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The Legal Landscape of Healthcare Access in Rural America

ABSTRACT. The healthcare system in the United States ought to provide its citizens with unhindered access to high quality medical care as well as equitable treatment and coverage. Legislation to advance access to healthcare, such as the creation of the Medicare and Medicaid programs in 1965 and the Affordable Care Act in 2008, have been appropriate steps forward in achieving these goals, but obstacles to healthcare access still persist for many Americans. Healthcare access is hindered by foundational problems, such as a large uninsured population, inadequate infrastructure and facilities, and high costs for services. In rural communities, these problems assume different social and economic contexts and thus require their own separate evaluation. Rural Americans currently lack effective access to healthcare, despite existing policies aimed at improving access by making healthcare more affordable. In this article, I will explain different facts of the discussion revolving around rural healthcare access and analyze specific problems in the area. There are three policy directives that are essential to the expansion of rural healthcare access: public private partnerships, loan forgiveness for doctors serving at critical access hospitals, and expansion of the telehealth network. These avenues expand rural healthcare access, minimize government expenditure, and maximize public benefits.

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INTRODUCTION

Racing through the West Texas desert, general physician Earl Turner[1] is on a mission to reach his hospital before their dispatched ambulance does.[2] At the hospital, Turner must treat a truck driver who collapsed at a local gas station and cannot feel his legs. Turner is the sole medical practitioner overseeing three rural counties east of El Paso, Texas, an area roughly equal to the size of the state of Maryland. In this vast region, he tirelessly provides medical care to a diverse array of areas, including oil encampments, truck stops, and budget motels. At age 68, Turner is tired. He has been waiting for years for another doctor to join him at Culberson Hospital in the town of Van Horn, Texas, which had a population of 2,063 people in 2010. Turner greets the ill truck driver and attempts to provide him with some reassurance. He gently informs the driver that he is fortunate that the incident occurred where it did, as there are no other hospitals within a 100 mile radius. From the physical ailments of undocumented migrants entering through the southern border to high school athletes in need of signatures on their physicals, Turner carries the weight of many responsibilities upon his shoulders. Despite his resilience, Turner's frequent 24 hour shifts still result in limited service. He often finds himself sending patients to see specialists in El Paso, for the facilities necessary for extensive care simply do not exist in a town like Van Horn. For Turner's patients, care falls short of achieving the quality that is considered standard in larger cities. They are subject to long wait times for treatment and lack easy access to health services because of geographic and logistical challenges. In many cases, such as that of the collapsed truck driver, patients' immediate physical wellbeing is dependent on an insufficient network of resources. Considering Turner's story, in the event that he was unable to reach the gas station due to a logistical obstacle or time constraint, the truck driver would lay helpless and be at grave risk of further injury.

Turner's story echoes those of countless other medical practitioners that reside in the vast rural expanse of the United States. For providers like him and the patients they treat, ensuring access to healthcare necessitates proactive effort. Rural hospitals lack necessary service infrastructure, with less physicians and hospitals available in areas far from cities.[3] The number of physicians per 10,000 people is 31.2 for urban areas but

[1] Pseudonym used.

[2] Eli Saslow, *Out here, it's just me*, Wash. Post, Sept. 28 2019.

[3] American Health Ass'n, Fast Facts: U.S. Rural Hospitals Infographic (2023), www.aha.org/infographics/2021-05-24-fast-facts-us-rural-hospitals-infographic.

only measures to 13.1 for non-urban areas.[4] This statistic has various negative implications for patients. They are forced to endure long wait times for care and often do not have access to certain specialists. Health care professionals in the fields of obstetrics/gynecology, mental health, substance abuse treatment, and dentistry, are, among others, underrepresented in rural communities.[5] These discrepancies mean that underserved rural populations need to travel long distances to receive specialized care, which can be an inconvenient and difficult challenge. For the providers that are present in these communities, facilities are consistently underfunded and overcrowded. To illustrate this reality, urban hospitals have on average 200 beds, which compares to 25 beds for rural hospitals.[6] Structural deficits like these result in longer wait times and more expensive services for patients. The lack of adequate infrastructure and its associated harmful externalities result in rural Ameircans being less likely to receive preventative care and more likely to require critical care in urgent incidents. In addition, rural Americans are also burdened by the economic costs of being self-employed and thus not receiving healthcare coverage from their employers. They are also more likely to receive less coverage from the federal Medicare and Medicaid programs.

The general goals of Medicare and Medicaid are to lessen issues related to the financial burdens of healthcare. Medicare aims to provide healthcare coverage for seniors and certain disabled individuals. Medicaid targets low-income individuals and families, including children, pregnant women, and people with disabilities, striving to alleviate financial barriers to healthcare and promote health equity. Both programs have expanded their provisions to aid rural healthcare, such as the enactment of the "critical access hospital" (CAH) designation. Under this designation, hospitals in sparsely populated areas with low economic productivity are deemed to be points of critical access, which means that they receive higher Medicare reimbursement rates from the government. A study conducted by Health Services Research used patient safety indicator software to evaluate the performance of critical access hospitals in Iowa. Their findings suggested that hospitals that converted to critical access status

[4] Nat'l Rural Health Ass'n, About Rural Health Care (Accessed on May 22, 2024), https://www.ruralhealth.us/about-us/about-rural-health-care.

[5] Theresa Capriotti et al., Health Disparities in Rural America: Current Challenges and Future Solutions (18 Feb. 2020), https://www.psychiatryadvisor.com/home/practice-management/health-disparities-in-rural-america-current-challenges-and-future-solutions/3/.

[6] Center for Health Quality & Public Responsibility, Two Types of Hospitals in the US, at 1-6 (Apr. 2024), chqpr.org/downloads/Two_Types_of_Hospitals_in_US.pdf.

provided safer and higher quality care than their unaltered counterparts.[7] This data has implications for the rural healthcare system at a national scale: tailoring to the specific needs of rural hospitals brings tangible benefits.

Still, there are challenges with the standing Medicare and Medicaid programs that result in many Americans possessing inadequate coverage, a phenomenon dubbed the "Medigap;" this population has their medical livelihoods in jeopardy in the event that an uninsurable incident were to happen to them.[8] In rural communities, the Medigap is wider and more salient. Combined with the reality that they are less likely to be insured, rural citizens often involve themselves with limited care plans that reflect their underserved medical infrastructure. Amendments to these programs have been well intentioned but do not take into account the degree to which rural America faces poverty, infrastructural challenges, and an overall feeling of neglect at a political level. The Government Accountability Office studied the over 60 million rural Americans and their lacking federal program coverage, gauging individuals' distance from emergency hospitals.[9] The study demonstrates the effects of hospital closure for Americans in inpatient care and substance abuse centers.

