

# Serving Rural America: How Health Insurance Providers Break Down Barriers to Ensure Access to Care



## EXECUTIVE SUMMARY

Nearly 97% of America's land is considered rural. However, only 20% of the total U.S. population — approximately 60 million Americans — live in rural areas. Americans in rural areas face greater health challenges than their contemporaries living in urban and suburban areas.

Rural residents are more likely to die from heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke than their urban counterparts.<sup>1</sup> Children living in rural areas who have mental, behavioral, and developmental disorders face more community and family-related challenges than children with the same disorders living in urban areas. Residents of rural areas tend to be older and sicker than their urban counterparts.<sup>2</sup>

Exacerbating these health issues, rural residents face greater challenges accessing care. Doctors and other health care providers are often in short supply, rural hospitals are closing,<sup>3</sup> and services available in rural areas of the country are being reduced. These challenges ripple throughout each community, impacting patients, their families, rural businesses, and taxpayers.

Health insurance providers are working hard to improve health care access and quality in rural areas, using a variety of tools to improve the health and well-being of their members, families, and communities.

Health insurance providers stand ready to work with policymakers at the state and federal levels to implement solutions that will increase the availability of rural providers, allow clinicians in rural areas to practice at the top of their licenses, and create environments where virtual care can flourish.

This report examines how health care challenges are magnified in rural communities, provides examples of innovative strategies insurance providers are using to address those challenges, and provides policy recommendations to improve care.

## Health Care Challenges in Rural Areas

Rural communities struggle with unique health and economic burdens. These burdens include difficulty accessing affordable care options including a diminishing number of hospitals and an acute shortage of behavioral health and specialty care providers, as well as infrastructure, economic, and social barriers. These challenges keep people living in those areas from achieving their best health.

### BARRIERS TO HEALTH CARE ACCESS

People living in rural communities have fewer options for health care, with fewer doctors and fewer hospitals. A scarcity of specialists prevents people with complex conditions from receiving the care they need, and for those clinicians who do choose to practice in rural areas, burnout is high.<sup>4</sup> Rural hospitals, which often serve as safety nets to rural communities, are closing at unprecedented rates<sup>5</sup>—one in five rural hospitals is at risk of closing due to financial challenges associated with delivering care in rural areas.<sup>6</sup> Americans in rural areas access preventive care at lower rates than in other parts of the country, with lower rates of cancer screening, immunizations, blood pressure checks, and diabetes screenings.<sup>7</sup>

### INFRASTRUCTURE, ECONOMIC, AND SOCIAL BARRIERS

In addition to the health care challenges associated with living in rural areas, there are also infrastructure and socioeconomic challenges that create barriers to care. For example, insufficient public transportation,<sup>8</sup> poor availability of broadband internet services,<sup>9</sup> and lack of available childcare can make it difficult for people to seek the care they need. Additionally, rural residents are both more likely to be employed in physically demanding and dangerous jobs in the agricultural sector and more likely to be uninsured.<sup>10</sup>

Social barriers, such as a lack of access to healthy foods, housing insecurity, limited access to transportation, poverty, and a lack of access to education or employment, are particularly acute in rural areas. Rural residents experience significant disparities in life expectancy and economic mobility, reflecting the complex relationship between health, opportunity, and geographic isolation. These disparities include high rates of:

- infant mortality;<sup>11</sup>
- mental, behavioral, and developmental disorders in children;<sup>12</sup>
- suicide;<sup>13</sup>
- cancers related to modifiable risks, such as tobacco use, human papillomavirus (HPV), and preventive screening;<sup>14</sup>
- preventable conditions such as obesity, diabetes, and injury;<sup>15</sup>
- high-risk health behaviors, such as physical inactivity, poor diet, and limited use of seatbelts;<sup>16</sup> and
- dramatically higher rates of opioid overdose deaths – as much as 45% higher than in non-rural areas.<sup>17</sup>

## AGING COMMUNITIES

Rural communities also tend to be older than the general population. One-quarter of all adults 65 and older live in rural areas.<sup>18</sup> With increased age comes a variety of health care challenges including increased prevalence of chronic conditions often necessitating access to coordinated teams of physicians, nurses, social workers, family caregivers, and long-term care providers.<sup>19</sup> Unfortunately, like hospitals, nursing homes in rural areas are shutting their doors or merging, often leaving seniors without access to long-term care.<sup>20</sup>

