



Keeping the Doctor Away
What Makes Arizona Unattractive to Physicians

By

Jeffrey A. Singer, MD, FACS

Craig J. Cantoni, MBA

Arizona Issue Analysis 165
October 2001
www.goldwaterinstitute.org

Note: Nothing written here is to be construed as necessarily reflecting the views of the Goldwater Institute or as an attempt to aid or hinder the passage of any legislation.

Executive Summary

Arizona has a shortage of physicians, a situation that will worsen unless the government policies and regulations that caused the shortage are revised or rescinded.

There is plenty of anecdotal evidence of a shortage. Patients complain about crowded emergency rooms and doctor offices, about the difficulty of making an appointment with a general practitioner or specialist, and about feeling like a widget on an assembly line once inside a hospital or doctor's office.

Doctors complain about long hours for less pay, about onerous paperwork and regulations, and about experienced peers retiring at a relatively young age from a profession they love—or would love if they were allowed to practice medicine without bureaucrats and lawyers coming between them and their patients.

The anecdotes are based in fact. The state's ratio of physicians to population is lower than recommended ratios and lower than most other states, although Arizona has a climate and lifestyle that should be attractive to physicians. The ratio is lower in Arizona because of factors that are outside the control of patients, physicians, insurance companies and even the state government. Although the same factors can be found to some degree in every state in the nation, few states can match Arizona in the way that the factors have come together to produce a shortage.

All patients in all states are suffering from misguided federal policies that stopped a free market in health insurance from developing 60 years ago. Unlike the other necessities of life like food, shelter and clothing, there is not a consumer-led, bottom-up free market in health insurance in America, in which the consumer is king and in which the consumer has a wide variety of service and price options.

All physicians in all states are being treated to some extent like indentured servants, having to provide many services below cost, having to provide uncompensated care for the uninsured and having to work in emergency rooms without recompense because of federal regulations.

But in Arizona these factors are exacerbated by the state's high percentage of uninsured patients, which is primarily the result of the state's high percentage of poor immigrants and non-citizens—which in turn is the result of federal immigration policy and the state's proximity to Mexico. In a very real sense, federal policy has put a hidden tax on physicians. This in turn results in fewer physicians being attracted to the state.

The authors of this report are very pro-immigration, believing that the long-term benefits of immigration far outweigh the short-term costs. However, the inescapable fact is that physicians and other health care providers are bearing a disproportionate share of the costs. The dilemma is this: There is little incentive for physicians to move to the state and treat the uninsured, and, given the lack of a true free market in health insurance, there are no options for poor immigrants other than to receive uncompensated care.

The dilemma cannot be solved by continuing the failed government policies of the last 60 years. It can only be solved by making health insurance more affordable and available for citizens and non-citizens alike, through free market reforms. This report specifies how that can be done and provides statistics to back up its findings and conclusions.

Such insurance reforms must go hand-in-hand with immigration reform. Although it is beyond the scope of this report to describe in detail what those reforms might be, it is clear that steps must be taken to address the underground immigrant economy and its impact on the health care delivery system in Arizona. At the minimum, consideration should be given to reforms that enhance the movement of immigrants out of the hidden economy and into the mainstream. In fact, our findings suggest that reform of immigration policy is a critical component of any comprehensive reform of the health care system.

Introduction

Anecdotal experiences of Arizona doctors and patients over the past several months have led many health care providers to the unproved perception of an incipient physician shortage in the state. One of this study's co-authors is a physician in active clinical practice, and has first hand knowledge of many of these anecdotes.

Patients complain of ever-increasing difficulty obtaining prompt appointments with primary care physicians or specialists, often waiting for periods of weeks for initial appointments. Many complain that, upon finally getting in to see the doctor, they are principally seen by physician-assistants or nurse practitioners, rather than by the doctor they had hoped to see.

The waiting rooms of doctors in specialties not known for handling high volumes of patients are oftentimes packed to "standing room only" capacity.