For rural Americans, the distances they have to travel to receive appropriate care are multiplied. Women in need of obstetric care and rural veterans also found themselves in positions of adversity, as their services became harder to access as a result of the closures. Medicare and Medicaid, although often constrained in rural areas, are essential to mitigate these disparities in access. In recent decades, there have also been active legislative attempts to severely undercut the funding for these programs, with some figures even claiming that they should be canceled altogether.[10]

Current laws do not adequately address rural healthcare needs, either in terms of the quality or the incidence of health insurance coverage. Firstly, I suggest an initiative to expand medical infrastructure by way of tax-based corporate incentives. Government direction, combined with private sector resources and expertise, can

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[7] Pengxiang Li et al., *Effect of Critical Access Hospital Conversion on Patient Safety,* 42 Health Serv. Res. 2089, 2089 (2007).

[8] Robert A. Berenson & Melissa M. Goldstein, *Will Medicare Wither on the Vine? How Congress Has Advantaged Medicare Advantage - And What's a Level Playing Field Anyway?*, 1 St. Louis U.J. Health L. & Pol'y 5, 7 (2007).

[9] U.S. Gov't Accountability Off. *Why Is Health Care Harder to Access in Rural America,* U.S. Gov't Accountability Off.: WatchBlog (May 16, 2023), https://www.gao.gov/blog/why-health-care-harder-access-rural-america.

[10] Nelda McCall et al., *Reforming Medicare Payment: Early Effects of the 1997 Balanced Budget Act on Postacute Care*, 81 Milbank Q. 277, 277-303 (2003).

produce marked improvements in rural medicine. Potential incentives for private health corporations include tax deductions and student loan forgiveness programs for doctors. With these avenues, private health groups have an incentive to engage with government healthcare expansion, emphasizing shared responsibility and innovation. A reform of Medicare financing plans would also be beneficial. As it stands, a sizable portion of rural hospitals are dependent on Medicare reimbursements. This fact, combined with rural and urban disparities in Medicare coverage, creates a negative feedback loop. I also suggest a technological approach to rural healthcare expansion. Telehealth services have been used as a medium for delivering medical consultations and acute care, with the sector expanding greatly in light of the Covid pandemic. Similar to facility infrastructure, the telehealth sector can have a considerable impact on rural medicine through partnerships with the private sector.

I. BACKGROUND ON CURRENT POLICY

A. Defining Actors

Discussion of healthcare policy necessitates knowledge of the actors involved in the medical system. Providers are parties associated with the delivery of healthcare services, which can be institutional (hospitals, ambulatory units, outpatient clinics, rehabilitation & assisted living facilities), meaning that they are part of a regulated organization, or individual (physicians, physicians' assistants, nursing staff, clerical staff). Unlike other groups involved in the healthcare sector, such as federal or state governments or insurers, providers are the group actively involved in supplying communities with healthcare services. Insurers are organizations whose primary purpose is to manage risk and pool resources to protect customers from high unexpected medical costs. Most insurers are private corporations, but there are government programs such as Medicare, Medicaid, and veteran's health benefits that also provide important coverage. Many Americans, particularly those employed in urban areas, receive health insurance as stipulation of their worker's benefits, wherein their employers create partnerships with insurance corporations to issue coverage plans. Patients are the consumers of the healthcare sector, who participate by purchasing health insurance, paying for healthcare-related costs, and paying taxes that fund federal programs. Nationwide, there are major differences between patients' ability to pay for healthcare, with impoverished Americans struggling to afford basic coverage and their wealthy counterparts possessing direct access to high quality medical care and expertise. All patients, regardless of their financial ability, bear the costs of the healthcare system

by paying out-of-pocket costs for services, which are raw fees not covered by insurance, and insurance premiums, which are fees paid to insurance corporations in exchange for coverage. Individuals who do not have health insurance are forced to pay higher out-of-pocket costs.

B. Medicaid & Medicare

Medicaid is a joint federal and state program designed to provide health insurance for low-income individuals. Unlike Medicare, which serves a similar purpose, there is no minimum age requirement for Medicaid. All who demonstrate financial need may be eligible for insurance coverage. The federal government regulates Medicaid, but states are left to oversee its implementation. Medicaid holds special implications for rural communities, with nearly a quarter of rural individuals under the age of 65 being covered by Medicaid.[11] In addition to this group of recipients, 22% of people in rural areas are dually enrolled in both Medicare and Medicaid.[12] Dual enrollment helps to remedy gaps in coverage. As these statistics suggest, income struggles are a crucial determinant of access to health insurance, with many Americans, rural and otherwise, being unable to sustain their healthcare from their own earnings. Policy concerning Medicaid has had varied results, with some state governments taking a more active role to protect it than others.

Medicare works in a similar fashion to Medicaid, with a major difference being that the program only covers people ages 65 and older. The program is divided into parts, A, B, C, and D. Part A, dealing with hospital insurance, pertains to inpatient hospital treatment, nursing facilities, hospice care, and home care.[13] Part B outlines provisions for medical insurance, which covers services from doctors, outpatient care, and durable medical equipment.[14] Parts A and B are considered to be the most basic and traditional forms of Medicare, providing a useful but limited range of resources. Part D covers the costs of prescription drugs, which Parts A and B notably omit.[15] Unlike Parts A and B, Medicare plans that cover prescription drugs are operated by regulated private insurance companies. Part C is separate from the other three because

[11] Medicaid and CHIP Payment and Access Commission, Medicaid and Rural Health, 1 (Apr. 2021), www.macpac.gov/wp-content/uploads/2021/04/Medicaid-and-Rural-Health.pdf.
[12] *Id.* at 1
[13] Medicare.gov, Parts of Medicare (Accessed 13 May 2024), www.medicare.gov/basics/get-started-with-medicare/medicare-basics/parts-of-medicare.
[14] *Id.*
[15] *Id.*

it involves a completely different coverage plan than the one offered by original Medicare.[16] Also known as Medicare Advantage, Part C works as a partnership between publicly operated Medicare and private health insurance companies, in which the companies follow rules ordered by state governing authorities and deliver services.[17] Medicare Advantage includes drug coverage and contains an out-of-pocket maximum, decreasing the likelihood of high premiums.