Numerous states and federal agencies have created specialized committees and task forces to define and address the challenges faced by rural seniors. In their work, these stakeholders have identified areas for action to address depression and loneliness,<sup>21</sup> physical inactivity,<sup>22</sup> medication management,<sup>23</sup> and dental health.<sup>24</sup> The Agency for Healthcare Research and Quality (AHRQ) has issued grants to pilot programs designed to solve these unique issues.<sup>25</sup> With over half of all rural veterans aged over 65, the Veterans Administration has also issued recommendations to address some of the challenges faced by rural veterans.<sup>26</sup>

In addition to these public efforts, private stakeholders—including health insurance providers—are working to develop and implement programs to assist rural residents to live healthier lives and to sustain the health of rural communities.

## How Health Insurance Providers Are Addressing These Challenges

Health insurance providers are working in partnership with doctors, hospitals, patients, community organizations, and state and local leaders to address rural health challenges. These collaborations help to improve health, access to care, and to address the infrastructure, economic, and social barriers facing rural Americans.

### TELEHEALTH SERVICES AND REMOTE PATIENT MONITORING IMPROVING ACCESS TO CARE

Expanding and improving the use of telehealth services helps ensure that rural Americans can quickly and effectively get the care they need from their own communities. Approximately one-quarter of rural adults say they have used telehealth for health care within the last few years.<sup>27</sup> Many insurance providers now contract with telehealth companies to connect patients with clinicians licensed in their states without traveling from their home or work.<sup>28</sup> These companies offer an existing telehealth infrastructure and an established network of doctors. Alternatively, in some cases, insurance providers contract directly with their existing network of physicians to enable those clinicians to care for their patients virtually. In either case, this virtual access supplements the network of clinicians physically available in the patient's own community.

Virtual care can be used for many types of care needs including primary care, substance use disorder (SUD) treatment, dermatology, medication management, radiology, and behavioral health care. Remote patient monitoring can be used to monitor patients managing chronic conditions like diabetes, high blood pressure, and cardiovascular disease from a distant location, directing the patient to in-person care when needed. Remote patient monitoring can also help patients manage their chronic conditions, improve personalized care, expedite diagnoses, reduce unnecessary emergency department visits, help lower health care costs, and help keep rural communities healthy.<sup>29</sup>

Here are just a few examples of how health insurance providers are increasingly investing in telehealth to improve health, enhance access, and reduce patients' costs:

- Anthem awarded a \$250,000 grant to the University of Virginia to expand specialty care to rural, underserved areas of Virginia via telehealth.<sup>30</sup>
- Capital District Physician's Health Plan (CDPHP) recently announced plans to expand its telehealth offerings to the underserved North Country of New York, which includes rural Franklin, Clinton, Essex, and Warren Counties.<sup>31</sup>
- Blue Shield of California has partnered with both telehealth companies (Teladoc) and providers (Adventist Health) to increase access to specialty care in rural areas, offering access to specialists in cardiology, dermatology, endocrinology, and rheumatology, among other specialties, via virtual connections.<sup>32</sup>
- The Global Partnership for Telehealth (formerly the Georgia Partnership for Telehealth) links all 159 counties in Georgia via a telehealth network, providing connectivity for rural patients and providers throughout the state. Peach State Health Plan (Centene)<sup>33</sup> and WellCare<sup>34</sup> participate in the network.

## INCENTIVES AND SUPPORT HELP MOTIVATE PROVIDERS TO PRACTICE IN RURAL SETTINGS

Health insurance providers recognize that clinician shortages must be addressed in rural communities. In order to address this issue, insurance providers seek to encourage, support, and engage with physicians and other clinicians who practice in rural areas.