Both doctors and patients are frustrated by the ever-increasing need to navigate complex menus when attempting to phone health care provider offices. These systems are brought online in order to deal with the great increase in phone calls inundating provider offices.

Appointments for tests or procedures have become more difficult as well, sometimes requiring several weeks before the test or procedure can be performed. These waiting times are not the result of health insurance pre-authorization requirements. Rather, they are due to the crowded schedules of the health care providers. The physician co-author of this report has personally intervened in attempts to facilitate appointments for his patients with consultants or for tests, only to find that the desired appointment times are legitimately "booked up."

Patients have reported seeking the services of hospital emergency rooms in hopes of "moving ahead of the queue" to receive tests and/or non-urgent medical attention. This has contributed to emergency room overcrowding, stressing Emergency Department staffs, and longer waiting times for emergency room care.¹ Doctors privately admit informing their patients, on occasion, that they might get needed tests more expeditiously if they present to an emergency room.

Physicians notice their colleagues retiring at earlier ages than originally planned. Many are selling their practices to hospitals and becoming employees of the practice, significantly shortening their work hours, and thus availability to patients. Doctors who had originally planned to work until they reached their 70s,

¹ See for instance, "A Tragedy Waiting to Happen? Several Factors Blamed For Acute ER Overcrowding in Valley Hospitals," Paul Matthews and Kerry Fehr-Snyder, *Arizona Republic*, January 13, 2001.

now intend to retire in their 50s. This changing attitude towards earlier retirement is augmented by reports in professional newsletters suggesting this phenomenon is nationwide.²

Many physicians report difficulties in recruiting doctors from other states, or who have recently graduated residency programs, to join their busy practices. Some have tried for more than 1½ years to sign on a new associate.

Articles abound in the peer reviewed medical literature highlighting a generalized malaise among health care providers as the patient-doctor relationship continues to undergo change.³ There is also the widespread perception among physicians that the quality of applicants to specialty residency programs is deteriorating.⁴ These factors further impact physician morale and perceptions.

Despite the fact that surveys in the peer reviewed medical literature do not point to an impending national physician shortage, the day-to-day experiences of patients and doctors in this region of the country have led many doctors to conclude intuitively that a shortage exists in Arizona.⁵

² The American College of Surgeons has long boasted that its active dues paying Fellows have a stable average retirement age of slightly over 62, exemplifying the tendency of surgical specialists to work until their later years. However, in February of this year, they reported that for the first time, the average retirement age has dropped significantly:

Year	# retirements	Average Retirement Age
1992	325	62.2
1993	396	62.1
1994	443	62.3
1995	522	62.6
1996	670	62.5
1997	705	62.7
1998	681	63.3
1999	931	63.2
2000	689	59.9

(Based on the age of Active Dues Paying Fellows at the time they report their retirement. Age for dues exempt status changed from 70 to 65 in 1999.) Source: American College of Surgeons, Chicago, Illinois.

³ See, for instance, "Why Are Doctors So Unhappy?" Editorial, *British Medical Journal*, Volume 322, page 1078, May 5, 2001.

⁴ "Is the Quality of Surgical Residency Applicants Deteriorating?" J.B. Cofer et al, *The American Journal of Surgery*, Volume 181 (2001), pages 44-49. "Medicare and Graduate Medical Education," John K. Iglehart, *New England Journal of Medicine*, February 5, 1998, Volume 338, Number 6, pages 401-407. "Graduate Medical Education, 1997-1998," Marvin R. Dunn et al, *JAMA*, September 2, 1998, Volume 280, Number 9, pages 809-812.

⁵ "The Projected Supply of Physicians, 1998 to 2020," Phillip R. Kletke, Ph.D., *Physician Characteristics and Distribution in the US, 2000 Edition*, pages 361-375, American Medical Association, Chicago, Illinois. "Patterns of Graduating Medical Student Career Selections From

The goal of this study was to find out if there is empirical evidence to back up the anecdotal suggestion of an Arizona physician shortage, and to uncover possible causes of the shortage, if a shortage is found.