C. Employer Sponsored Health Insurance

Rural individuals with employer-provided health insurance face socioeconomic factors that make their coverage less inclusive and effective than urban counterparts. The underinsurance rate in rural areas remains higher than that of urban areas, with residents experiencing fewer health care providers and higher expenditures.[18] The underinsurance angle of the rural healthcare discussion is equal in importance to the non-insurance perspective; oftentimes people do in fact receive coverage but still suffer from gaps and widespread inefficiency. Pervasive underinsurance reveals problems with the American healthcare system and is not merely an unavoidable symptom of wealth inequality. Unlike other market goods and services, rudimentary health insurance should not be treated as something determined by income level. Individuals' health and well-being should be considered a government concern because of the various positive externalities associated with a healthy population. The government is also an important player in this calculation because they hold the authority to implement and regulate insurance for the whole country, which corporations cannot realistically achieve. In the context of the United States, it is expected that an individual's access to wealth decides the quality of health services that they can access. Although the quality and convenience of medical care is often a factor of wealth, basic access to health insurance should not be. Similar to other government initiatives regarding social welfare, education, housing, and food, health insurance is another service that requires efforts for equitable access.

Employment losses from the 2008 global recession and the Covid 19 pandemic highlight the severe impact of national economic insecurity on healthcare access. A

[16] *See* Medicare.gov, *supra* note 13

[17] *Id.*

[18] Health Pol'y Inst., Rural and Urban Health (Accessed May 23, 2024), https://hpi.georgetown.edu/rural/#:~:text=Rural%20residents%20are%20more%20likely,for%20longer%20periods%20of%20time&text=Over%20one%2Dthird%20of%20rural,however%20(see%20Figure%205).

study by the Journal of General Internal Medicine focuses on the cases of low-income adults in Arkansas, Kentucky, Louisiana, and Texas, who were either chronically unemployed or lost their employment as a result of the Covid-19 crisis and thus were dealt losses to their health insurance coverage.[19] Members of the study were likely to be older, less educated, report chronic conditions, and most importantly, reside in rural areas.[20] Although job loss affects poor Americans in general, the effects on rural Americans are specific enough to warrant a different analysis. In the rural areas of the states in this study, communities face greater income instability and less opportunities than their urban counterparts, even if both parties are equally poor.

Evaluating these characteristics, particularly age, lack of income, and rural status, is crucial to consider the effects that job loss has on their healthcare access. Sociocultural factors are also involved in this assessment, as rural communities have diverse community needs that are not expressed in urban areas. These traits adequately describe a large portion of America's rural population, who face great difficulty in obtaining health insurance coverage and have experienced a collective setback in wake of the pandemic. Although the United States has been on the path to recovery from the Covid-induced recession, its effects on the healthcare security of rural and poor Americans linger. The pandemic resulted in hospitals suffering persistent financial losses. The Bipartisan Policy Center uses Wyoming as an example to demonstrate the negative outcomes of the pandemic's recession, elaborating that losses reached a high of 38% statewide.[21] Wyoming, the state with the highest proportion of rural hospitals (26 out of Wyoming's 28 hospitals are designated as rural) has suffered losses in coverage and an unprecedented number of hospitals at risk of closure.

D. Affordable Care Act Marketplace

The Affordable Care Act establishes "health insurance marketplaces" that are intended to help consumers understand and have available access and knowledge of affordable insurance options.[22] These marketplaces operate on a local, state level, with each state having their own website and directory for insurers near an individual's

[19] Jose F. Figueroa et al., *Changes in Employment Status and Access to Care During COVID-19 Pandemic Among Low-Income Adults in 4 Southern States*, 37 J. Gen. Intern. Med 2795, 2795 (Aug. 2022).
[20] *Id.* at 2975
[21] Julia Harris et al., The Impact of Covid-19 on the Rural Health Care Landscape 6 (May 4, 2022), https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2022/04/BPC-Rural-Hospital-Report-4-22-22.pdf.
[22] *See* Figueroa et al., *supra* note 19, at 2796

home. For individuals who live in areas in which multiple insurance providers operate, this system functions well and is able to provide good service. Following the trend of the urban-rural division of healthcare quality, this readiness of service providers is not as helpful for rural communities, where insurers are few and far between with their lacking quality notwithstanding. The rural population also faces a greater difficulty of being able to fund their own insurance through their reduced incomes, which suggests the notion that a service for finding insurance is not as useful as concrete, fundamental methods of lowering the costs of said insurance as a whole. The logistical systems are in place for rural Americans to *find* insurance, the difficult part of the matter is making sure they can *use* that insurance.

National Federation of Independent Business v. Sebelius, which was heard before the Supreme Court, explores the argument behind not requiring an individual to pay for their health insurance. The plaintiffs discuss the "shared responsibility payment" that must be paid to the government in lieu of an insurance subscription.[23] Although the case is argued from the perspective of business owners and other groups that oppose the Affordable Care Act for their own specific reasons, the perspective of mandatory insurance policies holds a separate context for rural Americans. In many rural communities, individuals face greater difficulty in possessing the means to adequate medical coverage.[24] The initial text of Medicare does not imply that providing healthcare is the sole responsibility of the government, but rather suggests that cooperation between federal and state governments, corporations, and individuals is necessary in order to maintain an effective healthcare system.

Considering this relationship, penalizing individuals for failing to enroll in insurance policies only exacerbates their negative situation. To help rural Americans, they should not be faced with consequences for failure to provide insurance, at least not in the same way more financially established Americans would be. Examining the Court opinion, Chief Justice John Roberts wrote for the majority and explained that the Court could not discuss the policies of the act, but could reason that the individual mandate and the Medicaid expansion mandate for states were unconstitutional.[25] Roberts cited the Commerce Clause and the principle of enumerated powers to explain that the federal government did not in fact have the authority to enforce health insurance purchases. Roberts suggested for the "Court to view the mandate as

[23] National Federation of Independent Business v. Sebelius, No. 11–393, slip op. at 1 (2012).
[24] Marci Nielsen et al., *Addressing Healthcare Challenges Head On*, 114 Mo. Med. 363, 363-366 (Sept.-Oct. 2017).
[25] *See National Federation*, No. 11-393, at 3.

imposing a tax."[26] Under this distinction, the shared responsibility payment is not categorized as a penalty, removing the question of unconstitutionality. Regarding Medicaid expansion, Justices Roberts, Breyer, and Kagan invoked the Spending Clause and argued that Congress could not "threaten[] to terminate other grants" or elsewise pressure states to adopt Medicaid by way of funding revocation.[27] Justice Ruth Bader Ginsburg asserted that the individual mandate was in fact legitimate, also using the commerce clause as justification.

