURAL HEALTH 494, 495 (2002). Eligibility to receive DSH payments depends on whether the provider meets a designated threshold of low-income patients, termed the disproportionate patient percentage (DPP), and the magnitude of DSH payments is structured as a percentage add-on to the diagnosis related group (DRG) amount. However, most rural hospitals must meet a higher threshold than urban hospitals to qualify for the DSH program, and they receive a lower fixed percentage add-on than urban hospitals of the same size and with a comparable DPP. For example, a 200-bed urban hospital with a DPP of 40 percent is eligible for an adjustment to the DRG amount of 22.2 percent, compared with only 5.25 percent if the hospital was located in a rural area. As a result, in 1997 approximately 50 percent of urban hospitals qualified for DSH payments compared with only 20 percent of rural hospitals, and 96 percent of aggregate DSH payments went to urban hospitals. The rationale for the initial differential treatment afforded to rural and urban hospitals was based on analyses conducted by the Congressional Budget Office and the Prospective Payment Assessment Commission, which showed that the relationship between low-income share and Medicare costs was only statistically significant for large urban hospitals with very large low-income shares. *Id*. at 495–96.

[140] *Hospitals Will See $4B DSH Payment Cut in 2020 Under CMS Rule*, ADVISORY BOARD (Sept. 25, 2019), https://www.advisory.com/daily-briefing/2019/09/25/dsh [https://perma.cc/JZF5-APRM].

[141] Michael Brady & Jessica K. Cohen, *DSH Fund Cuts Face Difficult Fight from Hospitals*, MOD. HEALTHCARE (Sept. 24, 2019, 4:42 PM), https://www.modernhealthcare.com/politics-policy/dsh-fund-cuts-face-difficult-fight-hospitals [https://perma.cc/R8N7-KK27] ("'The Affordable Care Act reduced payments to the Medicaid DSH program under the assumption that uncompensated-care costs would decrease as healthcare coverage increased,' the February letter [from various hospital organizations to Congress] read. 'Unfortunately, the coverage rates envisioned under the ACA have not been fully realized, and tens of millions of Americans remain uninsured.'").

[142] Susan Morse, *Hospitals Are Fighting DSH Payment Cuts*, HEALTHCARE FIN. (Sept. 26, 2019), https://www.healthcarefinancenews.com/news/hospitals-are-fighting-dsh-payment-cuts [https://perma.cc/MW7P-3CBT]; Sara Rosenbaum, *Keep Harmful Cuts in Federal Medicaid Disproportionate Share Hospital Payments at Bay*, COMMONWEALTH

Demographics, reimbursement, and other challenges result in a shortage of physicians in rural areas. One-fifth of Americans live in rural areas, but only one-tenth of physicians practice there.[143] "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."[144] Newly minted physicians, often saddled with considerable student loan debts, generally choose higher paying, more prestigious specialty practices, rather than small-town general practitioner posts. Various medical school scholarship and loan forgiveness programs seek to attract graduates to practice in rural and other underserved areas.[145] Some medical schools require rural health rotations or offer rural health electives to draw interest to those practice areas.[146] The federal government largely subsidizes graduate medical education residency programs through Medicare reimbursements to teaching hospitals.[147] In 1997, Congress capped federal funding for residency programs at 1996 levels, and that amount has not been increased.[148] Accordingly, there is fierce competition for high-demand specialty placements and little support for new placements in internal medicine, family practice, or similar specialties.[149]

A rather dated, but still apt, 1986 study suggested that one reason rural communities are failing to attract medical students is because of lack of facilities.[150] The study revealed the same vicious cycle later described in Weber, Marre, Fisher,

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FUND (Dec. 19, 2017), https://www.commonwealthfund.org/blog/2017/keep-harmful-cuts-federal-medicaid-disproportionate-share-hospital-payments-bay [https://perma.cc/YK7Q-3UV2]; Edith D. Gurewitsch Allen & Mark J. Bittle, *Linking Medicaid Expansion and Cuts to Disproportionate-Share Hospitals: Will Safety Nets Survive?*, 126 OBSTETRICS & GYNECOLOGY 442, 442–43 (2015).

[143] Olga Khazan, *Why Are There So Few Doctors in Rural America*, ATLANTIC (Aug. 28, 2014), https://www.theatlantic.com/health/archive/2014/08/why-wont-doctors-move-to-rural-america/379291/ [https://perma.cc/4J4H-6M5L].

[144] *About Rural Health Care*, NAT'L RURAL HEALTH ASS'N, https://www.ruralhealthweb.org/about-nrha/about-rural-health-care [https://perma.cc/V7HB-53JS] (last visited Oct. 22, 2020).

[145] *Scholarships, Loans, and Loan Repayment for Rural Health Professions*, RURAL HEALTH INFO. HUB, https://www.ruralhealthinfo.org/topics/scholarships-loans-loan-repayment [https://perma.cc/V9XR-UTJM] (last visited Oct. 22, 2020).

[146] *See, e.g.*, *Rural Rotation*, U. NEV. RENO SCH. OF MED., https://med.unr.edu/ome/curriculum/structure/rural-rotation [https://perma.cc/C6MH-N3PS] (last visited Oct. 22, 2020).

[147] Bobby Jindal, *Medicare's Role in Financing Graduate Medical Education*, 281 J. AM. MED. ASS'N 1228, 1228 (1999).

[148] Univ. Cal. Health, *Residency Cap Limits the Supply of Physicians* (Jan. 2020), https://www.ucop.edu/federal-governmental-relations//_files/fact-sheets/fgr-health-fact sheet-gme-f1.pdf [https://perma.cc/W376-RUHW].

[149] Joey Peters, *How Foreign-Trained Doctors Are Filling the Health Care Gap in Greater Minnesota*, MINNPOST (Dec. 19, 2017), https://www.minnpost.com/new-americans-greater-minnesota/2017/12/how-foreign-trained-doctors-are-filling-health-care-gap-grea [https://perma.cc/E2BG-RS9W].

[150] S. Akbar Zaidi, *Why Medical Students Will Not Practice in Rural Areas: Evidence from a Survey*, 22 SOC. SCI. & MED 527, 528 (1986).

Gibbs, and Cromartie's 2007 study assessing the human capital theory.[151] The study suggests that migration from rural to urban areas is a significant obstacle in improving the economic well-being of individuals and places in rural areas.[152] As an individual becomes more educated in order to improve her economic well-being, she is more likely to move to an area that has an industry that can accommodate her new level of education.[153] This migration steadily decreases the education level of the rural area as more newly educated individuals migrate out of the area. New industries, on the other hand, require a threshold level of education; a new business is unlikely to be attracted to rural areas, thereby, creating a vicious cycle where an educated person leaves because there are no opportunities and a new industry does not move into the area because there are no educated people to work for it.[154] In terms of medical providers, for instance, newly-minted physicians are deterred from returning to their small towns because of lack of facilities,[155] and hospitals are unlikely to invest in infrastructure in areas that do not appeal to physicians.

Attempts to address the rural physician shortage include state legislation subsidizing medical malpractice insurance for rural medical practitioners,[156] and reliance on foreign-trained or licensed professionals.[157] Given the cap on federal funding for new residencies, some states, such as Minnesota, have attempted to fill the gap by attracting internationally trained physicians to rural locales.[158] The recent federal immigration ban, however, could severely limit this potential lifeline for

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[151] Bruce Weber, Alexander Marre, Monica Fisher, Robert Gibbs & John Cromartie, *Education's Effect on Poverty: The Role of Migration*, 29 REV. AGRIC. ECON. 437 (2007).

[152] *Id.* at 437.

[153] *Id.* at 442–43.

[154] *Id.* at 437.

[155] Zaidi, *supra* note 150, at 528.

[156] *Rural Medical Practitioners Insurance Subsidy Program*, OR. OFF. OF RURAL HEALTH, https://www.ohsu.edu/oregon-office-of-rural-health/rural-medical-practitioners-insurance-subsidy-program [https://perma.cc/V2MX-8NRK] (last visited Oct. 22, 2020); *see also* Laura Harker, *Legislation Proposes Steps to Improve Rural Health Care, Omits Major Coverage Solution*, GA. BUDGET & POL'Y INST. (Mar. 12, 2018), https://gbpi.org/2018/legislation-improves-rural-health-care-omits-coverage-solution/ [https://perma.cc/3EQV-9T2M].

[157] *Foreign-Trained Doctors Are Critical to Serving Many U.S. Communities*, AM. IMMIGR. COUNCIL (Jan. 17, 2018), https://americanimmigrationcouncil.org/research/foreign-trained-doctors-are-critical-serving-many-us-communities [https://perma.cc/KCP4-87YM]; Peters, *supra* note 149; John Henning Schumann, *Let's Hope that Match Day Brings Us Lots of Foreign-Born Doctors*, NPR (Mar. 17, 2017, 11:18 AM ET), https://www.npr.org/sections/health-shots/2017/03/17/520407789/lets-hope-that-match-day-brings-us-lots-of-foreign-born-doctors [https://perma.cc/RJ2K-XK4J].

[158] Elizabeth Baier, *Foreign-Trained Doctors Could Soon Have Easier Path in MN*, MPRNEWS (Feb. 27, 2015, 10:00 AM), https://www.mprnews.org/story/2015/02/27/foreign-trained-doctors [https://perma.cc/KF95-M5KF].

rural communities.[159] Rural xenophobia also could impede recruitment efforts,[160] if foreign doctors find the communities less than welcoming.

Other rural communities rely on traveling physicians, "midlevel" providers, and telemedicine to address the staffing shortfall. The traveling physician, or *locum tenens*, model began in the 1970s, with a federal grant to the University of Utah to provide physician staffing to medically underserved communities in the West.[161] The model proved so successful that it quickly spread to other regions of the country and other levels of providers.[162] Essentially, "temp" doctors fill health care employer shortages created by vacancies, sabbaticals, illnesses, or other needs.[163] Traveling physicians find the flexibility and opportunity to travel attractive.[164] Moreover, competition may be fierce for jobs in their chosen specialties in urban markets. Thus, rural *locum tenens* positions may be a way to gain experience that will make them more competitive upon return.[165] For rural communities, *locum tenens* may not be a long-term, stable solution, but the strategy can help temporarily plug gaps, relieve overworked or burned-out providers, or fill vacancies more quickly and cheaply. Another option is relying more heavily on midlevel providers, or so-called physician extenders, including nurses, to perform a wider range of services.[166] Again, that is assuming that working age adults with training and skills remain living in rural areas. Even where midlevel providers are available, they may not be licensed under state law to provide a full range of services.[167]

The bottom line is that rural American demographic and economic shifts have produced a particular constellation of health conditions for rural residents. At the same time, access to care in rural America has been and continues to be very challenging, made worse by certain unintended consequences of the ACA. One response might be to shutter not only rural health care facilities, as already is happening, but rural communities themselves, as the next Part discusses. In Part IV,

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[159] Miriam Jordan, *Rural Areas Brace for a Shortage of Doctors Due to Visa Policy*, N.Y. TIMES (Mar. 18, 2017), https://www.nytimes.com/2017/03/18/us/doctor-shortage-visa-policy.html [https://perma.cc/G8ZR-QP6Z].

[160] *See* Fox, *supra* note 41.

[161] *About Locum Tenens Physician Staffing*, LOCUMTENENS.COM, https://www.locumtenens.com/about-us/what-we-do/what-is-locum-tenens/ [https://perma.cc/7RHA-KWTZ] (last visited Oct. 22, 2020).

[162] *Id.*

[163] *Id.*

[164] *Id.*

[165] Barton Team, *Are Locum Tenens Providers the Answer for Ailing Rural Medical Facilities?*, BARTON ASSOCS. (June 15, 2017), https://www.bartonassociates.com/blog/are-locum-tenens-providers-the-answer-for-ailing-rural-medical-facilities/ [https://perma.cc/U3FC-ZYC5].

[166] Roxanne Nelson, *Will Rural Community Hospitals Survive*, 117 AJN REPORTS 18, 19 (2017).

[167] *Meeting the Primary Care Needs of Rural America: Examining the Role of Non-Physician Providers*, NAT'L CONF. OF STATE LEGISLATURES, http://www.ncsl.org/research/health/meeting-the-primary-care-needs-of-rural-america.aspx [https://perma.cc/2332-AF7W] (last visited Oct. 22, 2020).

however, I suggest that before moving rural residents away from dying towns to areas of greater opportunities and services, we need to consider carefully the health effects of migration and agglomeration. Moreover, we need to recognize the various ways that not just health care, but rural health care, is exceptional in the United States.

II. AGGLOMERATION ECONOMIES: ARGUMENTS FOR AND AGAINST

As highlighted in the Introduction, David Schleicher offered the most recent, robust argument to let dying economies wither on the vine and, rather, to facilitate an ongoing cycle of mobility to areas of more promising economic opportunity. Several counterarguments, most notably by Naomi Schoenbaum and Michelle Anderson Wilde, suggest the value of place, or at least the importance of maintaining minimal services in dying places.

A. The Agglomeration Economies Thesis

David Schleicher's article, *Stuck! The Law and Economics of Residential Stagnation*,[168] asserts a controversial solution to all of the challenges of rural demographics, economic viability, health impacts of those trends, and persistent challenges with health care access and sustainability, described in the foregoing Parts: Simply let those communities fade away and facilitate their residents' movement to areas of greater economic promise, employment, and access to essential services. Schleicher's argument against preserving rural communities derives from the theory of agglomeration economies. The idea is that when people and capital congregate in particular cities and regions, they learn and trade more easily, and that process then creates wealth and generates economic growth. Preservation of dying small towns (and, by the same account, dying inner cities) may be good for existing residents on a microeconomic level but bad for the national economy on a macroeconomic level. While state and local governments may desire to invest and promote the interests of local families and homeowners, that agenda may not best serve those individuals or the national economy in the long run.

The agglomeration economies literature studies clusters or colocation of industries in a particular city. Despite the costs of such density, including higher rents, traffic, pollution, and crime, the benefits of reduced shipping costs, deeper markets, and information spillovers were determined to be offsetting.[169] The point about shipping costs is that if manufacturers could ship intermediate goods cost-free, there would be no reason not to locate far away from consumers, taking advantage of cheaper land and rents. But given the reality of shipping costs, intermediate goods producers are better off locating near final goods makers, with only the final goods

[168] Schleicher, *supra* note 6.

[169] *Id.* at 97 (citing 1 ALFRED MARSHALL, PRINCIPLES OF ECONOMICS 266–77 (8th ed. 1920)).

makers paying shipping costs to consumers.[170] The spillover effects of agglomeration include the casual information-sharing that occurs among residents and workers of vibrant economies. Think dot-com'ers in Silicon Valley chatting in the local Starbucks line.

The lessons of agglomeration economies, as outlined by Schleicher, are threefold: (1) "[Y]ou can't go home again. Once [regions] decline, they will not come back in the same form."[171] (2) "[I]ndividuals must be mobile to capture the gains from agglomeration."[172] The economic models assume that firms and people are mobile enough to easily and cheaply move their bases of operation to new opportunities. (3) "When people and firms fail to move to agglomeration economies, the overall economy" suffers in terms of output and growth.[173] Wages rise, and workers are more productive when there is competition for their jobs. Specialized training and education can be put to use.[174]

Thus, rather than investing in dying communities, policies should be structured to enable residents to move freely, following jobs and other opportunities presented in agglomeration economies. The particular locale of the desirable agglomeration economy de jour will shift over time as national and international policies, economies, markets, trade practices, and other dynamics shift. And, as those shifts occur, residents once again should be mobile enough to chase the new opportunities.