Physician-Patient Ratios

Free market economists are reluctant to enter into a discussion on the proper ratio of physicians to patients. Any attempt to predict or plan a “proper” allocation of goods or services in a given marketplace would amount to an exercise of what Nobel laureate Friedrich A. Hayek has called the “fatal conceit.” The price system, operating under the law of supply and demand, ultimately leads to the proper allocation of resources. Central planning cannot work efficiently in a social context.

The market is the spontaneous interaction of the needs, values, and aspirations of millions of individuals, each with his own individual context, each context changing from moment to moment. Using the price system as the principle means of transmitting information, and subject to the law of supply and demand, millions of transactions and interactions take place simultaneously, each serving the perceived best interests of the actor at the margin. The more populous and diverse a society, the more difficult is prediction and planning.

Nevertheless, regulatory processes, including systems of price controls, have been imposed on the health care industry for decades, thus precluding the development of an unfettered health care marketplace. In effect, health care has been subject to central planning for much of the latter part of the Twentieth Century. With no true market apparatus existing for the distribution of goods and services, health care policy planners have had no alternative but to determine optimal ratios to target the distribution of physicians (service providers) to patients (consumers) in society.

The Bureau of Health Professionals and the Graduate Medical Education National Advisory Committee have adopted criteria upon which they have based the development of physician-patient ratios. These ratios have been used to serve health policy planners for the last two decades. The Bureau of Health Professionals recommends a distribution of 230.9 physicians per 100,000 population; the Graduate Medical Education National Advisory Committee recommends 194.6 physicians per 100,000 population.⁶

1993 to 1998 and Their Effect on Surgery as a Career Choice,” Yale D. Podnos, et al, *Archives of Surgery*, Volume 134, August 1999, pages 876-881.

⁶ The Bureau of Health Professionals recommended physician/population ratios, as well as those recommended by the Graduate Medical Education National Advisory Council, are cited and used as guidelines in *Surveys of Arizona Physicians, 1992-1993*, *Surveys of Arizona Physicians 1992-1999*, and *State of the State: Graduate Medical Education in Arizona, January 2000*, all prepared by the Arizona Council for Graduate Medical Education, Phoenix, Arizona. All records for the Council have

In 1992, the Arizona Council for Graduate Medical Education, with data on the number of in-state physicians provided by the Arizona Board of Medical Examiners, used the average of the two above-referenced ratios to determine that the physician-patient ratio was satisfactory at that time. It projected an adequate supply of physicians in Arizona in the year 2000, using consistent criteria and population projections for the state.⁷

Utilizing this same approach, we compared the number of in-state Arizona physicians provided by the Arizona Board of Medical Examiners to the actual Arizona population as provided by the US Bureau of the Census for the year 2000.⁸ The results point to a shortage.

Table 1. Physician-Patient Ratios in Arizona		
	1990*	2000**
Arizona Population (millions)	3.7	5.1
In-State Arizona Physicians	7,306	9,474
Physician/Patient per 100,000	198	185
Source: * Data from the Arizona Council on Graduate Medical Education ** Data from Arizona Board of Medical Examiners and US Bureau of the Census		

Since the “number of in-state physicians” is not a true reflection of the actual number of physicians providing direct patient care, we then adjusted the data for the year 2000 by subtracting from the total in-state physician population the number of physicians who report themselves to be in Administrative positions rather than clinical medicine, and the number of physicians who maintain their licenses to practice, but report themselves retired from medical practice. This information was available from the Arizona Board of Medical Examiners for the years 1996 to 2000, but was not available for earlier years (and was not included in

been transferred to the Phoenix Area Medical Education Consortium. For information call or write: 4001 N. 3rd Street, Suite 405, Phoenix, AZ 85012, (602) 631-6551. The 2000 report, titled "State of the State: Graduate Medical Education in Arizona," says this about the Flinn Foundation and the Council: "AzCGME has been funded for ten years by the Flinn Foundation as part of the Foundation's continuing interest and commitment to medical education...As of January 2000, the Council will cease to exist."