II. LEGISLATIVE ACTS

A. Balanced Budget Act

In 1997, President Bill Clinton signed into law the Balanced Budget Act (BBA), which resulted in a significant reduction in federal spending for the turn of the millennium.[28] The goal of the act was to restructure the government's expenditure plan to help curtail the national debt. Medicaid suffered the largest cuts in funding allocation, resulting in the largest deductions in spending for the program since President Reagan in 1981 (legislation prescribed gross federal Medicaid funding to be cut by $17 billion over five years and $61.4 billion over ten years).[29] The budget cuts administered by the BBA resulted in the downsizing of Medicaid capabilities, which then failed to maintain established standards of care. Medicaid especially, which is predicated on the sole purpose of providing healthcare to low income individuals, was stunted in its abilities.

The Balanced Budget Act also reformed the Medicare Prospective Payment Program, which was introduced in 1983 to alleviate rising healthcare costs. The program, in which hospitals are reimbursed at a predetermined rate for Medicare related expenditures, was restricted in accordance with the sweeping cuts prescribed by Clinton's act.[30] *Transitional Hospitals Corporation of Louisiana, Inc. v. Shalala*

[26] *See National Federation*, No. 11–393 at 3.
[27] *See National Federation*, No. 11–393 at 5.
[28] Balanced Budget Act of 1997, 42 U.S.C. § 1395 et seq.
[29] Andy Schneider, Overview of Medicaid Provisions in the Balanced Budget Act of 1997, P.L. 105-33 (1997), https://www.cbpp.org/sites/default/files/archive/908mcaid.htm#:~:text=The%20Balanced%20Budget%20Act%20signed,over%20the%20next%20ten%20years.
[30] Transitional Hospitals Corp. of Louisiana, Inc. v. Shalala, 343 U.S. App. D.C. 82, 85 (D.C. Cir. 2000).

illustrates the payment system's impact on long-term outpatient care.[31] In the case, Transitional Hospitals Corporation justified that hospitals that contain people in inpatient care for an average stay of 25 days or more should be able to be reimbursed according to the costs of the care they receive, challenging the fixed rate outlined by the payment system. Although they are relatively rare, certain illnesses and injuries necessitate long periods of hospitalization, as described in the case. Rural Americans are more likely to be held in inpatient care due in large part to geographic obstacles causing their homes to be medically incompatible. In many cases, rural patients simply live too far from hospitals to easily make frequent visits to them. Furthermore, many rural hospitals tend to have longer periods of inpatient care as a result of their limited facilities and substandard efficiency. The Agency for Healthcare Research and Quality found that private insurance recipients had the lowest average lengths of stay, preceded by completely uninsured people, and then Medicaid recipients.[32] These statistics demonstrate the greater trend of federal healthcare programs lagging in quality when compared to other means of coverage. Returning to the case, Transitional Hospitals Corporation lost and the Department of Health and Human Services ordered that hospitals must adhere to the directions and requirements prescribed to them.[33] This decision had adverse ramifications for working class Americans faced with long term hospitalizations, their reimbursement (in case of a hospital stay longer than 25 days) is not protected by the prospective payment system.

The Balanced Budget Act also determines the level of Medicare funding that hospitals receive based on their geographical location. Under the provisions of the act, the funding that hospitals receive are scaled according to the average wages in their particular geographical area. A case that demonstrates the nuances of this condition is *St. Mary Medical Center v. Becerra.* The plaintiffs in the case argued that the minimum funding that rural hospitals receive should not be decreased on the basis of achieving budget neutrality.[34] The rural floor adjustment provided struggling rural hospitals with a baseline reimbursement rate for Medicare related fees, but the eventual decision by the Department of Health and Human Services ruled that this feature was an insufficient justification for preventing costs to be lowered.[35]

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[31] *See Transitional Hospitals,* 343 U.S. App. D.C. at 85.

[32] Lorena Lopez-Gonzalez et al., Characterizations of Medicaid and Underinsured Hospitalizations, Agency for Healthcare Research and Quality, Stat. Brief No. 182 (Oct. 2014).

[33] *See Transitional Hospitals,* 343 U.S. App. D.C. at 85.

[34] St. Mary Med. Ctr. v. Becerra, 581 F. Supp. 3d 119, 126 (D.D.C. 2022).

[35] *Id.* at 124

B. Affordable Care Act

The Affordable Care Act of 2010 (ACA), signed by President Barack Obama, yielded the most significant changes to the healthcare system since the inception of the Medicare and Medicaid programs. Unlike other healthcare legislation, the ACA described extensive provisions for rural healthcare, both in terms of federal reimbursements as well as more institutional improvements for medical facilities.[36] The ACA made important strides towards rural healthcare expansion, but its effectiveness has been limited by factors including implementation challenges and political opposition. The act contains explicit protections of specific aspects of rural medicine, including a focus on how inpatient and outpatient care function. The act also includes advice on how to better serve rural minority populations that historically have had very limited access to quality medical care.[37] Despite its benefits, the years following the passage of the ACA were marred with various attempts to stifle its power. In 2017, a Republican dominated House found themselves in prime position to revoke the ACA, but only managed to repeal portions of it.[38] One of these portions discussed the removal of premium tax credits, which can be used by lower income individuals to purchase health insurance. The value of these credits is predicated on the average price of insurance premiums in an individual's geographic area. For rural Americans, many of whom live in economically homogeneous communities, this condition provided assurance that their costs would remain stable. Removing this section also removes this sense of security for rural patients. In the past few years, states have been voting on whether or not to expand Medicaid coverage.[39] This further politicization of the issue hinders the process for all communities, particularly poorer rural ones, from benefiting from federal healthcare aid.