Schleicher proposes a range of legal and policy changes to facilitate mobility. Housing stock should be designed with an eye toward ease of expansion or reduction, rather than durability.[175] Government bailouts for natural disasters should target people instead of places, meaning that Houstonites should not be taxed to provide benefits to people in New Orleans following Katrina; rather, New Orleanians should move to Houston, an economy with virtually no land-use restrictions, tax burdens, and other barriers to entry.[176] Likewise, rather than trying to devise ways to make the Rust Belt a semblance of its former economic grandeur, we should allow it to fall by the wayside and shift resources (including human resources) to newer, more productive economies.[177]

Schleicher contends that state and local governments create significant legal barriers to mobility, including land-use laws that increase housing prices, public benefits eligibility rules, public employee pension policies, homeowner subsidies that disincentivize renting, state and local taxes, and property laws that inhibit exits

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[170] *Id.* at 98 (citing MASAHISA FUJITA, PAUL KRUGMAN & ANTHONY J. VENABLES, THE SPATIAL ECONOMY: CITIES, REGIONS, AND INTERNATIONAL TRADE 61, 67–68, 74 (1999)).

[171] *Id.* at 101.

[172] *Id.*

[173] *Id.* at 102.

[174] *Id.*

[175] *See id.* at 139.

[176] *Id.* at 141 (explaining that the government providing financial benefits to the city of New Orleans after Hurricane Katrina, instead of providing checks to each New Orleans resident, exemplified that government bailouts of cities are detrimental to mobility when they confer benefits on geographic locations rather than individuals).

[177] *See id.* at 105–06.

from low-opportunity states and cities.[178] Further barriers include building codes, mobile home bans, legal constraints on tear-downs, and municipal bankruptcy laws that limit the ability of cities to shrink gracefully.

Somewhat in contrast to the rural-to-urban migration patterns described in Part II, Schleicher notes that migration patterns in the United States have slowed since the 1980s.[179] Americans move less often than Canadians, and no more often than Finns or Danes. The most disadvantaged Americans seem even more "stuck," despite mobility seemingly being more important to their individual economic advancement than their more affluent counterparts (who nevertheless also could benefit from moving to the current agglomeration economy). Schleicher notes fewer Americans moving away from geographic areas of low opportunity, especially individuals with high school or less education, who tend to stay in areas hit by negative economic shocks.

The broad point about the merits of geographic mobility, of course, is not unique to Schleicher and harkens to Manifest Destiny and other core American values. Tyler Cowen, in his book, *The Complacent Class*,[180] makes similar points. He describes America's long history of interstate migration, and not just among the well-to-do, advantaged classes. Migration also shows up in the histories of the oppressed, downtrodden, and economically disadvantaged.[181] Cowen notes that, at least historically, education seemed to be a driver of mobility; those with college educations were more likely to have higher-paying job offers and to hear about opportunities.[182] Moreover, moving away for college primes individuals for the transitions associated with mobility.[183]

But more recently, the trend has flipped—Americans are better educated yet less mobile.[184] Cowen points to several of the same factors as Schleicher that make it expensive to move to larger cities with better employment opportunities, including high rents, restrictive housing codes, and limited infrastructure (including lack of public transportation).[185] He also provides support for Schleicher's suggestion that increased mobility improves individual and national economic status, evidenced by natural experiments, including post-Katrina migration out of New Orleans and a 1990s initiative extending vouchers to poor residents to move to higher-income neighborhoods.[186] Cowen's book takes a broader view of America's "stuck-ness" across a range of contexts, including decreased creativity, increased segregation, targeted marketing, decreased activism and political involvement, all of which lead

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[178] *Id.* at 124–32.

[179] *Id*. at 81 n.5 (citing several supporting studies).

[180] TYLER COWEN, THE COMPLACENT CLASS: THE SELF-DEFEATING QUEST FOR THE AMERICAN DREAM 23–46 (2017).

[181] *Id.* at 26.

[182] *Id.* at 29.

[183] *Id.*

[184] *Id.*

[185] *Id.* at 42–43.

[186] *Id.* at 40–42.

to stagnation. For purposes of this paper, his points support Schleicher's essential thesis about the perils of immobility.

B. Existing Rebuttals to the Agglomeration Economies Thesis

Schleicher's thesis attracted a number of pointed responses, collected in the *Yale Law Journal*'s online companion.[187] Some counterarguments are addressed in Scheicher's original article, and others in his online surreply.[188] The central difficulty in countering the agglomeration economies thesis is that arguments in favor of saving dying communities tend to come off as soft and sentimental, and thus nonresponsive to the macroeconomic objectives that Schleicher urges. Arguments about the value of place, community, and relationships; the morality of providing essential human services; benefits of geographic and other diversity; and preservation of natural places, tradition, and heritage fall on deaf ears to economists focused on how best to improve the U.S. GDP. At the same time, economic rationales for letting communities die sound harsh and unfeeling to those inclined to other lines of thinking.

Consider a hypothetical amalgamation of the rural resident profiles sketched above: A late-career, fifty-year-old manufacturing worker, with hypertension (high blood pressure, in his case, managed on medications), whose employer closes under the pressure of foreign competition. The worker did not finish high school and had worked for the same company since age eighteen. He and his wife, his high-school sweetheart, raised two children who now are out of the house and in school or the hunt for jobs in an urban area, some eighty miles away, just over the state line. The worker owns his three-bedroom house, passed down from his wife's family. His wife works part-time at the local post office. He is laid off and thus qualifies for unemployment. Also, due to his lower income and residency in a state that expanded Medicaid under the ACA, he qualifies for Medicaid. While not yet retirement age, the worker is not particularly inclined to retool his skills or complete his education. Even if he were to sell his house, he still could not afford housing in the city where his children live, where historic preservation laws, rent controls, zoning, and other housing and building codes increase rents and mortgages. Moreover, a move to a different state would, at least temporarily, endanger his Medicaid benefits, requiring him to reapply and requalify under the new state laws. Even if reinstated, his benefits and coverage would likely vary and would necessarily require locating new doctors, pharmacists, and other services. Schleicher suggests that our laid-off worker and his wife could move, if they chose, to better economic opportunities if only legal and other obstacles in their path could be removed. The counterarguments discussed next suggest reasons why the couple might remain in their rural home, notwithstanding the removal of those various impediments.

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[187] *See* Schoenbaum, *supra* note 20; Foster, *supra* note 20; Pratt, *supra* note 20; Anderson, *supra* note 20.

[188] *See* David Schleicher, *Surreply: How and Why We Should Become Un-Stuck*, 127 YALE L.J. F. 571 (2018).

One line of counterargument emphasizes the costs of mobility and the value of place.[189] Professor Naomi Schoenbaum points out that the very relationships that agglomeration economies purport to value, in fact, are compromised by mobility.[190] Typically, people move to new cities, jobs, and economies not as individuals but as families, with associated costs for the trailing spouse, most often, a woman, whose career opportunities and/or childcare support networks may be less than optimal in the new location.[191] Relationship strain can reduce productivity for all family members involved.[192]

When a family moves, other relationships are severed as well. Even accepting agglomeration economies' narrow focus on the economic value of relationships, one of the purported benefits is information-sharing among people. But as people move to chase new economic opportunities, existing ties grow weaker and new ties must be established. And not all ties are equal; sociologists distinguish between strong ties, such as close friends, and weak ties, such as acquaintances.[193] In the workplace, strong ties with customers, contractors, and consultants ultimately benefit the business, and those ties may not survive a geographic move and changed employer or line of work.[194]

Schoenbaum further argues that the benefits of relationships go well beyond economics. Relationships "communicate feelings of value, and a sense of 'belonging to a network of communications and mutual obligation.'"[195] They also "promote self-esteem and happiness, as well as physical and mental health."[196] They help "maintain a consistent sense of identity throughout one's life[.]"[197] Moreover, relationships support caregiving of children, elderly persons, and persons with disabilities, social services that, if not provided by friends and family members, might fall on already strained public service providers.[198] Schoenbaum posits that Schleicher undervalues social values and relationships because those benefits are captured by the communities in which people stay rather than by the rest of the nation.[199] Moreover, "[i]t is difficult to calculate the positive impact of strong ties, such as decreased healthcare costs, the value of care provided, sheer happiness, and so on."[200]

Schoenbaum also urges that the benefits of mobility will not accrue equally to all. Schleicher's Silicon Valley janitor example suggests that not only skilled workers but also unskilled workers who provide services to the skilled workers stand

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189 *See* Schoenbaum, *supra* note 20.
190 *See id.* at 463.
191 *Id.* at 470–71.
192 *Id.* at 464.
193 *Id*. at 465.
194 *Id*. at 465–67.
195 *Id*. at 468–69 (internal quotation omitted).
196 *Id.* at 469.
197 *Id.*
198 *Id.*
199 *Id.*
200 *Id*. at 469.

to benefit from agglomeration economies.[201] Schoenbaum counters by positing that even if entry barriers were lowered, the hypothetical janitor still would face higher rents and other disparities in the new, more competitive economy.[202] Less tangible, but no less important, values of place include happiness, supported by studies demonstrating that people in small towns, suburbs, and rural areas are happier than people in more densely populated places.[203] Moreover, the values of agglomeration economies run counter to the benefits of place. Schoenbaum suggests that people tend to "sort into and out of different physically defined communities."[204] Since the founding of the United States, place-based political communities have been important for local self-government.[205] Moreover, the benefits of place intersect with the values of federalism, including experimentation and diversity.[206] Schleicher, by contrast, sees local policy variation as a hindrance to mobility rather than a desirable outgrowth of the federal system.[207]

Other intangible values of place include preserving history and knowledge, making people "spiritually and morally more whole through the existence of households and environments beyond the hustle of urban materialism."[208] There is also value in the very notion of "home"—and preservation of home—as opposed to Schleicher's unfeeling suggestion to make housing stock cheaper and more readily disposable.[209] Accordingly, Schoenbaum urges, rather than a dichotomous debate between the terms "mobile" and the "stuck," a third category—the "rooted."[210]

To be clear, Schleicher does not entirely dismiss the value of place, nor does he suggest that people should be forced to leave places or even be offered incentives to move. Rather, he advocates reducing barriers to mobility, thus allowing people to choose labor markets as freely as possible. For example, while noting that government subsidies that incentivize homeownership (as opposed to renting property) discourage mobility, he also recognizes that stable populations encourage public and business investments.[211] People who stay in place develop beneficial social values and relationships and strengthen intergenerational bonds and long-term capital. They are more likely to invest in improving their communities. Local politicians, likewise, prefer an immobile electorate because it means that the voters

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[201] *See* Schleicher, *supra* note 6, at 83.

[202] Schoenbaum, *supra* note 20, at 475.

[203] *Id.* at 476.

[204] *Id*. at 476 (quoting David Fontana, *The Geography of Campaign Finance Law*, 90 S. CAL. L. REV. 1247, 1254 (2017)).

[205] *Id.*

[206] *Id.* at 477.

[207] Schleicher, *supra* note 6, at 88–89.

[208] *Id.* at 144 (quoting Michelle W. Anderson, *The Western, Rural Rustbelt: Learning from Local Fiscal Crisis in Oregon*, 50 WILLAMETTE L. REV. 465, 494–500 (2014)). *See id.* at 144 n.293 for Schleicher's response to that argument.

[209] Schoenbaum, *supra* note 20, at 478.

[210] *Id*. at 479 (citing Richard Florida, *America the Stuck*, BLOOMBERG CITYLAB (Feb. 2, 2017, 9:55 AM MST), https://www.bloomberg.com/news/articles/2017-02-02/why-americans-aren-t-moving [https://perma.cc/Q5DV-3MUL].

[211] Schleicher, *supra* note 6, at 133.

who elected them will stay in place and support their policies.[212] After articulating those arguments, however, Schleicher discounts them, noting that local politics tend to be dominated by anti-mobility stakeholders anyway, namely, homeowners and the elderly.[213] Thus, any political gains of catering to them only exacerbate the community members' stuck-ness.

Michele Wilde Anderson offers multiple counterarguments to Schleicher's point that people should not be forced to leave distressed areas but rather that entry barriers to better opportunities should be lowered.[214] Her arguments are largely humanitarian but further suggest that Schleicher oversimplifies the economic hardships of distressed areas and their residents. Even assuming Schleicher's point about entry barriers were correct, Anderson urges, for one, we cannot simply leave other residents behind without providing essential services in struggling communities.[215] Moreover, we cannot achieve the first goal of facilitating mobility to better markets without addressing the joblessness and lack of educational attainment in the communities left behind; those are necessary precursors to the very mobility that Schleicher advocates.[216]

Even accepting the desirability of mobility away from blight and toward opportunity, the shift will not happen immediately. Accordingly, Anderson urges that services and supports for declining areas cannot be totally withdrawn. Also, as the agglomeration economies literature implicitly recognizes, yesterday's "dying place" may be tomorrow's land of opportunity.[217] Thus, those areas should not be fully abandoned, which would only impair future mobility. She recognizes that most regions have a single thriving metropolis connected to the "modern knowledge economy," while other cities, mill towns, and rural areas continue to suffer under poor economic opportunity and dysfunctional local economies.[218] For those latter areas, a comprehensive anti-poverty agenda still is needed.

Anderson summarizes Schleicher's argument as an either/or proposition: Either move people to expanding economies or restore the job base and educational attainment in declining areas. She counters that the second strategy is inseparable from the first; the long-term joblessness and rising concentrations of poverty in the places left behind impede those residents' mobility.[219] As such, cutting local services and supports are counterproductive to the goal of creating opportunity and mobility. Anderson notes many of the same demographics discussed in Part II as barriers to mobility—concentrated poverty, lack of educational attainment, and job loss—as well as a host of additional complex issues, including home foreclosures, price gouging and code violations by landlords in weak markets, effects of opioids addiction on communities, as well as high rates of incarceration, homicide, and

[212] *Id*. at 110.
[213] *Id*. at 111.
[214] Anderson, *supra* note 20, at 527.
[215] *Id.* at 529–30.
[216] *See id*. at 526–27.
[217] *Id.* at 540–41.
[218] *See id*. at 523.
[219] *Id.* at 524.

accidental deaths. The point being that simply lowering entry barriers to expanding economies will not make it possible for all residents of declining economies to move, much less remedy that array of issues plaguing the places left behind.

Anderson's work on "New Minimal Cities" expands on those insights and further challenges Schleicher's thesis.[220] The term "minimal cities" derives from Gary Miller's description of communities that ab initio establish minimal local governments, by contract and luxury of resources, to keep property taxes low.[221] Miller's minimal cities (see, e.g., Costa Mesa, California, or Peachtree City, Georgia) keep municipal service needs low by excluding residents likely to have or generate greater service needs. For example, limiting residency to college graduates would tend to reduce crime rates, thus lowering the need for police and jail services. Anderson repurposes the "minimal cities" term to focus on blighted urban cores, such as Detroit and twenty-seven other municipalities that experienced bankruptcy or receiverships between 2013 and 2018. She then focuses on how to balance creditors' and residents' interests in those processes.[222]

One suggestion in the face of municipal bankruptcy has been to cut services to blighted areas that are a net drain on municipal resources, thereby encouraging residents to move elsewhere. On largely humanitarian grounds, Anderson opposes those policies. The starkest example is cutting emergency responder services, in essence, simply failing to respond to 911 calls for hours or days, literally leaving residents injured and dying. Other examples include cutting libraries, after-school programs, parks, services for the elderly, mental health services, and law enforcement. She notes, however, that those now-uninhabitable conditions will not self-correct.[223] There is a reason why public safety, sanitation, and utilities are classic public goods; impoverished residents will not be able to marshal resources to provide for themselves if cut off of public services, especially if those residents are economically disadvantaged from the outset.