⁷ *Surveys of Arizona Physicians 1992-1999*, Arizona Council for Graduate Medical Education, Phoenix, Arizona. This series of reports updated the original predictions made in a 1989 report prepared by the Flinn Foundation Commission on Medical Manpower, entitled “Arizona Physicians Today and Tomorrow.” A final report was released by the AzCGME in 2000 entitled *State of the State: Graduate Medical Education in Arizona, January 2000*. That report said that the prediction still holds and that doctors are keeping pace with population growth. It was completed prior to the 2000 US Census, based upon population estimates.

⁸ The authors wish to thank Ms. Sue Brown and the Arizona Medical Association for their assistance with the retrieval of data from the Arizona Board of Medical Examiners.

the AzCGME findings for 1990). The adjusted numbers suggest the shortage is actually more acute.

In-State Physicians	9,474
Number of Retirees	513
Percent Retirees	6
Number Administrative Physicians	120
Percent Administrative Physicians	1
Adjusted Physician/Patient per 100,000	172

This data does not take into account the number of physicians who maintain active clinical practice but have decreased their hours of work to part-time status. Unfortunately, such information is not collected by the Arizona Board of Medical Examiners or, to our knowledge, any other entity concerned with Arizona physician data. If one assumes that at least a segment of the Arizona physician population in active clinical practice works reduced or part-time hours, then it would be reasonable to assume the physician/patient ratio of 172 is actually an optimistic assessment.

Examination of data from the Arizona Board of Medical Examiners found that the number of licensed physicians listed as “retired” has increased from 5 percent in 1996 to 6 percent in 2000. Those listed as “Administrative” have remained stable at 1 percent during the same time period. We found no significant change in the distribution of doctors among the various specialty categories recognized by the Board of Medical Examiners over the same time period. However, recommended physician-patient ratios for specific medical specialties are not available to us, so it is inappropriate to conclude that the shortage is actually an “across-the-board” shortage of physicians, regardless of specialty. Further investigation may lead to the conclusion that some specialties are more adversely affected by the shortage than others.

Our findings are compatible with a report from the American Medical Association that, as of 1999, the last year for which they had available data, Arizona ranked thirty-second in the nation in the number of physicians per population—a counter-intuitive finding, given Arizona’s climate and lifestyle attractions.⁹

With the 2000 Census showing Arizona’s population to be aging across all age categories, and the median age (34.2) two years older than the median age in

⁹ *Physician Characteristics and Distribution in the US*, Division of Survey and Data Resources, 2001 and Prior Editions. American Medical Association, Chicago, Illinois.

1990, these findings could portend serious problems for future health care delivery in Arizona. As age advances, so does the likelihood of needing medical attention.

Causative Factors

In searching for factors causing the physician shortage, we started with the basic premise that the practice of medicine in Arizona has become less economically attractive. It stands to reason.

When deciding where to locate a business (i.e., medical practice), the first considerations are always economic. Physicians contemplating starting, joining, or relocating a medical practice access various information sources: publications such as *Medical Economics* (published by Dow Jones), newsletters, medical conventions, and word of mouth. They seek information on matters such as compensation, work hours, labor and overhead costs, cost of living, litigation climate, and quality of life. These criteria involve innumerable variables, and it is difficult, if not impossible, to precisely determine how each individual doctor decides where to locate his/her practice. If Arizona fares poorly in one or more of these parameters, it follows that this would impact the prospective doctor's decision. Arizona is one of the fastest growing states in the union. It provides an appealing environment to many segments of the American population. The fact that Arizona does not seem to have an equally strong attraction to the medical profession suggests that economic considerations are the principal factor, all other Arizona attributes being equal.