For example, insurance providers are actively promoting Project ECHO. Using hub-and-spoke models, Project ECHO allows rural providers to interact with specialists at larger tertiary care hospitals or other facilities to consult about patients with complex needs. This innovative communication channel expands patient access to specialty care and overcomes the geographic limitations of traditional health care services.<sup>35</sup>

Insurance providers also offer scholarships for medical students to encourage them to practice in underserved regions, often with a focus on high-need clinical areas like primary care services and behavioral health. In addition, health insurance providers offer financial incentives to encourage more doctors to practice in rural and underserved communities. Examples include:

- Blue Cross and Blue Shield of North Carolina provided \$800,000 to increase patient-centered primary care and to recruit more residents to practice in rural Rockingham County and neighboring communities.<sup>36</sup>
- BlueCross BlueShield of Oklahoma, a division of Health Care Service Corporation, contributes funding to the Oklahoma Medical Loan Repayment program, which provides grants of \$160,000 to help repay a portion of a rural physician's medical student loans.<sup>37</sup>
- WellCare awarded 20 one-year scholarships of \$5,000 each to incoming medical students at the University of Kentucky Medical School and 10 \$8,000 per-semester scholarships to the University of Kentucky College of Nursing to encourage doctors and nurses to practice in the state's rural areas.<sup>38</sup>

## INNOVATIVE PAYMENT AND DELIVERY MODELS ALIGN INCENTIVES TO IMPROVE CARE

Given all of the challenges of practicing medicine in rural areas, provider recruitment is increasingly difficult. This has led to significant provider shortages in primary care, specialty care, and behavioral health care.

Stakeholders, including insurance providers, are working to increase incentives for providers to practice in these areas. A key feature of new approaches is restructuring payments to rural health care providers to focus on quality and systemic stability targets while minimizing financial burden on patients. Both independently and through a set of innovative partnerships with the Center for Medicare & Medicaid Innovation (CMMI) health insurance providers are working to develop novel, state-specific programs to improve access in rural and other hard-to-serve areas.

### Examples of Innovative Payment Models:

- Maryland introduced an innovative All-Payer Model Agreement, which moved the state's hospital financing away from fee-for-service models and towards value-based, per capita budgets. Kaiser Permanente and CareFirst BlueCross BlueShield participate in this model, which provides more consistent, predictable financing to hospitals throughout the state, including rural areas, and de-stresses inpatient stays as a means of funding a hospital's operations. In a pilot program specific to rural regions in Maryland, rural hospitals saw reduced readmissions, increased resources for community supports and care, and ultimately financial viability.<sup>39</sup>
- In Pennsylvania, Gateway Health, Geisinger Health Plan, Highmark, Medicare, and UPMC Health Plan are working with the Department of Health and five hospital systems to create a global budget system to address economic challenges in rural areas. The payers and state are working together to ensure that rural communities have continued access to care, with the goal of creating a more stable economic environment for rural providers while shifting towards value-based care.<sup>40</sup>
- Blue Cross Blue Shield of Michigan designates small, rural acute care facilities eligible for Hospital Pay-for-Performance incentives, which gives these hospitals an opportunity to demonstrate value to their communities and customers by meeting expectations for access, effectiveness, and quality of care. For the 2019-2020 program year, incentives can comprise up to 6% of a hospital's payment.<sup>41</sup>

## ADDRESSING THE OPIOID EPIDEMIC

The opioid epidemic continues to hit rural America especially hard. According to the CDC, opioid prescribing rates are significantly higher in rural areas compared to large metro counties, putting rural residents at greater risk of addiction and overdose.<sup>42</sup> The rates of drug overdose deaths are higher in rural areas than urban; over 7,300 drug overdose deaths occurred in rural areas in 2015, a 325% increase since 1999.<sup>43</sup>

Further, the opioid epidemic is harder to address in rural regions. Rural areas face the challenge of community programs being underfunded and understaffed. While a Centers for Medicare and Medicaid Services (CMS) study concluded that most qualified health plans sold on exchanges do cover medication-assisted treatment (MAT) programs to treat and manage addiction,<sup>44</sup> there is often limited access to MAT and alternative pain management therapies in rural communities.

In 2019, AHIP released a paper outlining strategies to increase the capacity for SUD treatments, including expanding access to MAT. The report offered recommendations for both health insurance providers and broader stakeholders to address the opioid epidemic, many of which strategies which would help rural communities. Recommendations included providing support for physicians who administer SUD treatment, expanding telehealth and technology-based approaches to care, addressing social factors associated with addiction, providing incentives to encourage providers to participate in addiction treatment, and developing new payment and care delivery models to best support communities in need.<sup>45</sup> Health insurance providers are undertaking many of the initiatives outlined in the document, states are working to expand treatment capacity<sup>46</sup> and naloxone access,<sup>47</sup> and the federal Government Accountability Office issued a report supporting improved quality metrics,<sup>48</sup> in alignment with the AHIP recommendations.