Expanding the ACA, even beyond what was stated in the original document from 2010, would be of paramount importance to impoverished rural communities. Survey data from the Commonwealth Fund provides evidence that reductions in Medicaid funding result in lower coverage. The survey found that states that elect to

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[36] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).
[37] *Id.* at 290
[38] American Healthcare Act of 2017, Pub. L. No. 115-19, 131 Stat.119 (2017).
[39] *Status of State Medicaid Expansion Decisions: Interactive Map.* KFF, Dec. 1 2023 https://www.kff.org/affordable-care-act/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.

reduce their Medicaid spending also lose out on federal funds.[40] The relationship between Medicaid and federal funding functions in a way that for every dollar spent by a state on Medicaid, the federal government contributes additional funds to match a certain percentage of the state's spending. This matching rate varies depending on the state's per capita income, with higher-income states receiving a lower federal match and lower-income states receiving a higher federal match. It is the duty of the legislature to uphold these measures towards healthcare equity, or else the legal structure would fall into further disarray.

The ACA, thirteen years after its implementation, is standing despite repeated attempts to repeal it. Still, President Biden's Democratic government has been working to reverse actions intended to reduce its efficacy. Biden issued an executive order in April of 2022 which strengthened the existing ACA provisions.[41] In it, he lists off expanding insurance enrollment periods, overseeing the expansion of Medicaid in Midwestern states like Missouri and Oklahoma, including policies such as allowing pregnant mothers to keep their Medicaid coverage up to a year after the birth of their child.[42] Biden also discusses how 2020 and 2021 resulted in a nearly all-time low uninsured rate due in large part to his response to the Covid-19 pandemic and expansion of Medicaid coverage.[43] Although these are good markers of progress in the field, more potent reforms have to occur by way of foundational legislative action; temporary initiatives brought forth by executive orders can easily be discarded by changes in governments.

III. POLICY AMENDMENTS & ACTION

A. Policy Action

Expanding healthcare infrastructure via partnerships and incentive programs with corporations can be effective. This relationship combines qualities of the private healthcare sector, such as innovation, knowledge, and skills with public sector

[40] Edwin Park et al., *Jeopardizing a Sound Investment: Why Short-Term Cuts to Medicaid Coverage During Pregnancy and Childhood Could Result in Long-Term Harm*, Commonwealth Fund 7 (Dec. 8, 2020).
[41] Exec. Order No. 14070, 87 Fed. Reg. 20235 (Apr. 5, 2022).
[42] *Id.*
[43] *Id.*

responsibilities including social justice and public accountability.[44] This allows for a more thorough implementation plan, because both parties account for each others' potential deficits. In terms of funding, private sector partnerships alleviate a large portion of the government's financial burden. Private companies should not bear public burdens solely, but partnerships with the public sector can leverage their resources and expertise to address societal challenges. Along with finances, corporate partnerships take logistical and organizational responsibilities away from government agencies.

Other countries have utilized a version of the public-private partnership (PPP) model that includes thorough integration of both parties and their responsibilities. In Valencia, Spain, all primary care and referral clinics are included in the PPP contract, giving the private sector more freedom in the area.[45] This is different from the American system in that there is a greater degree of shared responsibility between government actors and private partners. In the United States, command-and control-policies dominate interactions in primary care, and PPP initiatives are relegated to healthcare finance. Under the system in Valencia, healthcare facilities in the area were more efficient in service delivery. This system has proven beneficial as it accounts for the deficiencies related to public medical care, especially in management expertise. PPP integration would also lower out-of-pocket costs for customers, which would benefit all working class Americans, according to a study by the Journal of Public Health Research.[46] The study implemented various performance indicators to measure the effects that PPP integration had on consumer costs, finding that it led to reduced costs in both the United States and abroad. For rural Americans especially, who face issues with healthcare facility operation, this partnership would reduce the costs and effort necessary to implement and maintain hospitals and clinics. Currently, funding and efforts to improve healthcare access are mainly conducted by wealthier states like California and New York.[47] Because there are less active funding opportunities for rural healthcare programs in rural states, there is a greater necessity for reform in the form of partnerships. In order to enforce the efficiency and governance of these partnerships,

[44] Masyitoh Basabih et al., *Hospital Services Under Public-Private Partnerships, Outcomes, and Challenges: A Literature Review,* 11 J. Pub. Health Res (Aug. 26, 2022).
[45] N. Abuzaineh et al., *PPPs in Healthcare: Models, Lessons and Trends for the Future, in Healthcare Public-Private Partnership Series No. 4*, at The Global Health Group, Inst. for Global Health Sci., U.C., San Francisco & PwC 1 (1st ed. 2018).
[46] *See* KFF, *supra* note 39
[47]Rural Health Information Hub, Funding & Opportunities by State, RHIhub, https://www.ruralhealthinfo.org/funding/states.

they should be based on incentives for healthcare providers. One potential incentive could be tax deductions for corporations that decided to partner with state agencies to expand rural healthcare networks. The Georgia HEART program is an example of one of these incentives, in which corporations receive tax credits for practicing in rural areas.[48] Depending on the plan, corporations can opt to receive up to 100% of tax credits according to their contributions to rural health organizations. This tax incentive would make corporations more keen to collaborate with rural health communities, functioning in a similar vein to businesses who intentionally elect to establish operations in states with relatively low corporate tax rates. Similar tax subsidies for employer-sponsored insurance can be useful, as discussed by the Congressional Budget Office.[49] Tax incentives targeted towards employers have the potential to compel them to expand workers' healthcare coverage. This addition would be beneficial in rural areas that face deficiencies in employer-sponsored care.

An additional incentive that could resolve issues with staffing in rural hospitals could be student loan rebates or even free medical school tuition for those willing to practice medicine in underserved rural communities. The University of Arizona Colleges of Medicine currently have a program that provides free tuition for students that commit to practicing primary care in both rural and urban underserved communities in the state, rather than selecting a more lucrative specialty.[50] Although this example includes a state university partnership, its fundamental logic can be applied to private sector partnerships. The National Health Service Corps, under the direction of the Health Resources & Services Administration, provides scholarships to medical students who agree to spend two years providing primary care services in health professional shortage areas.[51] In order to actualize these plans, established healthcare corporations must be willing to cooperate with government initiatives to fund scholarships or forgive loans. This process may be difficult, but certain larger

[48] Julianne F. Andrews, *Noteworthy Tax Credit Opportunities for Healthcare Providers, Physicians Practice* (Apr. 1, 2020), https://www.physicianspractice.com/view/noteworthy-tax-credit-opportunities-healthcare-providers.

[49] Cong. Budget Office, Health Coverage: *CBO's Baseline Projections for 2023 to 2032*, Cong. Budget Office (Sept. 2023), https://www.cbo.gov/system/files/2023-09/59273-health-coverage.pdf.