With the litigation climate in Arizona relatively stable over the past five years, and the relatively low cost of living still one of Arizona's positive attributes, compensation for hours worked appears to be the factor most worthy of investigation. We started by looking at some crucial aspects of Arizona's health care consumer population that can lead to decreased physician compensation for hours spent:

1. *HMO Penetration Rate*—because HMOs negotiate substantial discounts from doctors for services rendered, and have little if any out-of-pocket costs to consumers (therefore little feedback on demand), one would expect a population with heavy HMO penetration to result in lower compensation for hours worked.
2. *Medicare Penetration Rate*—because Medicare reimburses doctors at roughly 35-40 percent of their usual and customary fee (with doctors having to “write off” the balance), and because the Medicare-age population is more likely to have complicated and serious illnesses requiring a large time investment by the health care provider, one would expect a population with heavy Medicare penetration to result in lower compensation for hours worked.

3. *Medicaid Penetration Rate*—Medicaid also reimburses providers at reduced rates, and the indigent population on Medicaid has a higher incidence of serious health problems. For these reasons, a high Medicaid population should also lead to lower compensation for hours worked.
4. *Uninsured Rate*—most people who lack health insurance are unable or unwilling to pay for major medical services. These days, unfortunately, “uninsured patients” translate into “uncompensated care.” *Cost shifting* of the uncompensated care by the providers to those with good insurance coverage through increased fees is restricted these days: HMO, PPO, and other managed care contracts restrict the provider to an agreed-upon fee schedule; Medicare and Medicaid have government enforced price controls on physicians’ services.

Utilizing data provided by the Kaiser Family Foundation’s “State Health Facts Online,” we found the following:¹⁰

1. *HMO Penetration Rate*—Arizona’s HMO penetration rate is 31 percent. Arizona ranks 17th in the US in HMO penetration, tied with Florida and New Jersey. The national HMO penetration rate is 30 percent. California leads the nation in HMO penetration (54 percent). Massachusetts (53 percent), Connecticut, Maryland, Oregon, and Colorado are 2nd through 6th respectively, all having greater than 40 percent penetration. New Mexico is 7th with 38 percent penetration, and Nevada is 25th, with 23 percent penetration. These findings reveal nothing that suggests Arizona has an HMO penetration rate at any major variance with much of the country. It certainly compares well with neighboring states or states with similar attributes. The data are for the year 2000.
2. *Medicare Penetration Rate*—Arizona’s Medicare penetration rate is 12 percent. It ranks 17th in the nation, tied with eleven other states. The national Medicare penetration rate is 11 percent. California’s is 9 percent. Florida’s is 17 percent. Nevada’s is 11 percent. Again, nothing in the data suggests that Medicare penetration in Arizona is in any way extraordinary. (Data for 1977-99.)
3. *Medicaid Penetration Rate*—The national Medicaid penetration rate is 10 percent. Arizona’s is 9 percent. It ranks 26th. California’s is 13 percent. Nevada’s is 6 percent. Tennessee and the District of Columbia lead the nation with 19 percent, New York has 15 percent, and Florida has 9 percent. Once again, nothing in the data suggests Medicaid penetration is a major factor in decreased compensation when compared with other states. (Data for 1997-99.)

¹⁰ <http://statehealthfacts.kff.org>—drawing on data from the US Census Bureau, the Urban Institute, Kaiser Commission on Medicaid and the Uninsured, and The Interstudy Competitive Edge 10.2, Part II: HMO Industry Report, October 2000.

4. *Uninsured Rate*—the national percentage of uninsured is 16 percent. Arizona stands out with a 23 percent uninsured rate. This means that almost one in four patients will not have insurance—a significant cause of uncompensated care. It is tied with New Mexico in second place. Texas leads the nation with a 24 percent uninsured rate (but it ranks 29th in HMO penetration, at 19 percent, leaving more room for cost shifting of uncompensated care to those with regular insurance). Nevada has 20 percent uninsured, and California has 21 percent uninsured. New York has 17 percent uninsured. Florida’s rate is 19 percent. (Data for 1997-99.)