Health insurance providers use a comprehensive approach encompassing prevention, early intervention, and treatment and recovery to address the multi-faceted opioid crisis. In October 2017, America's Health Insurance Plans (AHIP) launched its [Safe, Transparent Opioid Prescribing \(STOP\) Initiative](#)®, designed to support widespread adoption of evidence-based clinical recommendations developed by CDC for pain care and opioid prescribing, and to further capture and disseminate best practices.

Working collaboratively with providers, community programs, and states, insurance providers are an integral part of the solution. Here are a few examples of health insurance providers fighting the opioid epidemic:

- Cigna provided the St. Vincent Healthcare Foundation in Billings, MT a \$100,000 grant to help improve outcomes of Native American women and babies through increased access to prenatal care, drug education, and healthy lifestyle information.<sup>49</sup>
- Magellan Health deployed its digital cognitive behavioral therapy programs to support the delivery of services in rural and underserved areas, including the SHADE program, which is a 10-session exercise designed to help change behavior and thinking around substance use that is delivered via mobile and web-based technology.<sup>50</sup>
- UPMC is administering a federal Substance Abuse and Mental Health Services Administration (SAMHSA) grant to expand access to MAT by recruiting clinicians and hosting training for those interested in receiving a Drug Enforcement Administration (DEA) waiver to prescribe MAT, targeted to rural Blair, Clinton, Erie, and Lycoming counties in Pennsylvania.<sup>51</sup>

## Policy Recommendations

While innovative approaches are helping to address the unmet needs of rural communities, AHIP supports comprehensive legislation to drive more systemic improvements. Together we can improve health and access in the rural communities that need it most.

### OFFER PROGRAMS AND INCENTIVES TO INCREASE CLINICIAN PRESENCE

Clinicians should be encouraged to practice in rural, underserved areas. Existing programs seek to recruit clinicians to practice in rural areas. Numerous states offer stipends and cash incentives to attract physicians and advanced practice professionals to work in federally designated health professional shortage areas, Visa waivers are available for foreign physicians committed to serving in rural, underserved areas,<sup>52</sup> and the National Health Service Corps encourages clinicians to practice in rural areas.<sup>53</sup> Loan forgiveness, financial support for medical schools that promote rural health care, and other programs that incent providers to practice in rural areas are available to some providers in specific areas.

However, given the growing shortages of providers in rural areas, more work is needed to recruit and retain rural practitioners. These existing programs should be expanded to include more regions and to recruit practitioners in primary care, specialty practice, and behavioral health care. Additional federal, state, and private financial investment can increase the number of providers available in designated health professional shortage areas, which could help rural states reduce provider shortages. Policymakers should consider providing tax incentives to health insurance providers and other private companies to facilitate the adoption of such financial investments.

In addition, provider access can be significantly improved if all clinicians are able to practice to the full scope of their license. Congress has already recognized the importance of removing barriers that prevent care providers from fully and appropriately handling all aspects of care for their patients. The 21st Century Cures Act instructed CMS to suspend enforcement of physician supervision requirements for outpatient therapeutic services in critical access hospitals and small rural hospitals in 2018 and 2019.<sup>54</sup> This provision should be made permanent, as it had previously been in place for 9 of the past 10 years.<sup>55</sup>

To address the challenges of serving rural areas, federal lawmakers should:

- **Remove the caps on the number of residents funded by Medicare and increase Medicare-funded residency positions.** Under current regulations, there is a cap on the number of residents eligible for Medicare Direct Graduate Medical Education. By removing this cap, rural hospitals could use Medicare payments to offset costs associated with training physicians during residency. Changes to this policy would also increase the number of residents practicing in rural hospitals, alleviating clinician shortages.<sup>56</sup>
- Loan repayment and other incentives are used to recruit clinicians to rural, underserved areas of the country. **The federal government should authorize loan repayment and other incentive programs for physician assistants and nurse practitioners** to further expand the capacity to deliver care to rural communities. Funding can also be used to provide incentives of clinical education and training to rural practitioners.
- To address provider shortages in rural areas, the federal government can create **grants for clinicians to practice in rural areas on a volunteer basis**, either through the expansion of the National Health Service Corps or through the creation of new programs.