[50] Univ. of Ariz. Health Sci., *UA Colleges of Medicine to Provide Free Tuition for Primary Care Medical Students* (Nov. 22, 2019), https://healthsciences.arizona.edu/news/releases/uarizona-colleges-medicine-provide-free-tuition-primary-care-medical-students.

[51] Nat'l Health Serv. Corps, NHSC Scholarship Program Overview, NHSC (2024), https://nhsc.hrsa.gov/scholarships/overview.

healthcare organizations can feasibly cooperate with this program. The issue of who owns the provision problem is also necessary to be addressed. I propose that the provision problem be divided between corporate and government partners. This collaboration allows for both parties to "pay the cost," sharing their responsibilities. This also applies to ownership to, with the government retaining ownership to their standing facilities and programs while corporates implement themselves into the existing model.

Amendments to Medicare financing models would benefit rural medicine as well as the greater population. Strong and sustainable provider and facility financing can alleviate pressures on rural communities, such as low Medicare reimbursement rates, sicker patients, and alarmingly frequent hospital closures.[52] Under current legislation, small, rural hospitals where over 60% of admissions consist of Medicare patients can receive the designation of being a "Medicare-dependent hospital."[53] In these facilities, recipients are subject to the base rate outlined by their prospective payment system, plus 75% of the difference between that rate and their inflation adjusted cost.[54] This program is beneficial, especially to rural communities where Medicare recipients are more common, but is limited. Broadening this designation to cover more hospitals (thereby getting rid of the 60% threshold) would expand peoples' ability to obtain coverage. Other similar financing models include the Save Rural Hospitals Act proposed by House members in May of 2023. Inspiring the legislation, the Alabama Hospital Association warned that over a dozen of the state's rural hospitals were at an immediate risk of closure as a result of the Covid pandemic.[55] Citing low patient volumes and financial strain as factors for the hospitals' dire situation, Alabama hospitals addressed flaws in the Medicare Area Wage Index. The current index has resulted in patients being given disproportionately low reimbursement rates.[56] The proposed Save Rural Hospitals Act suggests instituting a national minimum reimbursement rate of 0.85, which provides a necessary bonus for poorer Americans. Deficient Medicare reimbursement is one of the most prominent problems in rural healthcare. Establishing a high, steady reimbursement rate that does

[52] Am. Hosp. Ass'n, *AHA Recommendations to House Ways & Means Committee on Improving Health Care Access in Rural and Underserved Areas*, AHA 2 (Oct. 5, 2023).
[53] *Id.* at 2
[54] *Id.* at 2
[55] Reps. Sewell, *Ferguson Introduce Bipartisan Save Rural Hospitals Act*, U.S. Congresswoman Terri Sewell, Press Releases (May 24, 2023), https://sewell.house.gov/2023/5/reps-sewell-ferguson-introduce-bipartisan-save-rural-hospitals-act.
[56] *See* Am. Hosp. Ass'n, *supra* note 52

not take into account local wage rates or Medicare dependence would create a more equal environment for these facilities to thrive. In spite of the benefits of these policies, the negative economic incentives for the government to incur further expenditures towards Medicare reimbursement must be addressed. Government programs may not be predicated on profitability in the same manner that private sector initiatives are, but it is still efficient from a policy perspective to reduce costs to a minimum. This issue is pacified by the Medicare budget increases outlined by the Biden administration, which plan to raise expenditures from 10% of federal funding in 2021 to 18%.[57] This plan contributes to the expansion of Medicare enrollment as well as reimbursement provisions for peoples' existing coverage. Although this budgetary project may be subject to reversal by future administrations that may not value healthcare spending, it will expand Medicare coverage according to its current trajectory. The Inflation Reduction Act, signed into law by Biden in August of 2022, similarly outlines financial support for Medicare beneficiaries through a negotiation of prescription drug costs.[58] The act sets a $2,000 restriction on annual pharmacy costs, which would benefit about 1.4 million program beneficiaries nationwide.[59] Since its passing, the Inflation Reduction Act has shown tangible effects in reducing patient costs, with it being projected to reduce the federal budget deficit by $237 billion by 2031.[60]Advancing Medicare spending helps to reduce the rural Medigap and offset the negative outcomes associated with low reimbursement rates.

One relatively low cost method of improving care that can be specialized for rural communities is telehealth. The current rural medical infrastructure is plagued by outdated equipment and facilities, and many services provided by hospitals can appropriately be addressed through remote patient monitoring and consultations.[61] A focus on telehealth bypasses many of the logistical problems that concern rural healthcare. Under an expanded telehealth network, rural patients do not have to

[57] Juliette Cubanski & Tricia Neuman, *What to Know About Medicare Spending and Financing*, Kaiser Fam. Found. (Jan.19,2023), https://www.kff.org/medicare/issue-brief/what-to-know-about-medicare-spending-and-financing/.

[58] By the Numbers: *The Inflation Reduction Act, The White House, Briefing Room, Statements and Releases* , The White House (Aug.15,2022), https://www.whitehouse.gov/briefing-room/statements-releases/2022/08/15/by-the-numbers-the-inflation-reduction-act/.

[59] *Id.*

[60] Trevor Higgins, *The Inflation Reduction Act: A Year in Review,* CAP 20 (2023), https://www.kff.org/medicare/issue-brief/what-to-know-about-medicare-spending-and-financing/.

[61] Levert, Dominique, *Telemedicine: Revamping Quality Healthcare in America. Annals of Health Law Advance Directive*, Loyola University Chicago School of Law (Spring 2010).

concern themselves with geographic barriers or distances. For working class rural Americans, the time spent on traveling for a basic necessity such as medical care could be better spent on earning an income. Telehealth, by design, is limited by the technological boundaries of screens and video calls, but is still effective in treatments that revolve around the delivery of valuable medical advice rather than those that use technical instruments. In light of the Covid pandemic, the telehealth sector saw a massive increase in scope and operation. Within the first three months of the pandemic alone, telehealth communications increased by 766% in a study addressing 36 million working-age individuals.[62] Corporate investment in telehealth and digital care services has substantially increased, with the level of venture capital in the area tripling from 2017 to the midst of the pandemic in 2020.[63] Even though the pandemic has subsided, companies have still burrowed an avenue for profit through providing telehealth services and will continue to do so.