The data suggest that a 23 percent uninsured rate (nearly one in four patients will not compensate providers for most care rendered), combined with a remaining pool of payers that leave little opportunity for cost shifting, is a major factor making Arizona less economically attractive to doctors than possible.

In order to look at factors contributing to the extraordinary uninsured rate in Arizona, we started by looking at the make-up of the uninsured population.

Arizona’s Uninsured Population

Examination of data provided by the Kaiser Family Foundation’s “State Health Facts Online” for 1997-99 reveals the following information about Arizona’s uninsured in comparison with some other key states and the national average:

	AZ	CA	NM	TX	FL	NV	NY	USA
White	18%	15%	19%	16%	18%	18%	13%	13%
Black	22	21	NSD	31	27	19	23	23
Hispanic	43	38	31	40	34	37	35	35
Other	23	23	38	30	22	22	33	24

	AZ	CA	NM	TX	FL	NV	NY	USA
Under 100%	42%	39%	46%	39%	36%	39%	37%	36%
100-199%	32	31	28	31	27	25	27	29
200% or more	26	30	25	29	37	36	36	35
Under 200%	74	70	75	71	63	64	64	65

	AZ	CA	NM	TX	FL	NV	NY	USA
Native	85.0%	74.1%	92.8%	86.8%	80.3%	84.2%	77.7%	89.6%
Naturalized	0.2	0.2	0.1	0.2	1.9	0.6	2.1	3.9
Non-Citizen	14.8	25.6	7.1	13.0	17.8	15.2	20.2	6.5

	AZ	CA	NM	TX	FL	NV	NY	USA
White	64%	50%	46%	51%	66%	70%	65%	71%
Black	3	6	2	13	14	6	15	13
Hispanic	29	31	40	32	18	18	15	12
Other	3	13	13	4	2	6	5	5

The states of California, New Mexico, Texas, and Nevada were chosen for comparison to Arizona because, like Arizona, they are southwestern states that share, or are in close proximity to, the Mexican border. Florida and New York were chosen for comparison because they have large immigrant, non-citizen, and Hispanic populations, but differ significantly in geographic location. This difference would be expected to result in immigrant, non-citizen, and Hispanic populations of a different composition than those of the other states listed in the comparison.

Interestingly, Arizona ranks 7th in the nation in percent of non-citizen population. In addition, data from the 2000 US Census ranks Arizona third in the nation with respect to Mexican population as a percent of total state population:¹¹

1. California—25%
2. Texas—24.3%
3. Arizona—20.8%
4. New Mexico—18.1%
5. Nevada—14.3%

Florida and New York each have Mexican populations of less than 4.9 percent of total population.

The data tell us that a very major component of the uninsured populations of Arizona, California, New Mexico, Nevada, and Texas are very poor immigrants from nearby Mexico. All of these states either share a border with or are close to Mexico.¹² Many undocumented immigrants from Mexico are not included in this data. They also seek medical attention at hospital emergency rooms, clinics, and

¹¹ "Trying Amnesty Again?" *Wall Street Journal*, July 17, 2001, page A20—Graphic.

¹² A recent survey conducted by the California Medical Association entitled "And Then There Were None: the Coming Physician Supply Problem," warns that many of its doctors plan to flee the state or retire early due to low pay and frustration with managed care. This should come as no surprise, in light of California's 21 percent uninsured rate, its proximity to the Mexican border, and the fact that its extraordinary HMO penetration rate (54 percent—national average is 30 percent) leaves little room for providers to "cost-shift" their uncompensated care. *Wall Street Journal*, July 16, 2001, page B8: "California Doctors Warn of Exodus, But Draw Doubts," by Rhonda L. Rundle.

doctors' offices, and lack insurance. Therefore, the percentages of the uninsured population reported in these states may in fact be optimistic numbers.