Anderson's new minimal cities concept focuses on post-industrial urban neighborhoods and particular challenges with reorganization through municipal bankruptcy.[224] Although residents have no monetized claim to draw on city services, bankruptcy laws assume that some ongoing spending on health and welfare will occur during reorganization, without specifying what level of public services must be maintained. There is no concrete entitlement to police, fire, emergency response, water and water infrastructure, and solid waste and wastewater. That said, Anderson urges on both humanitarian and economic grounds that at least minimal services remain in place. After all, the residents who remain in these failing communities are taxpayers who can continue to support payments to creditors through the bankruptcy proceedings.

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[220] Michelle Wilde Anderson, *The New Minimal Cities*, 123 YALE L.J. 1118 (2014) [hereinafter Anderson, *The New Minimal Cities*].

[221] *Id.* at 1126.

[222] *Id*. at 1123–24.

[223] *Id*. at 1217–19.

[224] *See generally* Anderson, *The New Minimal Cities*, *supra* note 220.

Moreover, the downstream effects seem pretty clear: If law enforcement is cut, crime may rise, including drug markets, pill mills, and other effects of the opioid crisis that are plaguing both urban cores and rural America in particularly acute ways. If medical, maternity, pediatric, and elder care services are cut, hospitals may see sicker patients and experience rising health care costs. Reduced spending on libraries, the arts, and after-school programs may result in a less educated population and reduced ability to compete for employment. Reduced spending on sanitation can lead to the spread of contagious disease and deterioration of critical infrastructure. Lead exposure among residents of Flint, Michigan, provides a stark cautionary tale for that point.

In tracing the broad outlines of minimal public services—what Anderson calls, "mapping out heuristics for decisionmakers and the public to use in thinking about essential public spending"—she analogizes to property law.[225] Property law already recognizes a minimum standard of habitability for dwelling places; the suggestion is to extend that guarantee to the space around the dwelling—streets, sidewalks, and parks. A warranty of habitability would apply not just between landlord and tenant but also between local government and residents.[226]

Although Anderson's arguments were crafted in the context of dying urban communities, the same observations and suggestions certainly could be made with respect to rural communities. Indeed, she takes up that point in a different article, focused on rural timber counties in Oregon.[227] The demographics of Josephine County, Oregon, track many of the trends described above in Part II.[228] The Josephine County population is substantially older than state or national averages, with close to one-quarter over the age of sixty-five.[229] Educational attainment also is lower; "only 16% of the population has a bachelor's degree or higher, and 23% of the population aged eighteen to twenty-four has less than a high school degree or equivalent."[230] Young people in the county are not returning, despite strong attachment to family and landscape.

Rural areas, including timber counties, have suffered economic decline through automation of manufacturing and global markets for construction materials. The Great Recession only deepened the wounds. Just as in the minimal cities' urban cores of the Rust Belt, hard times in Josephine County and similar areas mean cuts to public services. Some timber counties are experimenting with providing little more than public safety in true emergencies.

Anderson queries: "America's post-industrial cities and regions are testing a new nadir in local public services. Is there a floor beneath these cuts—some level of

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[225] *See id*. at 1118, 1127.

[226] *Id*. at 1197–99.

[227] Michelle W. Anderson, *The Western, Rural Rustbelt: Learning from Local Fiscal Crisis in Oregon*, 50 WILLAMETTE L. REV. 465, 466–67 (2014) [hereinafter Anderson, *The Western, Rural Rustbelt*].

[228] *Id*. at 466.

[229] *Id.*

[230] *Id.*

services to which every American should be entitled?"[231] Health law scholars and policymakers have asked the same of health care: Is there some minimal level of medical care to which every American should be entitled?[232] To Anderson's point, even assuming that everyone agreed in principle about the necessity of maintaining public services in dying communities, there are widely different opinions on what those essential, minimal services should be.[233] The same question arises in health when contemplating the content of any recognized right to health care or minimum essential benefits for health plans.

Anderson's question echoes a debate common in health law and policy circles, again bringing home this Article's point that health care is a particularly useful lens for considering the question of whether to save dying rural communities. The absence of clear entitlements to public services and health care, particularly, is a feature of the United States' strongly held negative rights orientation.[234] The country was founded on individual rights to be *free from* government intrusion, not on desires for government to provide affirmative rights or essential services. Even state constitutions that articulate some overarching value or "right" to health care do so in the most general, non-enforceable terms.[235]

Municipal bankruptcy law, as Anderson describes it, is no different in terms of failing to create an entitlement to public services. Moreover, both health care and local public services tend to follow a get-what-you-can-pay-for approach, resisting cross-subsidization from the haves to the have-nots. State bailouts and other funding redirection from thriving communities to failing communities tend to generate strong political objections. Likewise, cost-shifting in health care by charging higher rates to insured patients to make up for the financial shortfall from un- and under-insured patients tends to rankle privately insured consumers.[236]

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[231] *Id*. at 486.

[232] *See*, *e.g.*, Bipartisan Patient Protection Act of 2001, S. 1052, 107th Cong. (2001); Katherine L. Record, *Litigating the ACA: Securing the Right to Health Within a Framework of Negative Rights*, 38 AM. J.L. & MED. 537, 538 (2012); Russell Korobkin, *Determining Health Care Rights from Behind a Veil of Ignorance*, 1998 U. ILL. L. REV. 801, 802 (1998); Alicia Ely Yamin, *The Right to Health Under International Law and Its Relevance to the United States*, 95 AM. J. PUB. HEALTH 1156, 1157 (2005).

[233] *See* Anderson, *The Western, Rural Rustbelt*, *supra* note 227, at 493.

[234] *See* Weeks, *State Constitutionalism*, *supra* note 22, at 1331–46.

[235] *See generally id*.

[236] *See, e.g.*, TERESA A. COUGHLIN, JOHN HOLAHAN, KYLE CASWELL & MEGAN MCGRATH, UNCOMPENSATED CARE FOR THE UNINSURED IN 2013: A DETAILED EXAMINATION, KFF (May 30, 2014), https://www.kff.org/report-section/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination-cost-shifting-and-remaining-uncompensated-care-costs-8596/ [https://perma.cc/DM45-QK88]; Jack A. Meyer & William R. Johnson, *Cost Shifting in Health Care: An Economic Analysis*, 2 HEALTH AFFS. 20, 21 (1983).

Much of my prior work, like this Article, seeks to bridge the recurrent divide between economic and humanitarian arguments.[237] Rather than advocating a single-payor, or universal care system, I consistently have recognized the merit of market-based approaches (albeit highly regulated markets) to drive quality and cost containment in health care, while acknowledging the unique nature of health care as distinct from other goods and services, which posture allows that some groups' ability to access health care should not be determined by principles of supply and demand. Accordingly, the debate between Schleicher and his critics does not strike me as unexpected or insoluble. Rather, insights from American health law can be applied fruitfully to inform the question of sustainability of America's rural places.

III. THE HEALTH CARE CASE FOR SAVING RURAL AMERICA

This Part turns to the health care arguments for saving rural America, as outlined in the Introduction, including the negative health effects of migration on both migrants and those left behind; the health benefits of being treated close to home; and the long-standing public policy recognition of rural healthcare delivery models as exceptional, serving as laboratories for healthcare innovations.[238]

A. Health Costs of Mobility

Neither Schleicher's original article nor the responses to it fully account for the adverse health impacts of migration and agglomeration. Naomi Schoenbaum notes the costs of mobility in terms of severed relationships and reduced productivity for some family members, including the health effects of those losses. She also notes that the value of relationships is not merely sentimental but can have real economic impact, a rebuttal to the agglomeration economies' suggestion about the value of informal networks and other relationships built in the new economy.[239]

Examining the costs of migration through a health care lens reveals an even stronger impact on migrants, including environmental contaminants, contagious disease, chronic disease, and mental health impacts. The health effects of migration within the United States have not been systematically studied, but there are myriad studies on health effects of domestic migration in other countries. These studies

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[237] *See* Weeks, *Death Panels, supra* note 24; Elizabeth Weeks Leonard, *Right to Experimental Treatment: FDA New Drug Approval, Constitutional Rights, and the Public's Health*, 37 J.L. MED. & ETHICS 269 (2009); Weeks, *Gauging the Cost of Loopholes*, *supra* note 24.

[238] *See infra* Part II.A–B (describing healthcare delivery innovations). I borrow the notion of disparate actors testing novel innovations, without risk to, but with possible benefit for, a larger entity from a well-recognized value of the United States' federalist system. *See* New State Ice Co. v. Liebmann, 285 U.S. 262, 311, 386–87 (1932) ("It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.").

[239] Schoenbaum, *supra* note 20, at 465–66.

suggest that, whatever positive effects agglomeration economies may have on the nation's economy, those gains must be offset by the negative health impacts produced by mobility.

Several international studies indicate that "many chronic, non-infectious diseases occur more frequently among urban residents."[240] One reason for the disparity may be that increased risk of disease is attributable to environmental contaminants found in urban areas, namely exposure to increased pollution.[241] Another suggestion is that "persons migrating from rural to urban areas are exposed to deleterious social stress."[242] The first explanation is rather intuitive—there are more environmental contaminants within a city, ranging from air and water pollution to occupational hazards, to which a migrant might not have been exposed in her indigenous rural area.[243] For example, in Delhi, India, a heavily polluted city with less restrictive regulations, more than 4.4 million children have irreversible lung damage due to pollution.[244]

Qiu, Tian, Zhu, Liu, Gao, and Zhou conducted a survey to determine the array of pollutants released in the agglomerated Central Plain Urban region of China.[245] They found emissions of nitrogen oxide (NO_x), sulfur dioxide (SO_2), particulate matters (PM_{10} and $PM_{2.5}$), carbon monoxide (CO), volatile organic compounds (VOCs), and ammonia (NH_3).[246] Although many of these pollutants are emitted from the industrial sector, commercial and residential sectors contribute significantly as well.[247] The survey evidences that the concentration of environmental contaminants is greater in a city rather than rural areas.[248] Therefore, agglomeration could increase the risk of deleterious effects for urban migrants from exposure to a greater concentration of pollutants than their rural counterparts.[249]

Marion and Aurelie studied the effect of NO_x on labor productivity, acknowledging that agglomeration tends to increase labor productivity.[250] At the same time, they argued that studies investigating the effect of agglomeration on labor

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[240] *See* A. Benyoussef, J. L. Cutler, A. Levine, P. Mansourian, T. Phan-Tan, R. Baylet, H. Collomb, S. Diop, B. Lacombe, J. Ravel, J. Vaugelade & G. Diebold, *Health Effects of Rural-Urban Migration in Developing Countries—Senegal*, 8 SOC. SCI. & MED. 243 (1974).

[241] David Briggs, *Environmental Pollution and the Global Burden of Disease*, 68 BRITISH MED. BULLETIN 1, 18 (2003).

[242] *Id.*

[243] *Id.* at 244.

[244] Gus Stahl, *Health Impact: The Pros and Cons of Living in a City*, GLOBAL CITIZEN (Oct. 31, 2015), http://www.globalcitizen.org/en/content/health-impacts-of-living-in-a-city/ [https://perma.cc/M9P4-D7R5].

[245] Peipei Qiu, Hezhong Tian, Chuanyong Zhu, Kaiyun Liu, Jiajia Gao & Junrui Zhou, *An Elaborate High Resolution Emission Inventory of Primary Air Pollutants for the Central Plain Urban Agglomeration of China*, 86 ATMOSPHERIC ENV'T 93 (2014).

[246] *Id.*

[247] *Id.* at 97.

[248] Benyoussef et al., *supra* note 240, at 243.

[249] *Id.*

[250] Marion Drut & Aurelie Mahieux, *Correcting Agglomeration Economies: How Air Pollution Matters*, 96 REG'L SCI. 381, 384 (2017).

productivity must take into account the effect of the incidental increase of pollution associated with agglomeration.[251] Their literature review suggested that air pollution could adversely affect labor productivity due to its effect on workers' physical health[252] and cognitive performance, among other factors.[253]

Marion and Aurelie also designed a study to assess the impact associated with commuting.[254] The authors chose NO_x, an emission generated from the exhaust of diesel vehicles, to assess the impact of pollution on labor productivity.[255] The study showed that a 1 percent increase in NO_x emissions decreased labor productivity by 0.07 percent.[256] Marion and Aurelie labeled the results as "a negative and significant impact of air pollution on productivity."[257] The rebuttal to this argument is that hyper-agglomeration should, theoretically, eliminate concerns for the generation of pollutants by eliminating the need to commute. Although the study was limited to analytes associated with commuting, it stands for the broader point that the positive effects of agglomeration must be adjusted by the negative effects associated with agglomeration-based increases in pollution.[258]

In addition to environmental impacts, agglomeration is also associated with other health effects. With the increase in population and influx of people moving to big cities, "crowding and numerous social contacts may afford more opportunities for the transmission of infectious diseases," although this claim may be difficult to evaluate since there may be other factors such as poor nutritional level or "detailed social networks of persons who migrate to cities."[259] Another researcher maintained that crowding could increase the risk of disease transmission through the creation of high-population density clusters.[260] These high-population density clusters correspond to an increase in incidences of contact between people leading to a greater transmission of diseases.[261] For example, airspace is shared between more people in a smaller area, leading to a greater transmission of airborne diseases such as influenza.[262]

Most recently, COVID-19's impact on cities exposed the health risks facing those who live in high-population density clusters during a pandemic.[263] COVID-19

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[251] *Id.* at 381.
[252] *Id.* at 391.
[253] *Id.*
[254] *Id.* at 384.
[255] *Id.* at 391.
[256] *Id.* at 393.
[257] *Id.* at 397.
[258] *Id.*
[259] Benyoussef et al., *supra* note 240, at 243–44.
[260] Emilie Alirol, Laurent Getaz, Beat Stoll, François Chappuis & Louis Loutan, *Urbanisation and Infectious Diseases in a Globalized World*, 11 LANCET INFECTIOUS DISEASES 131, 132 (2011).
[261] *Id.* at 134.
[262] *Id.*
[263] Michele Acuto, *COVID-19: Lessons for an Urban(izing) World*, 2 ONE EARTH 317, 317–18 (2020), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7159854

epicenters, such as New York City, Milan, London, and Madrid, each have high population density and host many visitors throughout the year.[264] While COVID-19's spread cannot be entirely attributed to density in urban cores, overcrowded housing and crowded public transportation created many opportunities for COVID-19 to quickly infect large numbers of people.[265]

The relationship between urbanization and infectious diseases is also affected by connectivity, another product of agglomeration.[266] A study by Hamidi, Sabouri, and Ewing concluded that metropolitan population levels were strong predictors of COVID-19 infection and mortality rates.[267] While metro counties are less dense than the nearby cities, the sheer number of residents created opportunities for COVID-19 to easily spread.[268] The authors concluded that, when an urban core is surrounding by many highly populated counties, the areas have many economic, commuting, and social exchanges.[269] The exchanges inevitably lead to cross-border contamination of large groups of people.[270]

Furthermore, Oscar Patterson-Lomba and Gomez-Lievano's study illustrates how urbanization makes it easier for people to interact, resulting in an increased risk of transmitting sexually-transmitted diseases.[271] Higher population densities can also result in greater zoonotic disease transmission. A World Health Organization report revealed that rapid urbanization placed a large group of nonimmune individuals at risk of contracting yellow fever, because the high population density made the area they occupied an attractive feeding ground for mosquitoes.[272] The severe acute respiratory syndrome (SARS) epidemic is an illustrative case study demonstrating

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[https://perma.cc/8789-F2EV]; Tim Dixon, *What Impacts Are Emerging from COVID-19 for Urban Futures?*, CTR. FOR EVIDENCE-BASED MED. (June 8, 2020), https://www.cebm.net/covid-19/what-impacts-are-emerging-from-covid-19-for-urban-futures/ [https://perma.cc/EFE5-ADF4]; Colin McFarlane, *The Urban Poor Have Been Hit Hard by Coronavirus. We Must Ask Who Cities Are Designed to Serve*, THE CONVERSATION (June 03, 2020, 9:48 AM EDT), https://theconversation.com/the-urban-poor-have-been-hit-hard-by-coronavirus-we-must-ask-who-cities-are-designed-to-serve-138707 [https://perma.cc/5U3U-2YRS].