Although a telehealth focused solution only applies to acute care or advisory services, procedures that require hands-on examination or use of technical instruments still require in-person action. This limitation can be combated through market-based approaches that can incentivize providers to create specific programs that are tailored to certain diseases, expanding remote care offerings. Additionally, a reliance on technology can be difficult for hospitals that lack the necessary infrastructure and hardware. For hospitals that lack the necessary equipment for reliance on telehealth, market-driven initiatives can promote the development and implementation of telehealth platforms that can improve upon the capabilities of existing hardware. The physical restrictions brought on by quarantine policies gave telehealth a proper platform to be tested, with its widespread usage demonstrating its capabilities in acute care settings. Considering policy action, an effective outline for expanding technological infrastructure in hospitals is necessary. All medical facilities, and rural hospitals in particular, are capable of providing services through telehealth communications. Providing an incentive for corporations to collaborate with the government could be an option; groups involved in telecommunications, computer technology, and software would be able to benefit from such a partnership.

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[62] Julia Shaver, *The State of Telehealth Before and After the COVID-19 Pandemic*, 49 Primary Care 4 (2022).

[63] Oleg Bestennyy et al., *Telehealth: A Quarter-Trillion-Dollar Post-COVID-19 Reality,* McKinsey & Co. (July 9, 2021), https://www.mckinsey.com/industries/healthcare/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality.

Another factor to consider about the price of this program would be the logistical costs saved by switching to a variety of virtual treatments. Shifting a financial focus on expanding telehealth would help alleviate costs related to travel, staffing, and facility operation. At a base level, health services conducted through video calls only require the costs of internet and computer technology, where in-person consultations and service necessitates more attention and financial burden. Telehealth expansion can be achieved through corporate partnerships or through standalone legislation. The Consolidated Appropriations Act of 2023 explicitly allocates additional funding for the expansion of the existing telehealth network, which is a decision beneficial to rural communities.[64] This recent legislative action has created an environment conducive to the growth of telehealth, but requires additional effort to stand as a lasting method of improving healthcare opportunities for impacted communities. Telehealth infrastructure development is crucial, as the technological facilities of rural hospitals must meet a certain standard. A study conducted by the Federal Communications Commission (FCC) in Appalachia discusses the relationship between cancer care patients and internet access.[65] The FCC found that the majority of counties with the highest lung cancer rates also had below average rates of broadband internet access. People in these counties would be able to benefit from telehealth, as they can receive check-ups and screenings remotely, but this infrastructural deficiency is an obstacle in this process. Establishing internet and computer systems in rural regions like Appalachia would be an effective, one-time cost that would return profits to telehealth providers as well as benefits to patients who would gain more access to acute care.

B. Counter Arguments

The ethical, economic, and social benefits of expanding rural healthcare access notwithstanding, there are a variety of counterarguments that critics utilize to reason against further progress in the area. The most distinctive of these positions relies on a neoliberal understanding of the federal budget, with particular scrutiny on healthcare spending through Medicare/Medicaid programs. Per the budget appropriations of 2022, Medicare spending is expected to rise from the current 10% of the national GDP

[64] Consolidated Appropriations Act, 2023, Pub. L. 117-328, §123 (2023).

[65] David Raths, *Expanding Internet Access Improves Health Outcomes*, Gov't Tech. (2020), https://www.govtech.com/network/expanding-internet-access-improves-health-outcomes.html#:~:text=%E2%80%9CStudies%20have%20shown%20a%20greater,patient%20satisfaction%20is%20much%20higher.%E2%80%9D&text=David%20Raths%20is%20a%20contributing%20writer%20for%20Government%20Technology%20magazine.

to 18% in 2032, as a result of growing enrollment, evolving costs of care, and increased use of medical services.[66] As expected, this rising allocation has been faced with challenges, with politicians forced to either increase taxes to fund these programs or cut their benefits, with this divide usually aligning with the party split.[67] This creates a difficult situation for all parties involved, but the fact of the matter is that proper attention to medical care is necessary. The long-term benefits of investment in Medicare/Medicaid are prominent and cost-saving. The Center on Budget and Policy Priorities finds that Medicaid expansion has resulted in an estimated 39 to 64% reduction in mortality rates for older Americans who gain coverage.[68] It is essential to consider the broader economic context, including the rate of GDP growth relative to Medicare spending. While healthcare investments may yield long-term benefits, it's crucial to ensure that they are sustainable and aligned with overall economic growth objectives. Therefore, policymakers must carefully balance the benefits of healthcare expansion with the need for fiscal responsibility to ensure the long-term viability of these programs.

The study also states that Medicaid expansion has resulted in more low-income adults using medications to treat chronic conditions such as heart disease and diabetes.[69] These two conditions, along with other similar ones such as hypertension and stroke, are markedly more prevalent in rural communities.[70] These statistics demonstrate the tangible effects that these federal programs have on the longevity and livelihood of low income Americans, they have been shown to positively impact their healthcare outcomes. Another point that offsets short term costs would be the fact that states that have undergone Medicaid expansion have seen significant coverage gains and reductions in uninsured rates.[71] These two outcomes, if sustained, allow for patients to

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[66] Juliette Cubanski & Tricia Neuman, *What to Know about Medicare Spending and Financing,* KFF (Jan. 19, 2023), https://www.kff.org/medicare/issue-brief/what-to-know-about-medicare-spending-and-financing/.

[67] Dennis W. Janse & Andrew Rettenmaier, *Why It's Hard For The US To Cut Or Even Control Medicare Spending,* Tex. A&M Univ. Coll. of Arts & Sci. (Mar. 17, 2023).

[68] Matt Broaddus & Aviva Aron-Dine, *Medicaid Expansion Has Saved at Least 19,000 Lives, New Research Finds* 1 (2019), https://www.cbpp.org/sites/default/files/atoms/files/11-6-19health.pdf.

[69] *Id.* at 1

[70] Rahul Aggarwal et al., *Rural-Urban Disparities: Diabetes, Hypertension, Heart Disease, and Stroke Mortality Among Black and White Adults*, 1999-2018, 77 J. Am. Coll. Cardiol. 1480, 1 (2021).

[71] Madeline Guth et al., *The Effects of Medicaid Expansion under the ACA: Studies from January 2014 to January 2020*, Kaiser Fam. Found. 2 (Mar.17, 2020), https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/.

experience higher quality and more thorough care, as well as gains to the labor market and overall economic growth.[72] These latter externalities may not appear to be direct results of healthcare policy reform, but are positive consequences of Americans being healthy. With a relieved burden regarding healthcare, individuals are given more area to exert effort into their occupations and spend their income towards other sectors of the economy. It is correct that there are various financial costs related to the expansion of federal healthcare programs, but their long-term effects are economically beneficial.