Arizona's status as a state bordering on a relatively impoverished nation confers stresses upon its health care system that are unique to a handful of states. This means that federal health care policy designed as "one-size-fits-all" has the potential to impact Arizona completely differently than the majority of states.

Policies that Increase the Uninsured Population in Arizona

The Double Whammy

Federal and state health care policies often have the unintended consequence of increasing the number of uninsured. This can occur in various ways.

- The policy can increase the population of uninsured by attracting uninsured to a given geographic region.
- The policy can result in an increase in the cost of insurance, making it unaffordable for many individuals to purchase.
- The policy can result in an increase in insurance premiums, causing employers to drop the health insurance coverage they provide as a benefit to employees.
- The policy can result in an increase in the cost of providing health care, generating an increase in charges to insurers, and thus an increase in premiums charged to employers or individuals.

When policies lead to an increase in the number of uninsured, they hurt the population in two ways:

1. The number of people with inadequate access to health care increases.
2. The resultant increase in uncompensated care makes the market unattractive to health care providers, leading to a net decrease in providers, and thus impeding health care access for the general population.

This "double whammy" is happening in Arizona, and is likely occurring in other states as well. It is important to note that each state has its own unique demographic and socioeconomic context. Therefore, federal health care policy that is applied equally across the nation will have unintended consequences that vary in degree and intensity among the individual states.

EMTALA

The Emergency Medical Treatment and Labor Act (EMTALA), passed by the US Congress in 1986, requires, among other things, that hospital emergency rooms give necessary emergency treatment to any person who presents, without any consideration as to that person's ability to pay. Patients *may not* be transferred to other facilities for care, unless they request the transfer, or unless a needed service is not available at the facility to which the patient presents. The physician on call to the emergency room must respond promptly, and must care for the patient. Failure to comply with these requirements can result in severe criminal penalties, monetary and otherwise.

Before EMTALA, most hospitals maintained voluntary emergency room on-call schedules of staff physicians and specialists. However, because of the strict requirements regarding prompt coverage for any and all patients, with the threat of severe penalties to hospitals that fail to comply, many hospitals have found it necessary to make emergency room call mandatory for all staff physicians.

Physicians on call must respond promptly to the emergency room within a defined set of EMTALA guidelines, regardless of the circumstances (e.g., the physician on call might be involved in performing surgery at the time he is called—failure to respond promptly or to send another physician in his place can result in severe federal penalties). This added pressure to the physicians, coupled with the fact that, a significant amount of the time, the care rendered will go uncompensated, has led a great number of doctors to resign from the staffs of all but their most utilized hospitals. As a result, many of Arizona's emergency rooms find themselves unable to find enough doctors to provide the needed emergency room coverage in various specialties.¹³

In a letter addressed to Helene Toiv, Assistant Director of the US General Accounting Office, on April 22, 2001, The Arizona Hospital and Healthcare Association complained that EMTALA is resulting in care delays and bottlenecks, with patients spending more time in emergency departments. It mentioned that the hospitals are having increasing difficulty getting medical coverage for their emergency patients, since doctors are resigning from their staffs. The letter went on to point out that EMTALA is placing a great financial burden on the hospitals, requiring many to cut back services, personnel, or to even consider closing. These financial burdens are caused by the federal requirement that they increase the amount of uncompensated services rendered. The letter also pointed out that the

¹³ See "Valley Doctors Shun ERs—Hospitals Scrambling For Help," by Jodie Snyder, *Arizona Republic*, June 3, 2001; see also "ER Woes Not Fault of Law, GAO Says," by Jodie Snyder, *Arizona Republic*, June 26, 2001.

compliance costs of EMTALA, ranging from personnel costs to attorneys' fees, are also adding to the strain.¹⁴

According to The Arizona Hospital and Healthcare Association (AzHHA), "both insured and uninsured patients are using the emergency department with increased frequency for a huge variety of medical problems, including primary care. (See introduction.) Because so much of this care is uncompensated, hospitals are facing a crushing financial burden."