## EXPAND ACCESS TO CARE THROUGH TELEHEALTH

In addition to improving access to in-person care in rural areas, policymakers must recognize the growing trend towards using virtual care to further expand access to health services. Some state and federal restrictions on telehealth hamper the ability for insurance providers to deliver solutions that meet patient needs, especially in rural health shortage areas. For example, numerous states restrict telehealth based on originating site, established doctor-patient relationships, and the condition for which a patient is being seen. And with roughly one in five people older than 65 living outside of a metropolitan area, Medicare plays a significant role in addressing the issues of rural health care, where telehealth can be a valuable tool in delivering high-quality, affordable care to seniors in rural communities.

Federal and state lawmakers can fix this by:

- **Supporting establishment of multi-state licensure compacts.** In many cases, providers can only offer services in a state where they are licensed. If a patient can only use an in-state doctor, this closes off doctors that would otherwise be available through national provider networks. Allowing multi-state licensure compacts can promote expedited licensure for physicians and/or reciprocity for certain providers applying in multiple states, increase the number of accessible services, and expand provider networks available to consumers.
- **Enhancing flexibility by not establishing state mandates related to reimbursement and/or payment parity, site-specific use, prior visit requirements, or specific technology use.** Inconsistent state laws and mandates can make providing access to telehealth services difficult for health insurance providers, particularly those that operate in multiple states. State mandates to cover telehealth in specific ways and under specific requirements hinder flexibility to design benefits that meet the needs of consumers.
- **Designating telehealth as a means of satisfying health insurance network adequacy requirements.** Under 45 CFR 156.230, the Department of Health and Human Services (HHS) should establish telemedicine as an option to meet federal requirements for network adequacy standards. In a 2016 revised model law, the National Association of Insurance Commissioners included the use of telemedicine as an option to meet network adequacy standards.

And, several states have passed laws or updated regulation to incorporate telehealth in their network adequacy requirements. As part of updating standards to allow greater use of telemedicine, states can identify guardrails to ensure telemedicine use is expanded for scenarios for which it is clinically appropriate.

- Current Medicare Advantage (MA) network adequacy criteria, which rely on time and distance criteria, generally fail to consider how telemedicine, mobile medical applications, and other electronic information and telecommunications technologies can ensure beneficiaries receive the high-quality care they need, when they need it. Beginning last year, CMS expanded flexibility to allow MA plans to request an exception to the network adequacy requirements for rural areas.<sup>57</sup> In addition, through CMMI, the agency has expanded its MA-Value-Based Insurance Design (VBID) model for CY 2020 to test “how plans can use telehealth services to complement and augment their current network of providers” in rural communities with few providers.<sup>58</sup> We believe these are important steps and that **the agency should provide MA plans with even more flexibility in meeting network adequacy requirements through the use of telehealth providers and other high value care and delivery system innovations and approaches.**
- Additionally, federal legislation should **permit first-dollar coverage of telehealth services in HSA-eligible health plans.** Existing law restricts what care or services a plan may cover pre-deductible in a high-deductible health plan while retaining HSA-eligibility. Telehealth is not only increasingly popular, it is a means of accessing care that is highly affordable for both the plan and the consumer. Permitting plans to cover telehealth services with first-dollar coverage reduces overall costs to the system and allows greater flexibility and affordability for consumers. The approach to expanding HSAs described in the recommendation “Expand HSA Options” is a more comprehensive approach to HSA modernization that would allow for first-dollar coverage of telehealth. As a fallback, Congress should consider a more limited bill to allow first-dollar coverage of telehealth.
- To address workforce issues, we recommend that Congress pursue legislation that **defines the necessary licensure and training needed to deliver care via telehealth.** While state licensing boards have the right to define required training to practice within the field, Congress should mandate minimum training requirements for the use of telehealth technology.

## MAKE INSURANCE MORE AFFORDABLE IN RURAL AREAS

A stable health insurance market is vital to the health of rural communities. Without insurance, most Americans can’t afford the full cost of health care. Fewer uninsured people also means less bad debt for rural hospitals and providers that are struggling to keep their doors open.