[264] McFarlane, *supra* note 263.

[265] Acuto, *supra* note 263; McFarlane, *supra* note 263.

[266] Shima Hamidi, Sadegh Sabouri & Reid Ewing, *Does Density Aggravate the COVID-19 Pandemic?*, 86 J. AM. PLAN. ASS'N 495, 496 (2020).

[267] *Id.*

[268] *Id.* at 506. Density had a similar effect of exacerbating COVID-19 spread in rural areas featuring plants, prisons, and nursing homes. *See supra* note 101.

[269] Hamidi et al., *supra* note 266, at 496.

[270] *Id.*

[271] Oscar Patterson-Lomba & Andres Gomez-Lievano, *On the Scaling Patterns of Infectious Disease Incidence in Cities*, ARXIV 1, 17–18 (2018), https://arxiv.org/pdf/1809.00277.pdf [https://perma.cc/SDR7-FFK8].

[272] *See The Yellow Fever Situation in Africa and South America in 2004*, 29 WKLY. EPIDEMIOLOGICAL REC. 250, 255–56 (2005).

the risks associated with infectious disease proliferation as a factor of urbanization.[273]

In addition to contagious disease, a number of studies reveal the physiological effects of the stress of migration and relocation. For example, Professor Syme, who extensively researched the relationship between coronary heart disease and mobility, advances a theory that social change imparts a risk to disease.[274] The mobility, regardless of the type (generational, occupational, residential, or situational), carries with it a degree of uncertainty—the migrant's inability to "anticipate the social consequences of his behavior" due to "different and unknown rules" of the new world, which in turn "leads to stress and pathophysiological changes."[275] Other studies revealed an increased incidence of various chronic conditions among rural-urban migrants. For example, Poulter, Khaw, Hopwood, Mugambi, Peart, Rose, and Sever, in 1990, found that migrants in cities in Kenya "often suffer[ed] from hypertension and ha[d] higher blood pressure than the non-migrants."[276] Another study by Torun, Stein, Schroeder, Grajeda, Conlisk, Rodriguez, Mendez, and Martorell in 2002 reported that migration to a city "increased sedentarism and undesirable eating habits among men and women in Guatemala."[277]

The mental health effects of migrants also are well documented. In 2009, Li, Stanton, Fang, Xiong, Yu, and Lin compared the mental health symptoms among 1006 rural-urban migrants in Beijing with those of their counterparts in two settings—the rural areas from which they emigrated and the urban areas to which they immigrated.[278] The finding was that the migrant group "suffered from poorer mental health status than both counterparts."[279] Likewise, a study on Chinese rural-urban migration revealed various factors affecting the psychological well-being of the migrants and strongly affecting the future trajectories of their health, including "stigmatization, stress that comes from economic pressure, workload, family separation, expectation-reality discrepancy, and discrimination and difficulty in

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[273] Ronak B. Patel & Thomas F. Burke, *Urbanization—An Emerging Humanitarian Disaster*, 361 NEW ENGLAND J. MED. 741, 742 (2009) ("The outbreak of [SARS]. . . demonstrate[s] how dense urban living could ignite a global health crisis.").

[274] Benyoussef et al., *supra* note 240, at 244.

[275] *Id.*

[276] Yang Song & Wenkai Sun, *Health Consequences of Rural-to-Urban Migration: Evidence from Panel Data in China*, 25 HEALTH ECON. 1252, 1254 (2016) (citing N. R. Poulter, K. T. Khaw, B. E. Hopwood, M. Mugambi, W. S. Peart, G. Rose, P. S. Sever, *The Kenyan Luo Migration Study: Observations on the Initiation of a Rise in Blood Pressure*, 300 BRIT. MED. J. 967(1990)).

[277] *Id.* (citing Benjamin Torun, Aryeh D. Stein, Dirk Schroeder, Ruben Grajeda, Andrea Conlisk, Monica Rodriguez, Humberto Mendez & Reynaldo Martorell, *Rural-to-Urban Migration and Cardiovascular Disease Risk Factors in Young Guatemalan Adults*, 31 INT'L J. EPIDEMIOLOGY 218 (2002)).

[278] *Id.* at 1255 (citing Xiaoming Li, Bonita Stanton, Xiaoyi Fang, Qing Xiong, Shuli Yu, Danhua Lin, Yan Hong, Liying Zhang, Xinguang Chen & Bo Wang, *Mental Health Symptoms Among Rural-to-Urban Migrants in China: A Comparison with Their Urban and Rural Counterparts*, 11 WORLD HEALTH & POPULATION 24 (2009)).

[279] *Id.*

acculturation . . . ."[280] The study also found major depression and insomnia common among the migrants and their families.[281]

Yao Lu's longitudinal study of rural to urban migration in Indonesia[282] also found increased "risk of psychological disorder as measured by depressive symptoms" among urban migrants, stemming from reduced social support, barriers to health utilization in their new urban homes, and work-related stress and hazards.[283] Although the migrants enjoyed certain upward mobility and a sense of fulfillment, those economic gains "are often accompanied by exposure to work stressors and unfavourable working environments because migrants are over-represented in undesirable and labour-intensive jobs."[284] Moreover, the migrants may not consistently benefit from the economic gains themselves if they feel the need to send money back home.[285] The study concluded that rural-urban migration increased psychological disorders, cardiovascular illnesses, weakened immune systems, and led to unhealthy behavioral responses, all of which, Lu suggested, are typical manifestations of stress,[286] attributable to "[s]everal forms of change associated with migration[.]"[287] The adjustment process following any migration often entails various stressful circumstances as the migrant adapts to the new environments and lifestyles (aptly called "acculturation stress"), which is aggravated if the migrant lacks social support or has difficulties establishing new social networks.[288]

Lu's study emphasized that migration also is associated with "reduced social control," making individuals more prone to external influences and tending to engage in unhealthy behaviors when detached from "the restraining social influences . . . in their place of origin."[289] To that point, a study by Andreas Meyer-Lindenberg of the Central Institute of Mental Health showed that urban dwellers react to and handle stress much worse than their country counterparts, exhibited by the more pronounced activity of the amygdalae and the pACC regions in the brain, which control fight-or-flight reactions when presented with stressful situations.[290] The

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[280] Jin Mou, Sian M. Griffiths, Hildy Fong & Martin G. Dawes, *Health of China's Rural-Urban Migrants and Their Families: A Review of Literature from 2000 to 2012*, 106 BRITISH MED. BULL. 19, 25 (2013) (footnote omitted).

[281] *Id.*

[282] Yao Lu, *Rural-Urban Migration and Health: Evidence from Longitudinal Data in Indonesia*, 70 SOC. SCI. & MED. 412, 412 (2010).

[283] *Id.*

[284] Yao Lu, *Mental Health and Risk Behaviors of Rural-Urban Migrants: Longitudinal Evidence from Indonesia*, 64 POPULATION STUD. 147, 149 (2010) (internal citation omitted).

[285] *Id.*

[286] *Id.*

[287] *Id.*

[288] *Id.* at 147, 149–50.

[289] *Id.* at 150.

[290] *See* Stahl, *supra* note 244; *see also* Leo Benedictus, *Sick Cities: Why Urban Living Can Be Bad for Your Mental Health*, GUARDIAN (Feb. 25, 2014, 3:00 EST), http://www.theguardian.com/cities/2014/feb/25/city-stress-mental-health-rural-kind [https://perma.cc/3G87-8PZP].

research cited frequent environmental stressors and perpetual overcrowding in cities as contributors. In particular, "the sheer reality of constantly being surrounded by people is interpreted by the brain as a lack of control . . . which increases anxiety."[291] Coupled with the inevitable acculturation stress, it is easy to see how rural-urban migration could lead to a decline in the migrants' mental health.

Another study of the migration trend among young adults in Thailand[292] found, somewhat surprisingly, that migrants to urban areas enjoyed significantly *improved* mental health, compared to their peers who stayed in their places of origin or returned home after deciding against urban lifestyles. That finding, however, merits a couple of caveats, as the study authors themselves noted. First, they recognized that young people were more likely to leave home because they were unhappy there to begin with; thus, their reports of improved mental health post-migration could be skewed by that baseline motivation.[293] Also, rural residents' reports of reduced mental health could be explained by the "midnight train effect," which refers to the tendency of more compromised and disillusioned migrants to return to their rural places of origin. Thus, it is difficult to discern whether the returnees who reported lower mental health left urban areas because they were faring worse there, or fared worse because they returned. The upshot is that the improved mental health of migrants reported in the study may be exaggerated.

The foregoing studies focused on the health effects of migration on those who leave. But those left behind also experience negative health effects. Several studies in China show that the migration of adult children has an adverse effect on the mental health of their left-behind parents.[294] Despite the fact that the left-behind parents may have better access to health care thanks to the financial remit from their children, these studies indicate a decline in mental health. Specifically, an additional migrated adult child "increases the probability of his or her parents' being in poor [self-reported health status] . . . by about 8%."[295] The impact was even greater on parents from low-income households, older than sixty, or with only one child.[296] Migration, it seems, "estranges parents and children," thus making the children less likely to care for and take care of their parents.[297] The impact is especially pronounced in China, where there is a strong tradition of family support for elderly parents, who often live with their children instead of alone or in a nursing home.

In sum, these international studies reveal a host of mental and physical health effects on both migrants and those left behind, for which Schleicher does not fully account in suggesting that residents of dying communities get "unstuck" and move to places of greater economic opportunity. Those health effects have real costs that would have to be offset against any purported macroeconomic gains of

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[291] Stahl, *supra* note 244.

[292] Nauman et al., *supra* note 38, at 242–43.

[293] *Id.*

[294] Xiang Ao, Dawei Jiang & Zhong Zhao, *The Impact of Rural-Urban Migration on the Health of the Left-Behind Parents*, 37 CHINA ECON. REV. 126, 127 (2016).

[295] *Id.*

[296] *Id.*

[297] *Id.*

agglomeration. Anderson's counterarguments regarding the need to maintain essential services both as a prerequisite for mobility and for the humanity of those left behind also do not fully consider that migration itself may increase the need for essential services, in both the communities left behind and the new agglomeration economies. Schoenbaum notes the economic costs of mobility in terms of relationships and productivity, and briefly flags the physical and mental health impacts of those changes. The foregoing studies buttress and expand that point, focusing particularly on the health effects of migration. Thus, this discussion emphasizes the importance of viewing the survivability of rural America through a health care lens. Simply lowering entry barriers for individuals to move to better economies will not address the host of significant environmental, public health, and individual health impacts that would accompany such mobility.

B. Health Benefits of Home

An important complement to the foregoing discussion of the health costs of mobility is recognizing the health benefits of home. Research demonstrates that individuals are more resilient, adaptive, and emotionally stable when connected to familiar places. Included within familiar places are not just one's house or residence, but the geography, community, and social supports that comprise a broader notion of home.[298] The "aging in place" literature[299] is particularly instructive, but research on non-elderly groups reveals similar insights.

First, a study by Cook, Martin, Yearns, and Damhorst is informative on the question of the health benefits of not just one's home or house, but one's place outside of and surrounding the home.[300] The study attempted to explain the sense of loss experienced by rural participants as they endure changes in the places that they have lived for many years.[301] Because one's identity is tied to one's community, changes in that community can pose a significant threat to an individual's "optimum continuity."[302] As individuals age, they increasingly are exposed to stressful events, losses, and limitations on functional abilities.[303] Study participants included changing landscapes, shifts from localized shopping to larger discount stores, and

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[298] Patricia Vanleerberghe, Nico De Witte, Claudia Claes, Robert L. Schalock & Dominique Verté, *The Quality of Life of Older People Aging in Place: A Literature Review*, 26 QUALITY LIFE RSCH. 2899, 2900 (2017); *see also* Jon Pynoos, Christy Nishita, Caroline Cicero & Rachel Caraviello, *Aging in Place, Housing, and the Law*, 16 ELDER L.J. 77, 78 (2008).

[299] Vanleerberghe et al., *supra* note 298; Pynoos et al., *supra* note 298.

[300] Christine C. Cook, Peter Martin, Mary Yearns & Mary Lynn Damhorst, *Attachment to "Place" and Coping with Losses in Changed Communities: A Paradox for Aging Adults*, 35 FAM. & CONSUMER SCI. RES. J. 201, 202 (2007). Vanleerberghe et al., *supra* note 298, at 2900; *see also* Pynoos et al., *supra* note 298.

[301] Cook et al., *supra* note 300, at 201.

[302] *Id.* at 204.

[303] *Id.*

the decline of farming as a way of life among the losses that they experienced.[304] Such stressors negatively influence adaptational outcomes, including well-being, social functioning, and somatic health. The study concluded that coping with a sense of loss of place compounds and even exacerbates personal losses in health and independence.[305] The policy implication is to focus on helping elderly adults maintain a sense of place and connection to their locales.[306] Even if institutional care becomes necessary, family members and other familiar caregivers that comprise that broader sense of place are important to aging well.[307]

The authors pointed to three gerontological perspectives supporting the study's findings, including continuity, developmental adaptation, and selective optimization with compensation.[308] Under the continuity model, "[e]xternal continuity refers to living in familiar environments and interacting with familiar people."[309] The study found that "continuity in the social and physical environment is essential to optimal aging."[310] Diminishing community resources—the loss of farming as a way of life, Main Street retailers, neighborhoods and community—"reflected core threats to the understanding of self and ability to adapt to personal changes[,]" including health changes.[311]

The developmental adaptation model emphasizes the importance of past experiences for influencing adaptational outcomes later in life.[312] The study observed, however, that the positive impact of those past experiences may be diminished by changes in internal or external resources.[313] For example, positive past experience with family farming or harmonious family life may lose its effect on overall life satisfaction once the family farm is sold or a young person moves away from the community.[314] Again, changes in external community resources seem to impair optimal aging.