A comparative examination of international healthcare systems reveals methods to reduce financial costs while also maximizing care. A study by The Commonwealth Fund shows that the United States pays more for doctors, pharmaceuticals, and healthcare administration than other comparable high-income developed countries.[73] Reducing overall healthcare provision costs could directly benefit Medicare by potentially alleviating financial strain on the program. By lowering costs, Medicare could stretch its budget further, enabling it to cover more individuals and services without compromising quality. Moreover, decreased costs could lead to more stable premiums and copayments for beneficiaries, making healthcare more affordable and accessible for those enrolled in the program. These high costs do not correlate to superior care, as the study also discusses areas where the United States lags behind other countries, such as life expectancy.[74] A large portion of these surplus costs are attributed to the high prices of labor and pharmaceuticals, as well as administrative costs. The new capacity for the government to bargain directly with corporations will ideally reduce these regulatory and administrative costs, given that there are less actors involved in service delivery. By engaging in direct negotiations, the government willsecure more favorable terms for pharmaceutical purchases, thereby lowering medication costs. Furthermore, streamlining administrative processes through centralized bargaining can lead to efficiency gains and cost savings. With fewer intermediaries involved in service delivery, regulatory and administrative overheads are expected to decrease, allowing resources to be redirected towards improving patient care and expanding access to essential services. Consequently, leveraging this new capacity for direct negotiation may yield significant cost reductions and enhance the overall effectiveness of Medicare and other healthcare programs. By adopting efficient

[72] *See* Guth et al., *supra* note 71 at 2

[73] Irene Papanicolas et al., *Health Care Spending in the United States and Other High-Income Countries,* Commonwealth Fund (Mar. 13, 2018).

[74] *Id.* at 1028

healthcare practices that resolve these unnecessary costs, the government, healthcare providers, and the general public will all benefit financially.

While politicians must consider budgetary concerns, denying Medicaid expansion exacerbates healthcare disparities. Alternate solutions such as the market partnerships I described above can be useful in ensuring equitable access without compromising fiscal stability. By balancing budgetary concerns with the imperative to address healthcare disparities, policymakers can minimize the financial costs of healthcare expansion while benefiting citizens. Under local delivery systems, state governments can decide not to comply with federal Medicaid funding allocations. The Biden government has been working to dismantle these actions conducted by state governments, hoping to better enforce the ACA.[75] The political barriers brought on by bureaucratic processes are, at their base, unnecessary and only serve to hinder the healthcare expansion process. It does not aid the situation that the states that are most ardent in their stance against Medicaid expansion are those with large, working class rural populations that would directly benefit from them. The majority of people who fall victim to the existing Medicaid coverage gap are in fact people living in the South, which has a higher proportion of rural residents in comparison to other regions of the country.[76]

In spite of this tense politicized landscape, there have been bipartisan healthcare policy successes. H.R. 5013, otherwise known as the Value in Health Care Act, calls for a redesign in alternative payment models for Medicare. The bill continues the existing 5% incentive payments for healthcare providers to participate in these alternative payments programs, which are designed to prioritize the quality and value of care over the volume of services provided.[77] Authored by House members from both parties, this bill demonstrates the reality that it is indeed possible for healthcare legislation to overcome intense politicization. According to The Commonwealth Fund, healthcare advancement policies have been successful in conservative states such as Ohio.[78] They found that after the passing of the ACA, the city of Akron stood out

[75] *See* Aggarwal et al., *supra* note 70, at 1.

[76] Sherry A. Gilded & Mark A. Weiss, Impact of the Medicaid Coverage Gap: Comparing States That Have and Have Not Expanded Eligibility (Sept. 11, 2023), https://www.commonwealthfund.org/publications/issue-briefs/2023/sep/impact-medicaid-coverage-gap-comparing-states-have-and-have-not.

[77] Kevin O'Reilly, New Bipartisan Bill a Crucial Boost to Medicare Value-Based Care (2023), https://www.ama-assn.org/practice-management/payment-delivery-models/new-bipartisan-bill-crucial-boost-medicare-value-based.

[78] David C. Radley et al., *Rising to Challenge,* Commonwealth Fund, 10 (2016).

nationally in various areas, such as reductions in uninsured rates, mortality rates after long term stays, and quality of nursing home care.[79] Cities in other regions of the country also demonstrated marked improvement, including those in the South. Even though medical programs have been subject to intense politicization, all states benefit from them and thus should be considered viable.

IV. CONCLUSION

For the foreseeable future, Earl Turner will continue to work tirelessly to serve his pocket of rural America. In spite of his growing age and withering stamina, oil workers in his Texas counties will continue to suffer injuries, aging residents will still need consultations for their chronic illnesses, and expectant mothers will reach their due dates. To Turner, serving his community is his duty, it is something he does thanklessly with every expectation of difficulty. He is cognizant of the disparities between the work he does and the work of an urban doctor, but he pushes forward nonetheless. The healthcare situation in rural West Texas may be inferior and fundamentally flawed, but that is not the fault of hardworking Americans like Turner.

Turner will continue to fulfill his duties as a rural doctor, and it is only just for policymakers to fulfill their duties to keep his interests in mind and work to expand opportunities for rural medicine. The challenges that Turner and countless other rural medical practitioners face are part of a broader debate surrounding the topic of the American healthcare system. Like other areas of great contention, issues with the healthcare system intersect the areas of law, policy, and ethics. I have described various policy measures that appropriately act towards creating a truly equitable healthcare environment for all Americans, but a definitive repair of the system requires foundational changes. For these policy initiatives, as well as future ones, consistent evaluation and assessment of realistic improvements is crucial to monitoring their efficacy. Transcending political divisions, the positive effects of these policies will be felt by a wide body of Americans, with no regard for partisan affiliation. The main goal of expanding healthcare access is to provide higher quality care to patients regardless of their financial ability or zip code. There stands a formidable record of adversities related to rural healthcare. Problems that are relevant to medical facilities in all areas of the country assume a greater severity for rural peoples. Infrastructure, personnel, funding, volume, insurance, and federal programs each take on a special context in

[79] *Id.* at 10

rural communities. Still, with a vested commitment to delivering justice by way of policy, the framework of rural healthcare in this country can be rightfully improved.