Nationwide 7% (about 20 million people) buy their own coverage on the individual health insurance market rather than getting it from an employer or program like Medicaid or Medicare.<sup>59</sup>

For the millions of people living in rural areas who don’t have access to employer coverage or Medicaid or Medicare, the individual insurance market is their only option for coverage that will protect them financially if they experience a serious illness. People in 39 states use [HealthCare.gov](https://www.healthcare.gov) to buy their own insurance and nearly one-in-five [HealthCare.gov](https://www.healthcare.gov) consumers lived in a rural area in 2019.<sup>60</sup> Unfortunately, for Americans who don’t qualify for help with individual market premiums, individual market coverage may be unaffordable.

Small populations and the high prevalence of high cost health conditions in rural areas can drive higher premiums for individual market plans. Insurance premiums are driven by the cost of care in an area and the amount of health care the people insured in that area will need. Premiums are lower when costs are spread across a large group of people that includes people who are healthy and people who need care. Finally, it’s difficult for insurers to offer options in counties where there are not enough providers available to serve the residents of that area. As discussed above, rural populations often need more health care and have fewer providers to get it from than people in other areas.

- To make premiums more affordable in rural areas, **states can implement reinsurance programs for the individual market.** Reinsurance programs cover some of the costs for the patients with the highest costs, lowering premiums for everyone in the state who buys individual market coverage. A permanent federal reinsurance program would provide the benefits of reinsurance nationwide without each state being required to seek a federal 1332 waiver.

- States are encouraged to **create programs that streamline the transition from Medicaid to commercial insurance** (or vice versa) to reduce churn between the two and minimize lapses in insurance coverage. Individual states also should decide whether Medicaid expansion is right for their residents. Improving or expanding Medicaid can help enhance access to coverage and care for rural residents while improving health outcomes.<sup>61</sup>

## PROMOTE HEALTH FOR INDIVIDUALS AND COMMUNITIES

Health insurance providers offer a range of programs to address the needs of people living in rural areas, including coordinating assistance for members who may have issues with housing, food insecurity, job training, and transportation, among other needs. Health insurance providers play a unique role in facilitating care coordination for patients who may need extra help. Federal and state policymakers should engage with other stakeholders to promote community-based efforts to address underlying issues that contribute to health, education, and income disparities in rural areas.

- Virtual technologies can efficiently provide evidence-based prevention programs in rural communities. However, Medicare coverage of the Diabetes Prevention Program (DPP), which was intended to increase access to the lifestyle change program, only allows Medicare beneficiaries to be covered for the program through in-person classes. In order to increase access to the program for Medicare beneficiaries who may have difficulty consistently attending or finding available in-person classes, **Medicare should cover the DPP through virtual technologies**. Otherwise, rural residents either would not have access at all or would be required to travel great distances to participate in the program.
- Virtual prevention and public health initiatives have been proven effective in addressing issues faced by underserved rural communities, including American Indian and Alaska Native populations.<sup>62</sup> **Existing virtual prevention and public health programs that demonstrate effectiveness should be expanded to other high-risk rural populations** and to other rural regions to further promote healthy living.
- SUD treatment and recovery programs to address the opioid crisis are vital to improving the health and wellbeing of people and families in rural communities. **Federal, state, local, and private sector funding and partnerships are needed to increase the capacity of prevention, early intervention, treatment, and recovery programs** that meet the needs of those suffering from opioid use disorder and prevent more people from becoming addicted. Further, telehealth and virtual technologies should be used to deliver SUD treatment and increase remote access to specialists through Project ECHO and other programs. In addition, public education programs should be provided for patients, families, communities, and clinicians to better understand pain management options and their associated advantages and disadvantages, the benefits and potential risks of prescription opioids, and potential risk factors for addiction. And, **to prevent overdose deaths, people at high risk of overdose should have access to overdose reversal medications**. All pharmacies in the country should be encouraged to dispense the medication.

## Conclusion

The health care challenges facing Americans are even more severe in rural health communities. Health insurance providers are deploying strategies to improve access to high-quality, affordable care and coverage for residents in rural areas.

Federal and state policymakers can help augment these strategies to help improve the health of individuals and populations residing in rural communities. Solutions will require partnerships and collaborations between a variety of stakeholders. Those stakeholders include health care associations, community-based organizations, state and local officials, the federal government, physicians and other clinicians, hospitals, academic centers, funders, and foundations.

***Every American deserves affordable coverage choices that provides them with access to high-quality care. Geography does not need to be a barrier. By working together, we can ensure that everyone in our communities can get the care they need at a cost they can afford – for improved health, well-being, and financial security.***

# Endnotes

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