The implications of selective optimization with compensation theory is that older individuals in rural areas may have fewer options to compensate for loss.[315] Older adults tend to be less adaptive as a general matter, but even those who might be willing to engage in other activities or community support (e.g., exercise programs, Bingo nights, nutrition programs) may not have access to them in rural areas.[316] The study focused on the elderly in rural areas, who are a significant cohort of that population, as discussed above, but similar issues could be salient for younger

[304] *Id.* at 201.
[305] *Id.* at 211.
[306] *Id.*
[307] *Id.* at 212.
[308] *Id.* at 203–04.
[309] *Id.* at 210 (internal citation omitted).
[310] *Id.* at 204.
[311] *Id.* at 210.
[312] *Id.*
[313] *Id.*
[314] *Id.*
[315] *Id.* at 210–11.
[316] *Id.* at 211.

rural residents as well.[317] Schleicher's suggestion to shift populations as economic opportunities shift gravely discounts the importance of not just home but place to "optimum continuity."

Another study, by Erickson, Call, and Brown, directly set out to examine the suggestion in Schleicher's and similar literature that residents are "stuck" in dying rural places.[318] Specifically, the study sought to determine whether elderly rural residents in Utah are staying in place because they are stuck or because they are attached to their communities.[319] The study concludes with a third suggestion—they are staying because they are *satisfied* with their communities. Prior literature tended to conflate attachment and satisfaction.[320] The study's model separated satisfaction—"i.e., subjective evaluations of one's ability to satisfy consumption projected onto one's community"[321]—and found that it had "a stronger relationship with migration intentions."[322] Thus, rather than staying because of economic or resource-dependent reasons[323] (the stuck thesis), or because of the social and personal satisfaction derived from being part of the community, the lack of economic opportunities, health care, and other services notwithstanding[324] (the place thesis), elderly residents' stronger "emotive connection" to the place allowed them to see the available resources in a most favorable light.[325] That rose-colored-glasses view of home resulted in greater satisfaction with the community and a desire to stay. The study did note that residents with more health problems tended to view the community's medical services "more harshly than those with few problems."[326] Those with few problems tended to think having to travel to Salt Lake City or other challenges to accessing primary care worth the effort when balanced against the other services offered in the community with which they are satisfied.[327]

The study's findings, of course, directly counter Schleicher's thesis that residents of dying communities are stuck and would move to more robust economies if entry barriers were lowered. They are not staying simply because of irrational, sentimental attachment to place but because they perceive (accurately or inaccurately) the place to satisfy their needs. Further, the study suggests that improving medical services in rural places could increase the feeling of satisfaction

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[317] *Id.* at 202 (noting limits of the study, "[u]nanswered questions regarding younger and older, rural and urban adults persist").

[318] Lance D. Erickson, Vaughn R.A. Call & Ralph B. Brown, *SOS—Satisfied or Stuck, Why Older Rural Residents Stay Put: Aging in Place or Stuck in Place in Rural Utah*, 77 RURAL SOC. 408, 408 (2012).

[319] *Id.*

[320] *Id.* at 414 (noting, for example, that an elderly widow with chronic health conditions that cannot be treated locally may be unsatisfied with her community yet still feel very attached to it).

[321] *Id.* at 429

[322] *Id.*

[323] *Id.* at 408.

[324] *Id.* at 411.

[325] *Id.* at 430.

[326] *Id.*

[327] *Id.*

even among those with greater health care needs, of whom there are a considerable number, as the rural health demographics above detail.

The study stopped short of drawing any normative conclusions about the merits or demerits of aging in place; it simply sought to better explain why elderly people stay put. That said, it seems intuitively correct that satisfaction relates to psychological well-being, which, as studies in the preceding section suggest, relates to physical well-being.[328] The study's findings thus are at least consistent with the suggestion that place is beneficial to health. Accordingly, rather than facilitating mobility to agglomeration economies, the policy prescription would seem to be helping people stay in their existing communities.[329]

Schoenbaum's point about the costs of mobility and severing of relationships is that not all relationships are equal. Those long-standing connections left behind may not be replaced equally by new relationships in areas of greater economic opportunity. Evidence supports her suggestion that those deep relationships positively impact individuals' mental and physical health. See, for example, Bromley, Gabrielian, Brekke, Pahwa, Daly, Brekke, and Braslow's 2010 study on the meaning and effect of community and community involvement on individuals with existing mental illnesses.[330] A series of interviews with the study participants "elicited the places and people that they associate with the experience of community and the larger meaning of community in their lives."[331] The participants described four experiences "integral to their concepts of community: receiving help, minimizing risk, avoiding stigma, and giving back."[332] The results showed that participants looked for communities that provide reliable support and that most "experienced communities centered on mental health treatment or mentally ill peers as providing opportunities for positive engagement."[333] Extending the findings beyond the context of mental illness, the study implies that individuals seek out others with something in common to form communities—geography, family, hobbies, and even illnesses.

Schleicher asserts that rural-to-urban migrants could readily establish such connections in big cities as they pursue improved economic opportunities. Indeed,

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[328] *See* Cook et al., *supra* note 300, at 204; *see also* Rosalba Hernandez, Sarah M. Bassett, Seth W. Boughton, Stephanie A. Schuette, Eva W. Shiu & Judith T. Moskowitz, *Psychological Well-Being and Physical Health: Associations, Mechanisms, and Future Directions*, 10 EMOTION REV. 18, 27 (2018); Christina Bryant, Bei Bei, Kim Gilson, Angela Komiti, Henry Jackson & Fiona Judd, *The Relationship Between Attitudes to Aging and Physical and Mental Health in Older Adults*, 24 INT'L PSYCHOGERIATRICS 1674 (2012).

[329] *See, e.g.*, Pynoos et al., *supra* note 298, at 88–104 (discussing proposals to promote aging in place, including making subsidized housing more affordable, improving the Fair Housing Amendments Act, and creating age-friendly communities).

[330] Elizabeth Bromley, Sonya Gabrielian, Benjamin Brekke, Rohini Pahwa, Kathleen A. Daly, John S. Brekke & Joel T. Braslow, *Experiencing Community: Perspectives of Individuals Diagnosed as Having Serious Mental Illness*, 64 PSYCHIATRIC SERVS. 672 (2013).

[331] *Id.* at 672.

[332] *Id.*

[333] *Id.*

that sort of informal networking and information spillover is one of the benefits of agglomeration. For instance, someone living in New York can grab a coffee with a financier and learn about the industry, or someone living in San Francisco can get lunch with a venture capitalist or engineer and absorb their knowledge in the field.[334] Notwithstanding his premise, the kind of connections in those examples often provide only surface-level acquaintances, which may assist in job searches and facilitate the economy, which is the main focus of his argument. Those connections, however, fall short of being the kind that would lay a foundation for establishing a close-knit community, one that would be beneficial to the health and well-being of migrants.

C. Rural Health Care Exceptionalism

The arguments for saving rural America provide a different lens for viewing perennial conflicts in U.S. health policy—the commitment to market-based models on the one hand and recognition of the essential nature of health care on the other.[335] Although the United States has stopped well short of codifying a right to health care, we do recognize that it is different from other goods and services—that it is exceptional. As U.S. Supreme Court Justice Ruth Bader Ginsburg stated in *National Federation of Independent Business v. Sebelius*, "[u]nlike the market for almost any other product or service, the market for medical care is one in which all individuals inevitably participate[,]"[336] and "[v]irtually everyone . . . sooner or later, will visit a doctor or other healthcare professional."[337] What is distinctive about healthcare is that "the time when care will be needed is often unpredictable. . . . Inescapably, we are all at peril of needing medical care without a moment's notice."[338] Although all individuals are affected by health care, Justice Ginsburg noted that the government has previously recognized some portions of the population as especially vulnerable, such as indigents, women, and people with disabilities.[339] Provision of health care is "today a concern of national dimension."[340]

As just one example of U.S. health care exceptionalism,[341] consider the Emergency Medical Treatment and Active Labor Act (EMTALA).[342] For many decades and increasingly in the 1980s, "patient dumping" was common practice. Hospital emergency departments and physicians refused to treat patients in an

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[334] *See* Schleicher, *supra* note 6, at 103.
[335] *See supra* notes 22–28 and accompanying text.
[336] 567 U.S. 519, 590 (2012) (Ginsburg, J., concurring in part).
[337] *Id.*
[338] *Id.* at 591.
[339] *Id.* at 624.
[340] *Id.* at 589.
[341] *See* Neumann, *supra* note 21.
[342] *See* EMTALA Consolidated Omnibus Budget Reconciliation (COBRA) Act of 1985, 42 U.S.C. § 1395dd (examination and treatment for emergency medical conditions and women in labor).

emergency due to the patients' lack of insurance or ability to pay.[343] The patients "often suffered adverse health consequences as a result of delayed care."[344] In response, Congress enacted EMTALA, which requires Medicare-participating hospitals to provide emergency care "if any individual . . . comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition,"[345] regardless of the patient's ability to pay. For violations, EMTALA allows a private cause of action by the patient or "dumpee" hospital, as well as government enforcement against the hospitals and physicians, along with potential loss of participation in the Medicare and Medicaid programs.[346]

EMTALA operates as a stark exception to the common law of torts "no-duty rule" under which hospitals and physicians otherwise enjoy wide discretion in selecting or refusing to treat prospective patients.[347] In *Manlove v. Wilmington General Hospital*, a case decided prior to the enactment of EMTALA, the defendant hospital turned away a four-month-old baby who had been brought to the emergency department because the parents "failed to account for the formality of admission requirements."[348] The Delaware Supreme Court rejected the defendant's "no duty of care" defense, noting that liability may be predicated "on the refusal of service to a patient in case of an unmistakable emergency."[349] *Manlove* is among many cases that paved the way for EMTALA, which is viewed as "the culmination of a generational shift in how courts and legislatures viewed hospitals' emergency care obligations."[350] Indeed, Justice Ginsburg cited EMTALA in support of her conclusion that the commerce power clearly authorized Congress to regulate the health insurance market.[351] That conclusion demonstrates that health care is different in terms of how, when, and under what circumstances individuals access it; it is not a market that individuals realistically can choose whether or not to enter; and policymakers repeatedly have affirmed the exceptional operation of health care in laws like EMTALA.

U.S. health law and policy remains largely wedded to the conviction that health care should be delivered and accessed like other market goods and services. We are

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[343] Robert A. Bitterman, *EMTALA: The Law that Forever Changed the Practice of EM*, ACEP NOW (Sept. 25, 2018), https://www.acepnow.com/article/emtala-the-law-that-forever-changed-the-practice-of-em/ [https://perma.cc/TX2T-DY5S].

[344] Emily Friedman, *The Law that Changed Everything—and It Isn't the One You Think*, HOSPS. & HEALTH NETWORKS (Apr. 5, 2011), https://www.hhnmag.com/articles/5010-the-law-that-changed-everything-and-it-isn-t-the-one-you-think [https://perma.cc/38GY-WZAX].

[345] 42 U.S.C. § 1395dd(a).

[346] *Id.* § 1395dd(d).

[347] Sara Rosenbaum, *The Enduring Role of the Emergency Medical Treatment and Active Labor Act*, 32 HEALTH AFFS. 2075, 2075–76 (2013).

[348] 169 A.2d 18, 19 (Del. Super. Ct. 1961), *aff'd*, 174 A.2d 135 (Del. 1961).

[349] Manlove v. Wilmington Gen. Hosp., 174 A.2d 135, 140 (Del. 1961).

[350] Rosenbaum, *supra* note 347, at 2075.

[351] *Sebelius*, 567 U.S. 519 at 593 (Ginsburg, J., concurring in part) ("Federal and state law, as well as professional obligations and embedded social norms, require hospitals and physicians to provide care when it is most needed, regardless of the patient's ability to pay.").

nowhere close to treating health care as an essential service—minimal or otherwise—that the government is obligated to provide. That said, we have moved in the direction of ensuring access to essential health care services for most Americans, funded by federal and state governments, in the form of Medicare and Medicaid,[352] or through cross-subsidization in the private market via various state and federal coverage mandates, including the ACA's Essential Health Benefits (EHB) package.[353] To be sure, there are many Americans who remain outside of those coverage strategies,[354] and the rates of uninsured are especially high in rural areas, especially in rural areas of states that opted not to expand Medicaid to low-income adults irrespective of categorical eligibility.[355] Nevertheless, the ACA's EHB and Medicaid provisions are just some of the more recent examples of policy recognition that health care does not, and should not, operate according to principles of market competition, in short, these are examples of health care exceptionalism.[356]

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[352] *See* Lindsay F. Wiley, *Medicaid for All?: State-Level Single-Payer Health Care*, 79 OHIO ST. L.J. 843, 846–48 (2018); Huberfeld, *Universality of Medicaid*, *supra* note 27; David Orentlicher, *Health Care Reform: What Has Been Accomplished? What Comes Next?*, 44 OHIO N.U. L. REV. 397, 397–98 (2018).

[353] *See generally Health Insurance & Managed Care*, KAISER FAM. FOUND., https://www.kff.org/state-category/health-insurance-managed-care/pre-aca-state-mandated-health-insurance-benefits/ [https://perma.cc/TR4V-NR9D] (last visited Oct. 23, 2020) (outlining the state of care prior to the ACAs mandated benefits); *State Insurance Mandates and the ACA Essential Benefits Provisions*, NAT'L CONF. STATE LEGISLATURES (Apr. 12, 2018), https://www.ncsl.org/research/health/state-ins-mandates-and-aca-essential-benefits.aspx [https://perma.cc/TVH4-34WQ]; *see also* The Patient Protection and Affordable Care Act, 42 U.S.C § 18022 (2011); James Bailey, *The Effect of Health Insurance Benefit Mandates on Premiums*, 40 E. ECON. J. 119, 123–24 (2014) (demonstrating that mandated benefits increase group health plan premiums).

[354] Jennifer Tolbert, Kendal Orgera & Natalie Singer, *Key Facts About the Uninsured Population*, KAISER FAM. FOUND. (Dec. 13, 2019), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/ [https://perma.cc/EMX6-TTMM] (discussing improved rates of uninsured individuals post-ACA while acknowledging the still significant number of individuals who fall through the gaps and remain uninsured).

[355] Jennifer Cheeseman Day, *Rates of Uninsured Fall in Rural Counties, Remain Higher than Urban Counties*, U.S. CENSUS BUREAU (Apr. 9, 2019), https://www.census.gov/library/stories/2019/04/health-insurance-rural-america.html [https://perma.cc/LV9U-6Z3T]; JACK HOADLEY, JOAN ALKER & MARK HOLMES, HEALTH INSURANCE COVERAGE IN SMALL TOWNS AND RURAL AMERICA: THE ROLE OF MEDICAID EXPANSION 2 (2018), https://ccf.georgetown.edu/wp-content/uploads/2018/09/FINALHealthInsuranceCoverage_Rural_2018.pdf [https://perma.cc/FFE3-6VVD].

[356] *See* Nicolas P. Terry, *Regulatory Disruption and Arbitrage in Health-Care Data Protection*, 17 YALE J. HEALTH POL'Y, L. & ETHICS 143 (2017) (describing other examples of healthcare exceptionalism such as the Health Insurance Portability and Accountability Act, Rehabilitation Act, Americans with Disabilities Act, Genetic Information Non-Disclosure Act, and Substance Abuse Confidentiality Regulations).

