# COMMITTEE ON WAYS AND MEANS

## U.S. HOUSE OF REPRESENTATIVES

## WASHINGTON, DC 20515

July 10, 2020

Fellow Americans:

In July 2019, the Ways and Means Committee announced the creation of the bipartisan Rural and Underserved Communities Health Task Force (the Task Force). We were selected to co-chair this Task Force with a bipartisan commitment to discussing the challenges in delivering health care in underserved communities and tackling health and social inequities that have plagued our nation for generations. To better understand these issues and identify solutions, in November 2019, we issued a Request for Information (RFI) to solicit feedback on the key factors driving health inequities. We are pleased to present our summary and discussion of those responses.

One year after the creation of the Task Force, our nation finds itself in the midst of an unprecedented time in human history – a once-in-a-century pandemic and a once-in-50-year social movement – demanding action. As of July 2020, there have been over three million confirmed coronavirus (COVID-19) cases throughout the United States, resulting in over 133,000 deaths. While this deadly pandemic has made its way into every corner of this nation, its effects are especially devastating among residents of color who live in the very communities that this Task Force has been asked to examine – underserved areas where social and structural deficiencies drive poor health outcomes and inequities. The disparate impact that COVID-19 continues to have on minority and underserved communities has underscored why our work to address the health, societal, and economic inequities faced by our constituents is so urgent.

As the Task Force RFI summary outlines, populations in underserved areas tend to be older, more likely to live below the federal poverty level, and unfairly exposed to risks that make them more prone to chronic health conditions. Black, Indigenous, and people of color (BIPOC) are also more likely to live in underserved communities, which frequently include pockets of medically underserved areas (MUAs) that lack access to primary care, behavioral health services, or sufficient hospital beds to appropriately care for a population at high-risk for COVID-19. The summary also describes the dire need for more health resources – workforce and facilities – in rural and underserved areas, and opportunities to ensure access to those resources through insurance coverage. Gaps in rural infrastructure cause rural residents to have fewer health care visits and less preventive care. For example:

- Task Force Co-Chair and Congresswoman Terri Sewell (D-AL) represents Alabama's seventh congressional district – one of the nation's 23 majority Black congressional districts. Over 400,000 residents, or about 64 percent of the district, is made up of Black Americans. The district stands out as persistently underserved in nearly every analysis demonstrating deficiencies in health care or economic mobility, including those showing medical provider shortage areas, morbidity and mortality rates, transportation options and life expectancy.

- Task Force Co-Chair and Congressman Brad Wenstrup (R-OH) represents Ohio's second congressional district, where access to behavioral and primary health care is sparse. Each of the district's rural counties – some being hardest hit by the opioid crisis – are designated by the Health Resources and Services Administration (HRSA) as behavioral and primary health profession shortage areas (HPSAs).

- Task Force Co-Chair and Congressman Danny K. Davis (D-IL) represents Illinois's seventh congressional district, which is similarly majority BIPOC, with over 350,000 Black Americans residing in the district. The life expectancy gap between neighborhoods in the seventh district is upwards of 30 years.

- Task Force Co-Chair and Congressman Jodey Arrington (R-TX) represents Texas' 19th congressional district, where the uninsured rate is a staggering 21.3 percent. In Texas, 20 rural hospitals have closed since 2010 – the most in the nation. Texas also exhibits the highest uninsured rate in the nation, as nearly one in four Texans lack health insurance.

While the congressional districts we represent differ starkly in geography and racial and ethnic makeup, we each represent severely underserved communities that face horrendous health inequities. Our constituents are more likely to lack access to behavioral health care, primary care, and reliable internet or broadband. Such health equity issues affect both underserved and racially diverse communities, where structural deficits in social determinants drive the health disparities and poor outcomes that have put health equity out of reach for too many of our constituents.

We have identified four policy areas to concentrate on moving forward: addressing direct social determinants of health, enacting payment system reforms, strengthening technology and infrastructure, and reinforcing our workforce. No one policy can be a silver bullet, but we believe progress in these areas can make a meaningful difference. In the wealthiest nation in the world, it is unacceptable that any American be deprived the opportunity to attain their highest level of health – and yet that is the reality for too many Americans. Underserved communities have for too long experienced crippling inequities that make access to strong, affordable health care nearly impossible. Addressing health disparities requires us to address inequities in our system using a holistic approach, which transcends health coverage and considers all of the factors – both health care and non-health care – driving health inequity in this nation.

The Task Force thanks all the organizations who submitted feedback to its 2019 RFI and for their thoughtful, engaging, and perceptive responses which help clarify steps needed to achieve our goal of health equity for every American.

Sincerely,

The Honorable Terri A. Sewell
Task Force Co-Chair

The Honorable Danny K. Davis
Task Force Co-Chair