1. Rural Health Care Policy Designations

Likewise, various federal laws and policies essentially codified the particular exceptionalism of rural health care, including special designations for certain types of hospitals and health centers, namely: (a) Sole Community Hospitals, (b) Critical Access Hospitals, (c) Rural Community Hospitals, (d) Rural Referral Centers, (e) Rural Health Clinics, (f) Federally Qualified Health Centers, and (g) the 340 B Program.[357] Providers that receive such recognition enjoy more favorable government health care program reimbursement and other advantages.[358] These special designations, which specifically target or particularly benefit rural health care providers, are a necessary response to the rural demographics and rural health care delivery challenges described in Part II.

(a) Sole Community Hospitals

Congress created the Sole Community Hospital (SCH) designation in 1983 to support short-term general hospitals that "by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals, [are] the sole source of inpatient hospital services reasonably available in a geographic area to Medicare beneficiaries."[359] SCHs received higher Medicare reimbursement for both inpatient and outpatient services.[360] The enhanced payment for inpatient care was part of the original enactment.[361] Congress added the outpatient enactment in 2006.[362] In addition, SCHs qualify for other adjustments based on patient volume and participation in certain other federal reimbursement incentives.[363] The continued congressional recognition of SCHs through those allowances signals a well-established federal commitment to rural hospitals and to ensuring access to care in rural areas.

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[357] *Rural Hospitals*, RURAL HEALTH INFO. HUB, https://www.ruralhealthinfo.org/topics/hospitals#community-benefit-spending [https://perma.cc/H87Q-Q83L] (last visited Oct. 23, 2020); *Federally Qualified Health Centers (FQHCs) and the Health Center Program,* RURAL HEALTH INFO. HUB, https://www.ruralhealthinfo.org/topics/federally-qualified-health-centers [https://perma.cc/R3TT-GWLW] (last visited Oct. 23, 2020) [hereinafter *FQHCs*]; *Rural Health Clinics (RHCs)*, RURAL HEALTH INFO. HUB, https://www.ruralhealthinfo.org/topics/rural-health-clinics [https://perma.cc/UX6N-H7SH] (last visited Nov. 4, 2020); *340B Drug Pricing Program*, HEALTH RES. & SERVS. ADMIN., https://www.hrsa.gov/opa/index.html [https://perma.cc/6R9A-7SD8] (last visited Nov. 4, 2020).

[358] *FQHCs*, *supra* note 357.

[359] 42 C.F.R. § 405.476 (1983).

[360] SHARITA R. THOMAS, RANDY RANDOLPH, G. MARK HOLMES & GEORGE H. PINK, THE FINANCIAL IMPORTANCE OF THE SOLE COMMUNITY HOSPITAL PAYMENT DESIGNATION 1 (2016), https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2016/11/SCH-Financial-Importance-1.pdf [https://perma.cc/3SX3-DSSJ].

[361] *Id.*

[362] *Id.*

[363] *Id.*

A hospital is eligible for SCH status if it is: (1) located at least 35 miles from a comparable hospital; or 2) is between 25–35 miles from a comparable hospital, and meets one of the following criteria: [a] "No more than 25% of its total inpatients or 25% of Medicare inpatients admitted are also admitted to similar hospitals within a 35 mile radius; or [b] It has fewer than 50 acute care beds and would admit at least 75% of inpatients from the service area were it not for some patients requiring specialized care that the hospital does not offer"; or (3) the hospital is between 15–25 miles from other comparable hospitals that are inaccessible for at least 30 days in two out of three years due to topography or weather; or (4) traveling to the nearest hospital takes at least 45 minutes due to distance, posted speed limits, or predictable weather.[364]

Once qualifying for the designation, SCHs are eligible to receive the higher of two possible reimbursement rates: (1) the Inpatient Prospective Payment System (IPPS) rate under which other Medicare-participating hospitals are reimbursed, which includes geographic adjustments for the area wage-index and other overhead costs, or (2) an updated hospital-specific rate, based on the hospital's costs in a base year, updated to the current year and adjusted for changes in the case mix.[365]

(b) Critical Access Hospitals

Another special designation for rural hospitals recognized under federal law is Critical Access Hospitals (CAHs).[366] The Balanced Budget Act of 1997 stated that in order to obtain CAH designation, the nonprofit or public hospital must: (1) be "located more than a 35-mile drive . . . from a hospital"; (2) be "certified by the State as being a necessary provider of health care services to residents in the area"; (3) "make[] available 24-hour emergency care services" as determined necessary by the State"; (4) have no more than 25 acute care inpatient beds; (5) provide an average length of stay of 96 hours or less for acute care patients.[367] A CAH receives certain benefits to "reduce the financial vulnerability of rural hospitals and improve access to healthcare by keeping essential services in rural communities."[368]

The biggest advantage for CAHs is cost-based reimbursement. Historically, since the beginning of the Medicare and Medicaid programs in 1965, the government paid all providers on a cost basis, meaning, essentially, that for every dollar spent, the provider submitted a bill to the government and recovered that amount.[369] Cost-based reimbursement has an obvious inflationary incentive—spend more, get

[364] *Id.*

[365] *Id.* at 1–4.

[366] *Critical Access Hospitals*, RURAL HEALTH INFO. HUB, https://www.ruralhealthinfo.org/topics/critical-access-hospitals#benefits [https://perma.cc/YKQ3-T4UY] (last updated Aug. 20, 2019).

[367] Balanced Budget Act of 1997, Pub. L. No. 105-133, § 1820(c)(2), 11 Stat. 251, 370–71 (1997); *see also Critical Access Hospitals*, *supra* note 366.

[368] *Critical Access Hospitals*, *supra* note 366; Jordan, *supra* note 159.

[369] Transitional Hospitals Corp. v. Shalala, 222 F.3d 1019, 1021 (D.C. Cir. 2000).

more—which came under scrutiny as health care costs continued to rise.[370] In the early 1980s, CMS adopted a different approach for Medicare hospital reimbursement—the inpatient prospective payment system (IPPS).[371] Under IPPS, hospitals receive a predetermined, bundled payment, based on the average cost of treating certain conditions, coded according to diagnosis-related groups (DRGs).[372] The average DRG rate is adjusted for particular features of the hospital, including DSH status, teaching (or graduate medical education (GME)) hospital, organ transplant center status, as well as geographic wage variations and other overhead costs.[373] The intended effect of IPPS is to reduce spending and encourage efficiency.[374] Hospitals that manage to treat patients for lower costs than the predetermined amount may retain the excess, while hospitals that spend more than average, must eat those extra costs (subject to an additional possible adjustment for designated "outlier" cases).[375] IPPS is considered a success in reducing Medicare costs, and similar prospective payment systems have been adopted across other services (including outpatient, mental health, and other providers) and payers (including private insurers).[376]

The CAH designation, however, allows hospitals to revert to the pre-IPPS cost-based reimbursement methodology, which may allow those essential rural community providers to stay in the black. CAHs receive costs plus 1 percent for Medicare patients, and, depending on the state, may also receive cost-based reimbursement from Medicaid. Again, the designation recognizes that rural hospitals are essential to their communities and operate under different financial and other pressures.

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[370] William J. Scanlon, *The Future of Medicare Hospital Payment*, 25 HEALTH AFFS. 70, 71 (2006), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.25.1.70 [https://perma.cc/2SU9-QNWW]; *see also* Rand Health, *Effects of Medicare's Prospective Payment System on the Quality of Hospital Care* 1 (2006), https://www.rand.org/pubs/research_briefs/RB4519-1.html [https://perma.cc/55A2-7VHM].

[371] Scanlon, *supra* note 370, at 71–72; *see* Health, *supra* note 370.

[372] *Acute Inpatient PPS*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS [https://perma.cc/3MSU-4FWN] (last updated Feb. 20, 2020, 2:43 PM).

[373] CTRS. FOR MEDICARE & MEDICAID SERVS, ACUTE CARE HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEM 1, 8–15 (2020), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AcutePaymtSysfctsht.pdf [https://perma.cc/6PH9-DEC7] [hereinafter ACUTE CARE HOSPITAL IPPS].

[374] *Transitional Hospitals*, 222 F.3d at 1021.

[375] *Outlier Payments,* CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/outlier [https://perma.cc/ZH2B-AYC3] (last updated Apr. 10, 2013, 10:36 AM).

[376] Stuart Guterman & Allen Dobson, *Impact of the Medicare Prospective Payment System for Hospitals*, 7 HEALTH CARE FIN. REV. 97, 104–06 (1986), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4191526/pdf/hcfr-7-3-97.pdf [https://perma.cc/2E6R-CJ37].

(c) Rural Community Hospitals

Another federal designation is Rural Community Hospitals (RCHs). RCHs include hospitals that are too large to be designated CAHs.[377] The RCH program is a demonstration project initiated under the Medicare Modernization Act of 2003.[378] Initially, hospitals were invited to apply for a five-year period,[379] and the statute authorized thirty hospitals to participate.[380] The demonstration was established "to test the feasibility and advisability of establishing rural community hospitals to furnish covered inpatient hospital services to Medicare beneficiaries."[381] The RCH program's goals include caring for underserved individuals (because of those individuals' geography or economic status) as well as the entire rural community.[382] The program has since been renewed twice, for additional five-year periods.[383] Because the program "focuses on promoting high quality and efficient healthcare delivery . . . , applicants are asked to specify interventions that both increase access to and improve the quality of care, while enhancing patient care options and the ability for beneficiaries to remain in their own rural communities."[384] The third round of solicitations gives priority to hospitals located in one of the twenty states with the lowest population densities.[385]

The precise requirements for RCH designation is a hospital (1) "located in a rural area" (as defined by the Social Security Act); (2) has "fewer than 51 acute care inpatient beds" (excluding psychiatric and rehabilitation unit beds); (3) "makes available 24-hour emergency care services"; and (4) "is not eligible for designation,

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[377] *Rural Community Hospital Demonstration,* CTRS. FOR MEDICARE & MEDICAID SERVS., https://innovation.cms.gov/innovation-models/rural-community-hospital [https://perma.cc/G5FA-6ZLE] (last updated Apr. 28, 2020).

[378] Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 410A, 117 Stat. 2066, 2272–73 (2003).

[379] *Rural Community Hospital Demonstration*, *supra* note 377.

[380] Fact Sheet, *Rural Community Hospital Demonstration*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Apr. 17, 2017) https://www.cms.gov/newsroom/fact-sheets/rural-community-hospital-demonstration [https://perma.cc/M955-9GQR] [hereinafter R.C.H.D.].

[381] *Id.*

[382] Janelle Ali-Dinar, *CMS Creates More Rural Innovation—Round 3—Rural Community Hospital Demonstration Program to Meet Rural Needs*, RACMONITOR (May 24, 2017), https://www.racmonitor.com/cms-creates-more-rural-innovation-round-3-rural-community-hospital-demonstration-program-to-meet-rural-needs [https://perma.cc/Z5FB-XT9V].

[383] *Id.*

[384] *Id.*

[385] Susan Morse, *CMS Seeks Rural Hospitals' Participation in Medicare Inpatient Demonstration*, HEALTHCARE FIN. (Apr. 18, 2017), https://www.healthcarefinancenews.com/news/cms-seeks-rural-hospitals-participation-medicare-inpatient-demonstration [https://perma.cc/T6N4-JKEP] (noting that the twenty states include: Alaska, Arizona, Arkansas, Colorado, Idaho, Iowa, Kansas, Maine, Mississippi, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Vermont, and Wyoming).

or has not been designated, as a critical access hospital[.]"[386] As with CAHs, the main advantage of the RCH designation is cost-based reimbursement, which applies for the first cost-reporting period of the demonstration project. For subsequent cost-reporting periods, participating RCHs receive the lesser of reasonable costs or a target amount. The target amount is defined as the preceding cost reporting period's target amount increased by the IPPS update factor (which would apply to other hospitals paid under IPPS) for that particular cost reporting period.[387]

The RCH demonstration, and subsequent renewals, again, provide evidence that federal policy continues to recognize the unique status of rural hospitals, and the renewals of the program highlight the continuing financial and other challenges for those providers.

(d) Rural Referral Centers

Congress created the Rural Referral Center (RRC) designation in 1983.[388] The program "was established to support high-volume rural hospitals that treat a large number of complicated cases."[389] RRCs enjoy several benefits including a higher standardized payment rate, exemption from proximity and other requirements applicable to SCHs and RCHs, exemption from the 12 percent payment adjustment cap that applies to other rural hospitals, and eligibility to participate in the 340B Program at a lower rate.[390]

A hospital must be in a rural area to qualify for the RRC designation. A rural hospital can qualify for RRC designation in three ways. First, any rural hospital with at least 275 beds qualifies. Second, if the hospital demonstrates:

> (1) at least 50 percent of the hospital's Medicare patients are referred by physicians in other hospitals or who are not employed by the hospital; (2) at least 60 percent of the hospital's Medicare patients live more than 25 miles from the hospital, and (3) at least 60 percent of all services provided to Medicare patients are provided to patients who live more than 25 miles from the hospital.[391]

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[386] Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 401A(f)(1)(A), 117 Stat. 2066, 2273 (2003).

[387] *Rural Community Hospital Demonstration*, *supra* note 377.

[388] *See* Sameer Vohra, Carolyn Pointer, Amanda Fogleman, Thomas Albers, Anish Patel & Elizabeth Weeks, *Designing Policy Solutions to Build a Healthier Rural America*, 48 J. L., MED., & ETHICS 491, 494–95 (2020); 42 C.F.R. § 405.476 (1983).

[389] *Rural Referral Center Program*, CTRS. MEDICARE & MEDICAID SERVS. 1 (May 2014), https://static1.squarespace.com/static/5c13fd4150a54f21cf0140ad/t/5c140b0c03ce64b47cc3173a/1544817421707/CMS_Fact_Sheet_--_RRC.pdf [https://perma.cc/U93S-4PJQ].

[390] *What Is an RRC*, RURAL HOSP. COAL., https://www.ruralhospitalcoalition.com/what-is-an-rrc [https://perma.cc/XYE2-5GN5] (last visited Oct. 23, 2020).

[391] ACUTE CARE HOSPITAL IPPS, *supra* note 373, at 10.

The third way to qualify is by demonstrating that the hospital (1) "has a Case-Mix Index (CMI) equaling the lower of the median CMI value for all urban hospitals nationally or the median CMI value for urban hospitals located in its region"; and (2) discharges at least 5,000 or 3,000 patients annually (for an osteopathic hospital) or the median number of discharges for urban hospitals in its same census region and "(a) more than 50 percent of its active staff are specialists as specified by 42 CFR 412.96(c)(3)"; (b) "at least 60 percent of all discharges are for patients who live more than 25 miles from the hospital"; or (c) "at least 40 percent of all inpatients treated are referred from other hospitals or from physicians who are not on the hospital's staff."[392]

In sum, RRCs are high-volume acute care rural hospitals that treat large numbers of complicated cases. By creating reimbursement and other structures to support those facilities, RRCs "localize care, minimize the need for further referrals and travel to urban areas, and provide services at costs lower than would be incurred in urban areas."[393] As larger facilities, they typically also support "satellite sites and outreach clinics to provide primary and emergency care services to surrounding underserved communities."[394] RRCs often are essential to local economies, serving as major employers and making the community more attractive to other businesses and residents considering locating in the area.[395] As discussed above, treating patients close to home and reducing the need to travel for health care also contributes to improved outcomes. Approximately 135 hospitals in 38 states have RRC status.[396]

(e) Rural Health Clinics

The Rural Health Clinic (RHC) designation dates back to 1977 and was created to "increase access to primary care for patients in rural communities."[397] RHCs provide patients with an integrated team of cross-disciplinary members consisting of physicians, nurse practitioners, physician assistants, certified nurse-midwives, and clinical social workers.[398] By providing access to these other mid-level providers, RHCs combat the vacuum in care for Medicare and Medicaid patients

[392] *Rural Referral Center Program*, *supra* note 389, at 2.
[393] *What Is an RRC*, *supra* note 390.
[394] *Id.*
[395] *Id.*
[396] *Id.*
[397] *Rural Health Clinics (RHCs)*, RURAL HEALTH INFO. HUB, https://www.ruralhealthinfo.org/topics/rural-health-clinics [https://perma.cc/3FVR-FFKY] (last visited Oct. 23, 2020).
[398] CTRS. FOR MEDICARE & MEDICAID SERVS. & MEDICARE LEARNING NETWORK, RURAL HEALTH CLINIC 2 (May 2019), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/RuralHlthClinfctsht.pdf [https://perma.cc/5SXE-6XHX] [hereinafter CTRS. FOR MEDICARE & MEDICAID SERVS.].

created by the physician shortage in rural areas.[399] The main advantage of RHCs is higher reimbursement.[400]

RHC visits must be medically necessary, face-to-face, and related to a "service that requires the skill level of the RHC practitioner."[401] In order to qualify as an RHC, a clinic must (1) be located in a rural area and (2) "[e]mploy an NP or PA"; have an NP, PA, or CNM working at least 50 percent of the time during operational hours; "[d]irectly provide routine diagnostic and laboratory services"; "[h]ave arrangements with one or more hospitals to provide medically necessary services unavailable at the RHC"; "[h]ave drugs and biologicals available to treat emergencies"; provide various laboratory tests on-site; "[h]ave a quality assessment and performance improvement program"; "[p]ost operation days and hours"; "[n]ot be primarily a mental disease treatment facility or a rehabilitation agency"; "[n]ot be a Federally Qualified Health Center (FQHC)"; and "[m]eet all other state and Federal requirements[.]"[402]

(f) Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) are another designation important for rural providers. The designation is not limited to rural areas but also applies in medically underserved urban areas.[403] FQHCs provide a broader range of services than RHCs, including diagnostic and laboratory, pharmaceuticals, behavioral and oral health, hospital and specialty, after-hours care, case management, transportation, and interpretative services.[404] RHCs, by contrast, provide primary outpatient care, basic laboratory services, and emergency care.[405]

The FQHC designation was created in 1965[406] and supports outpatient services, including community health centers, migrant health care centers, community health centers for the homeless, public housing, primary care clinics, and similar

[399] *What Is an RHC & Why Are They So Important?*, AZALEA HEALTH, https://www.azaleahealth.com/blog/what-is-rhc/ [https://perma.cc/K9UN-KHZW] (last visited Oct. 23, 2020).

[400] *Id.*

[401] CTRS. MEDICARE & MEDICAID SERVS., *supra* note 398, at 4.

[402] *Id.* at 3.

[403] U.S. DEP'T OF HEALTH & HUM. SERVS., COMPARISON OF THE RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER PROGRAMS 1, 10 (2006), https://www.hrsa.gov/sites/default/files/ruralhealth/policy/confcall/comparisonguide.pdf [https://perma.cc/52PC-QTSW].

[404] *Id.* at 13–15.

[405] *Id.*

[406] Brad Wright, *Who Governs Federally Qualified Health Centers?*, 38 J. HEALTH POL. POL'Y L. 27, 27 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5602556/pdf/nihms902548.pdf [https://perma.cc/JC27-H2WA].

facilities.[407] FQHCs are required to accept all patients.[408] In order to qualify, the clinic must "offer services to all, regardless of the person's ability to pay, establish a sliding fee discount program, be a nonprofit or public organization, be community-based, serve a medically underserved area or population, provide comprehensive primary care services, and have an ongoing quality assurance program."[409] The main benefit for FQHC status designation is a separate FQHC PPS.[410] States also may establish alternative reimbursement methodologies for FQHCs for Medicaid-related expenses.[411] FQHCs are considered important "safety net providers in rural areas."[412]

(g) 340B Program

The 340B Drug-Finding Program (340B) encourages hospitals to divert savings from reduced drug prices to improving care for vulnerable populations, including but not limited to lower-income patients.[413] The program was created in 1992, and approximately 42 percent of general acute hospitals have been participating since 2012.[414] 340B helps qualifying hospitals gain more resources by making it cheaper for them to purchase outpatient drugs while receiving standard reimbursements for those drugs.[415] Organizations that are eligible for 340B include community health centers, children's hospitals, hemophilia treatment centers, CAHs, SCHs, RRCs, and public and nonprofit DSH hospitals.[416] Enrolled hospitals can achieve an average of 25 to 50 percent savings on pharmaceutical purchases.[417] 340B is critical to rural hospitals' financial viability.[418] Even though generating relatively modest average

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[407] CTRS. FOR MEDICARE & MEDICAID SERVS. & MEDICARE LEARNING NETWORK, FEDERALLY QUALIFIED HEALTH CENTER 1, 3 (Sept. 2019), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/fqhcfactsheet.pdf [https://perma.cc/4EWK-XV73].

[408] Tory Waldron, *How Many Federally Qualified Health Centers Are There?*, DEFINITIVE HEALTHCARE (July 1, 2019), https://blog.definitivehc.com/how-many-fqhcs-are-there [https://perma.cc/J63K-GKBY].

[409] *FQHCs*, *supra* note 357.

[410] *Id.*

[411] *Id.*

[412] *Id.*

[413] Sunita Desai & J. Michael McWilliams, *Consequences of the 340B Drug Pricing Program*, 378 NEW ENG. J. MED. 539, 540 (2018), https://www-nejm-org.proxy-remote.galib.uga.edu/doi/full/10.1056/NEJMsa1706475 [https://perma.cc/9MZE-XPWZ].

[414] *Id.*

[415] *Id.*

[416] AM. HOSP. ASS'N, FACT SHEET: THE 340B DRUG PRICING PROGRAM 1 (2019), https://www.aha.org/system/files/2019-01/fact-sheet-340b-0119.pdf [https://perma.cc/8H4Z-2JJ7].

[417] *Id.*

[418] *340B Program Helps Rural Hospitals Stay Afloat*, MANAGED HEALTHCARE EXEC. (June 23, 2019), https://www.managedhealthcareexecutive.com/hospitals-providers/340b-program-helps-rural-hospitals-stay-afloat [https://perma.cc/KRG4-VZYH].

annual savings of $10,000 for rural hospitals, that amount contributes significantly to those facilities' operating budgets and can make the difference between staying open or closing their doors.[419]

Schleicher and other proponents of agglomeration economies might argue that the need to shore up rural health providers with this array of programs is all the more reason why rural residents should be encouraged to move elsewhere. Rather than continuing to design exceptional policies to maintain services in dying locales, laws and policies should be reconsidered to facilitate mobility. But that thesis fails to consider the adverse health effects of agglomeration and health benefits of place, described above, not to mention repeated recognition that health care does not operate according to standard market principles. Anderson's arguments for maintaining essential services in "new minimal cities" both as a necessary prerequisite to mobility and a humanitarian consideration, are consistent with the point here. This Article, however, offers an additional imperative, namely that the well-recognized exceptional nature of health care is inextricably intertwined with the survivability of rural people and places.

2. Rural Health Care Market Exceptions

The special designations for rural health care providers described above represent one expression of health care exceptionalism, carving out special reimbursement rules for government health care programs, among other accommodations. Even where health care is left to the private market, it is a highly regulated market.[420] But the various health demographic and health care delivery challenges facing rural providers call for exceptions even to those existing regulations, as described next.

(a) Physician Recruitment Safe Harbor

One way that health care markets are regulated is through fraud and abuse laws that prohibit activities and arrangements permitted in other industries.[421] For one, the Physician Self-Referral Law, or Stark Law, prohibits physicians from referring patients to an entity in which they or an immediate family member have a financial

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[419] Joseph M. Devin, *Cuts to the 340B Program Threaten Rural Hospitals*, WASH. EXAM'R (May 25, 2018, 12:00 AM), https://www.washingtonexaminer.com/opinion/op-eds/cuts-to-the-340b-program-threaten-rural-hospitals [https://perma.cc/22LY-QD79].

[420] *See* John D. Blum, *New Governance and Health Care Regulation*, 2 ASIAN J. WTO & INT'L HEALTH L. & POL'Y 125, 128 (2007) ("Health care regulation in the United States, dominated by command and control models, can be characterized on its own as a major enterprise, estimated to cost close to $340 billion dollars annually, constituting a tax of $1,500 on the average American family.").

[421] *See generally* David A. Hyman, *Health Care Fraud and Abuse: Market Change, Social Norms, and the Trust "Reposed in the Workmen,"* 30 J. LEGAL STUD. 531 (2001); Joan H. Krause, *Ethical Lawyering in the Gray Areas: Health Care Fraud and Abuse*, 34 J. L. MED. & ETHICS 121 (2006).

relationship.[422] Likewise, the federal Anti-Kickback Statute (AKS) prohibits offering or receiving, or giving or accepting, remuneration in exchange for referral of government health care program patients.[423]

An example of rural health care exceptionalism in health law and policy is the AKS safe harbor for rural physician recruitment.[424] The AKS is interpreted broadly and criminalizes a wide range of activities and arrangements done with the purpose of inducing referral of government health care program patients, including Medicare and Medicaid beneficiaries.[425] The statute could be read to include recruiting a new physician to a hospital medical staff as a kickback. A hospital's compensation package to the new physician might include, for example, salary and benefits, moving expenses, a parking spot, educational loan repayment, free cafeteria meals, reimbursement for professional dues or continuing education training, all of which could be deemed "illegal remuneration" offered in exchange for the physician referring government health care program patients to the hospital. Such arrangements could trigger the AKS's criminal sanctions and, even more financially threatening, the federal False Claims Act's civil monetary penalties, treble damages, and other sanctions.[426]

In a rural area, the expectation that the new doctor will refer patients to the hospital that has recruited her is almost certain, given that it may be the only hospital in the area. Recognizing those challenges, Congress included a safe harbor in the AKS for recruiting physicians to rural areas.[427] If properly structured within the safe harbor, rural hospitals may have more leeway than urban hospitals to offer incentives to physicians joining their medical staffs. As the Zaidi study[428] and other anecdotal evidence reveal, lack of essential services in rural communities sets up a vicious cycle whereby educated, working-age individuals leave because there are no

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[422] Stark Law, 42 U.S.C § 1395nn.

[423] Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b) (2020).

[424] 42 C.F.R. § 411.357(e) (2011); *see generally The Anti-Kickback Statute Basics: Enforcement and Safe Harbors*, BARRETT & SINGAL, https://barrettsingal.com/services/the-anti-kickback-statute [https://perma.cc/G2X3-JYRL] (last visited Oct. 23, 2020).

[425] *See* United States v. Greber, 760 F.2d 68, 72 (3d Cir. 1985) (discussing the "one purpose" test for AKS); United States v. Borrasi, 639 F.3d 774, 783–84 (7th Cir. 2011); Hyman, *supra* note 421, at 534–35.

[426] False Claims Act, 31 U.S.C. § 3729 (2011). The ACA explicitly made a violation of the AKS a violation of the False Claims Act. *See* 42 U.S.C. § 1320a-7b(g) (2018) ("In addition to the penalties provided for in this section or section 1320a–7a of this title, a claim that includes items or services resulting from a violation of this section constitutes a false or fraudulent claim for purposes of subchapter III of chapter 37 of Title 31."). That "bootstrapping" theory previously was recognized under common law. *See, e.g.*, United States *ex rel.* Kosenske v. Carlisle HMA, Inc., 554 F.3d 88, 94 (3d Cir. 2009) ("Falsely certifying compliance with the Stark or Anti-Kickback Acts in connection with a claim submitted to a federally funded insurance program is actionable under the FCA.") (citing United States *ex rel.* Schmidt v. Zimmer, Inc., 386 F.3d 235, 243 (3d Cir. 2004) (other citations omitted)).

[427] 42 C.F.R § 411.357(e) (2011).

[428] *See* Zaidi, *supra* note 150.

opportunities, and new industries do not move into the area because there are no educated people to work for them. The rural recruitment safe harbor signals that federal policy recognizes the challenges and uniqueness of rural health care delivery.

(b) Certificate of Need Laws

Another way health care markets were historically regulated was through certificate of need (CON) laws. CON laws essentially grant government approval to anti-competitive conduct in health care markets. New York enacted the first CON law in 1964, a model that Richard Nixon's administration adopted as federal law in a 1972 amendment to the Social Security Act.[429] Although the federal law has since been repealed, a number of states still have CON laws on the books and require state approval for new construction, expansion of beds, addition of new equipment, and health care mergers and acquisitions to ensure that the change is in the community's best interest.[430] When a state denies a CON to a proposed new hospital, facility, or service, it essentially allows an existing provider to maintain a monopoly in the relevant geographic and/or product market. For that reason, CON laws are much maligned and have been repealed or scaled back in a number of jurisdictions.[431]

Even so, lawmakers in states with substantial rural areas advocate the importance of CON restrictions for protecting rural hospitals from competition from larger, urban-based health systems.[432] Imagine, for example, a large, urban health system that sees a business opportunity in establishing a new rural ambulatory

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[429] Clark C. Havighurst, *Regulation of Health Facilities and Services by "Certificate of Need,"* 59 VA. L. REV. 1143, 1151 (1973).

[430] *See, e.g.*, GA. CODE ANN. § 31-6-1 (West 2008); *see generally CON-Certificate of Need State Laws*, NAT'L CONF. OF STATE LEGISLATURES, https://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx [https://perma.cc/3KBN-6P8L] (last visited Oct. 23, 2020).

[431] *See* Adam Millsap, *Florida's Certificate-of-Need Laws Should Go*, FORBES (Feb. 13, 2018, 9:10 AM EST), https://www.forbes.com/sites/adammillsap/2018/02/13/floridas-certificate-of-need-laws-should-go/#3603bf668786 [https://perma.cc/JVZ3-87NZ]; Matthew D. Mitchell & Christopher Koopman, *40 Years of Certificate-of-Need Laws Across America*, MERCATUS CTR. (Sept. 27, 2016), https://www.mercatus.org/publication/40-years-certificate-need-laws-across-america [https://perma.cc/JZ98-6B3G].

[432] *See* NEV. HOSP. ASS'N, *Hospital Certificate of Need: Rural Necessity, Urban Expense*, ISSUE BRIEF 1 (2011), https://www.colorado.gov/pacific/sites/default/files/9-NV-Hospitals%20CON.pdf [https://perma.cc/3H6P-YGSZ] (last visited Oct. 23, 2020); Ariel Hart, *Bill Would Allow 'Micro-Hospitals' in Rural Georgia*, ATLANTA J. CONST. (Mar. 8, 2018), https://www.ajc.com/news/state--regional-govt--politics/bill-would-allow-micro-hospitals-rural-georgia/pq6AFJxpZY4LVKWzfhCwiI/ [https://perma.cc/3W5G-J2P6]; Travis Fain, *Certificate of Need Reform Bills Move; Heavily Lobbied Fight Rolls on*, DAILY PRESS (Feb. 4, 2016, 1:25 PM), http://www.dailypress.com/news/dp-nws-ga-copn-hospital-reform-20160204-story.html [https://perma.cc/8QUW-8TF8]; Katherine Restrepo, *Certificate of Need (CON) Forgets What's Best for the Patient*, JOHN LOCKE FOUND. (June 29, 2015), https://www.johnlocke.org/update/certificate-of-need-con-forgets-whats-best-for-the-patient/ [https://perma.cc/32P6-7RLY] (discussing rural argument).

surgical center (ASC) offering highly reimbursed orthopedic or cardiac procedures. The existing rural community hospital's viability may be further threatened as the new ASC draws off those higher reimbursement services, on which the rural hospital depends to balance out revenue losses from necessary but lower-reimbursement services such as emergency, acute inpatient care, and labor and delivery. Accordingly, some state law- and policymakers, despite supporting repeal of CON laws as a general matter, would allow exceptions for rural areas of their states.[433]

It bears emphasis that the policy drivers for maintaining patently anti-competitive CON laws for rural areas are not simply rural hospitals' financial viability. Those facilities also provide essential health care services to the community and stand as economic pillars for rural economies. As noted in Part II, when a rural hospital closes, rural communities often lose their major employer,[434] not to mention the ability to attract other employers and economic development opportunities.[435] Without essential services, manufacturing facilities, or retirement community amenities, potential employers are less likely to locate in rural areas.[436] Accordingly, some states have licensed or otherwise recognized delivery innovations that are aimed at ensuring access to essential health care services in rural areas. Two models, discussed next, include the micro hospital[437] and stand-alone

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[433] NEV. HOSP. ASS'N, *supra* note 432; Andy Miller, *Ga. Legislature Approves CON Changes, Medicaid Funding Plan, Hospital Transparency*, WABE (Apr. 1, 2019), https://www.wabe.org/breakthrough-legislature-approves-con-changes-medicaid-funding-plan-hospital-transparency/ [https://perma.cc/XQ7H-LMJF]; Ariel Hart & Greg Bluestein, *Kemp Threatens 'Executive Action' if Hospital Deregulation Push Stalls*, ATLANTA J. CONST. (Mar. 20, 2019), https://www.ajc.com/news/state--regional-govt--politics/kemp-threatens-executive-action-hospital-deregulation-push-stalls/eOl6UhgJVxGGQ7Nm0tERoJ/ [https://perma.cc/V4B9-SG8Q] (noting resistance from rural health care providers is among the reasons that Georgia enacted a more modest overhaul of its CON law); Christina L. Myers, *Lawmakers, Physicians Call for Repeal of Health Care Law*, ASSOCIATED PRESS NEWS (Feb. 26, 2019), https://apnews.com/f799b24784474919953b9ed805a4c905 [https://perma.cc/54R7-J57B]; Matthew D. Mitchell, *Do Certificate-of-Need Laws Still Make Sense in 2019?*, MANAGED HEALTHCARE EXEC. (Sept. 3, 2019), https://www.managedhealthcareexecutive.com/article/do-certificate-need-laws-still-make-sense-2019 [https://perma.cc/XZU9-VFWL].

[434] NAT'L RURAL HEALTH ASS'N, *supra* note 118; Rickets III & Heaphy, *supra* note 118.

[435] Wishner et al., *supra* note 119.

[436] Weber & Miller, *supra* note 92 (Candler County, Georgia "got a financial boost when Linzer Products Corporation opened up a paint manufacturing and distribution center in Metter [the county seat] last year, creating 200 jobs. It would be a lot harder to attract that kind of new business without a hospital, [Carvy] Snell [publisher of the city's 104-year-old local newspaper] said."); Blake Farmer, *Economic Ripples: Hospital Closure Hurts a Town's Ability to Attract Retirees*, KCUR 89.3 (Apr. 7, 2019, 7:05 AM), https://www.kcur.org/post/economic-ripples-hospital-closure-hurts-towns-ability-attract-retirees#stream/0 [https://perma.cc/TLR9-8TJV].

[437] Michelle Andrews, *Sometimes Tiny Is Just the Right Size: 'Microhospitals' Filling Some ER Needs*, KAISER HEALTH NEWS (July 19, 2016), https://khn.org/news/sometimes-

emergency room (ER).[438] CON laws may need to be repealed or modified to allow these innovations.[439] At the same time, necessity being the mother of invention, these streamlined approaches also may be adopted successfully in other, less perilous urban markets.

(c) Health Care Delivery Innovations

The two models described below—micro hospitals and stand-alone emergency rooms—roughly comport with Anderson's "new minimal cities" suggestion by converting full-service, acute care rural hospitals that have become financially unsustainable into more streamlined operations. Micro hospitals provide emergency services but also have the ability to admit and treat a small number of patients without transfer to a larger facility. These tiny hospitals may have a dozen or fewer beds and, in some cases, also provide outpatient surgery, primary care, and other services. Typically, micro hospitals are affiliated with a larger medical system, thus retaining some of the advantages of operations located in larger, agglomeration economies, including information sharing, cheaper supply chains, access to specialty services and consultants, and deeper job markets. At the same time, they retain the benefits of treating individuals in their homes and communities. To be clear, some of those advantages require micro hospitals to avail themselves of another innovation for rural health care delivery—telemedicine, for one, which presents associated challenges with respect to rural broadband access, professional licensure, and reimbursement.[440]

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tiny-is-just-the-right-size-microhospitals-filling-some-er-needs/ [https://perma.cc/B53P-LEAD].

[438] Ilene MacDonald, *Standalone ERs May Have Grown Too Fast in Texas, but Other States Continue to Embrace Them*, FIERCEHEALTHCARE (Feb. 7, 2018), https://www.fiercehealthcare.com/healthcare/stand-alone-ers-may-have-grown-too-fast-texas-but-other-states-continue-to-embrace-them [https://perma.cc/7REK-QXZC].

[439] *See, e.g.*, Michael L. LaBattaglia, *New Georgia Law Promotes Micro-Hospitals, Though CMS's "Primarily Engaged" Standard Looms*, JD SUPRA (May 14, 2018), https://www.jdsupra.com/legalnews/new-georgia-law-promotes-micro-80483/ [https://perma.cc/B3ME-W5TH]; Mark Niesse, *Micro-Hospitals Proposed to Provide Rural Georgia Health Care*, ATLANTA J. CONST. (Feb. 6, 2018), https://www.ajc.com/news/state--regional-govt--politics/micro-hospitals-proposed-provide-rural-georgia-health-care/POJ7E6OtUIGkjZy6IdRRkJ/ [https://perma.cc/4VB2-L94N]; Hart, *supra* note 432.

[440] *Barriers to Telehealth in Rural Areas*, RURAL HEALTH INFO. HUB (May 21, 2019), https://www.ruralhealthinfo.org/toolkits/telehealth/1/barriers [https://perma.cc/YD6C-THGN]; Coleman Drake, Yuehan Zhang, Krisda H. Chaiyachati & Daniel Polsky, *The Limitations of Poor Broadband Internet Access for Telemedicine Use in Rural America: An Observational Study*, ANNALS INTERNAL MED. (Sept. 3, 2019), https://annals.org/aim/article-abstract/2734029/limitations-poor-broadband-internet-access-telemedicine-use-rural-america-observational [https://perma.cc/8VV8-27A6]; *see generally* Judith F. Daar & Spencer Koerner, *Telemedicine: Legal and Practical Implications*, 19 WHITTIER L. REV. 3 (1997) (examining the implications of telemedicine including the challenges of its use).

Micro hospitals are fraught with other challenges, although they offer potential advantages over the stand-alone ER concept, including the ability to offer one-stop-shopping for inpatient and outpatient care. Like microbreweries, micro hospitals can offer a "small-batch product," a premium experience for patients, a more personalized model of care.[441] By affiliating with larger facilities or systems, micro hospitals can still offer the full array of specialties and expertise. Micro hospitals, sometimes called neighborhood hospitals, are the decentralization of health care, offering more streamlined services, faster discharges, and cheaper follow-up care.[442] The facilities can be more easily right-sized and tailored to the particular needs of communities. Although the first wave of these facilities are opening in urban and suburban areas, they offer the potential for addressing the health care access gap in rural areas as well, including but not limited to states that declined Medicaid expansion.[443] Lower start-up costs in terms of real estate, facilities, staffing, and supplies make the model viable for economically challenged communities.[444] Again, however, to fully realize the advantages, micro hospitals likely would need to be connected with larger health systems.[445]

Another model, stand-alone emergency rooms retain essential services capable of preventing fatalities and stabilizing emergency conditions adequately to allow transfer to a larger medical center with a fuller range of services.[446] Again, stand-alone ERs seem to address Anderson's minimal cities concerns, providing at least

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[441] *5 Common Questions About Micro-Hospitals, Answered*, BECKER'S HOSP. REV. (Apr. 11, 2017), https://www.beckershospitalreview.com/facilities-management/5-common-questions-about-micro-hospitals-answered.html [https://perma.cc/L7YT-BPNH].

[442] Berkeley Lovelace Jr., *No-Frills Micro Hospitals with as Few as 8 Rooms Emerge as a New Way to Cut Health-Care Costs*, CNBC (Mar. 2, 2018, 1:14 PM), https://www.cnbc.com/2018/03/02/no-frills-micro-hospitals-emerge-as-a-new-way-to-cut-health-care-costs.html [https://perma.cc/XD47-URDS].

[443] Elly Yu, *Bill Would Let 'Micro-Hospitals' in Rural Georgia Counties*, WABE (Mar. 16, 2018), https://www.wabe.org/micro-hospitals-rural-georgia/ [https://perma.cc/2BFY-4EGX].

[444] Beth Jones Sanborn, *Are Micro-Hospitals the Answer for Systems Looking for Low-Cost Expansions? They Might Be*, HEALTHCARE FIN. (July 12, 2017), https://www.healthcarefinancenews.com/news/are-microhospitals-answer-systems-looking-low-cost-expansions-they-might-be [https://perma.cc/2EZP-QUUN].

[445] Julie Henry, *Think Small: Making the Case for Micro-Hospitals*, HEALTHCARE DIVE (Aug. 2, 2016), https://www.healthcaredive.com/news/think-small-making-the-case-for-microhospitals/423710/ [https://perma.cc/P7LC-MPXF].

[446] Jenn Lukens, *Freestanding Emergency Departments: An Alternative Model for Rural Communities*, RURAL HEALTH INFO. HUB (Nov. 30, 2016), https://www.ruralhealthinfo.org/rural-monitor/freestanding-emergency-departments/ [https://perma.cc/B672-GW9D] ("First conceptualized in the 1970s as a solution for rural communities, freestanding emergency departments have recently been getting another look from providers and policymakers. The FSED is just one of several models that are being considered as sustainable options for rural communities that can no longer support inpatient facilities. As of December 2015, 32 states have a collective total of 400 FSEDs, with just a handful of them located in rural areas.").

essential, emergency treatment and stabilization in close proximity to residents. Studies suggest that increased journey distance to emergency rooms is associated with increased morbidity.[447] Some of these studies were conducted in response to trends to consolidate specialty services with an eye toward improving outcomes, demonstrating that consolidation may not be a positive trend in terms of quality of care.[448] If rural communities retain the capability at least to stabilize and transfer patients to larger, full-service facilities, they can satisfy the humanitarian concerns of caring for residents left behind.

The freestanding ER model, however, also faces a number of challenges to implementation, including facility licensing and regulation, and reimbursement.[449] State regulation of freestanding ERs varies widely, in terms of licensing, proximity to full-service hospitals, staffing and service requirements, CON laws, and other operating requirements.[450] Reimbursement presents another challenge: Independent ERs that are not affiliated with a larger hospital system currently may not receive Medicare or Medicaid reimbursement. Even if private insurance companies are willing to pay for services in freestanding ERs, those facilities typically are not able to negotiate favorable reimbursement rates. In many instances, patients will be left holding the bag, with surprise billing for unreimbursed emergency services.[451] Stand-alone ERs that are affiliated with larger systems stand in a somewhat better position in terms of reimbursement, but proposals to cut Medicare payments, if adopted, would likely spill over to other payers,[452] further endangering this model of minimal health care delivery.

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[447] Jon Nicholl, James West, Steve Goodacre & Janette Turner, *The Relationship Between Distance to Hospital and Patient Mortality in Emergencies: An Observational Study*, 24 EMERGENCY MED. J. 665, 667 (2007); Susan S. Lang, *Distance to Nearest Hospital Is Major Factor in Survival of Heart Attack Victims, Cornell Study Shows*, CORNELL CHRON. (Feb. 3, 2004), http://news.cornell.edu/stories/2004/02/distance-hospital-affects-heart-attack-survival [https://perma.cc/T3SD-7FS4].

[448] DANIEL AVDIC, A MATTER OF LIFE AND DEATH? HOSPITAL DISTANCE AND QUALITY OF CARE: EVIDENCE FROM EMERGENCY ROOM CLOSURES AND MYOCARDIAL INFARCTIONS 1, 2–3 (July 11, 2014).

[449] MacDonald, *supra* note 438.

[450] Catherine Gutierrez, Rachel A. Lindor, Olesya Baker, David Cutler & Jeremiah D. Schuur, *State Regulation of Freestanding Emergency Departments Varies Widely, Affecting Location, Growth, and Services Provided*, 35 HEALTH AFFS. 1857, 1865 (2016).

[451] Surprise billing is a current focus of federal legislation. *See, e.g.*, Rachana Pradhan, KAISER HEALTH NEWS, *Doctors Push Back as Congress Takes Aim at Surprise Medical Bills*, NPR (Feb. 12, 2020), https://www.npr.org/sections/health-shots/2020/02/12/804943655/doctors-push-back-as-congress-takes-aim-at-surprise-medical-bills [https://perma.cc/M9TG-STQ9].

[452] Michelle Andrews, *Congress Urged to Cut Medicare Payments to Many Stand-Alone ERs*, KAISER HEALTH NEWS (Apr. 17, 2018), https://khn.org/news/congressional-advisers-urge-medicare-payments-to-many-stand-alone-ers-be-cut/ [https://perma.cc/FHR6-NNSZ].

These and other emerging rural health delivery models represent rural health care exceptionalism and give credence to the various arguments rebutting the agglomeration economies thesis. Consistent with both Schoenbaum's arguments about the benefits of place and relationships and Anderson's practical and humanitarian points about essential services, these delivery innovations attempt to provide at least minimal services close to home.

Moreover, as demonstrated by numerous studies described above, moving has costs in terms of individual and public health for both migrants and those left behind, and home has value in terms of well-being, resilience, and adaptability. Moreover, U.S. health policy repeatedly has recognized the need to treat health care differently from other markets and, even more particularly, to treat *rural* health care differently from other government health care programs and markets. That exceptionalism benefits not only rural residents but also rural health care providers and rural economies. In sum, the suggestion that Americans simply are stuck in dying rural places is far more complex, when viewed through the health care lens, than the agglomeration economies thesis and Schleicher's suggested policy solutions depict.

CONCLUSION

This Article offers an extended response to the agglomeration economies thesis, viewed uniquely through a health care lens. That thesis posits that preserving America's admittedly struggling rural places hampers labor mobility and, thus, the economic advancement of society. But any purported gains from agglomeration economies must be set off against the real costs of mobility in terms of health and well-being of both migrants and those left behind. Moreover, preservation of home and place, while often seen as largely sentimental, in fact, also has real value in terms of health. Health care offers a particularly apt perspective for reconsidering the agglomeration economies thesis, as health care has long been recognized as an exception to standard market theory. For similar reasons, the question of preservation of rural places calls for consideration beyond the gross domestic product.