The AzHHA communication went on to discuss the impact of EMTALA on care for the "illegal immigrant" population: "...this is a huge problem, particularly in the border towns and in Tucson. It was noted that *undocumented aliens routinely move across the border because of their knowledge of EMTALA's requirements* (italics added). This population is rarely insured, thus creating additional financial burdens. The problem of INS agents leaving patients at the hospital rather than maintaining them in custody during the hospital visit was also discussed as a cost-shifting maneuver by the INS...most hospitals on occasion find themselves with patients who need to be transferred, for example, for long term rehabilitation care after emergency treatment at a hospital, but that Mexico, having no such parallel law, does not require its hospitals to take those patients back."

In June of 2001, the US General Accounting Office issued a "Report to Congressional Committees" on the impact of EMTALA on emergency care. While stating that "it is difficult to assess the relative importance of individual factors," the report went on to say that "other factors such as the growth of the uninsured population and the difficulty some managed care patients may have in obtaining timely appointments with their personal physicians, *can also explain* the increase in emergency departments visits..." It went on to suggest that many doctors might be resigning from hospital staffs due to factors other than uncompensated care, "such as the ability to perform procedures in non-hospital settings." There was no objective data offered to support these suggested explanations. Nor was there any attempt to assess the "relative importance of individual factors." (Italics added.)¹⁵

EMTALA has a major deleterious effect on the delivery of healthcare.¹⁶ But its harmful effects are not distributed equally across the country. It does more damage in states that border on a relatively impoverished nation (particularly

¹⁴ *Round-Up*, Official Publication of the Maricopa County Medical Society, Volume 47, Number 5, May 2001: "Special Report," pages 12-21. The letter to the Assistant Director of the US GAO from the AzHHA was signed by Sheri Jordan, Senior Director, Regulatory Affairs and Policy, AzHHA.

¹⁵ June 2001, United States General Accounting Office Report to Congressional Committees: "Emergency Care—EMTALA Implementation and Enforcement Issues," (GAO-01-747).

¹⁶ For a more detailed economic and legal analysis of the effects of EMTALA, see *Mortal Peril—Our Inalienable Right to Health Care?* by Richard A. Epstein, pages 91-105.(1997: Addison-Wesley Publishing Company, Inc., Reading, Massachusetts).

states with smaller populations and state budgets, such as Arizona) than it does in states in other regions of the country. EMTALA is increasing the percentage of uninsured by creating an incentive for poor Mexicans in need of medical care to cross the border and access Arizona's healthcare system. It allows Arizona to serve as an "escape valve" for Mexicans who are poorly served by their nation's healthcare system (ironically, Mexico provides universal coverage for all of its citizens). This adds to the amount of care that goes uncompensated, thus making the healthcare market less attractive to hospitals and providers. It also raises the costs incurred by hospitals and providers in their delivery of services. Where cost-shifting is possible, this contributes to an increase in costs to insurers, and ultimately, in the price of health insurance.

Mandated Benefits Laws

Federal and state laws mandate that health insurance meet a variety of requirements. Among those requirements are coverage requirements, i.e., coverage of specific diseases or specific health care services. In recent years, mandates have even dealt with the way medicine is practiced. For example, there are now hospital length-of-stay mandates for obstetrical care and mastectomies. In 1970 there were only 48 such laws in the US. By 1988 there were over 1000.¹⁷

State mandated benefits, along with other state regulations, are increasing the cost of health insurance and pricing one out of every four uninsured people out of the market.¹⁸ Mandated benefits laws increase the cost of health insurance by increasing the amount of services the insurance is required to cover. The increased cost of health insurance has been shown to cause a net decrease in wages at the same time that it prevents individuals from buying cheaper, less comprehensive health insurance policies—another example of the "double whammy."¹⁹

The "Patients' Bill of Rights" under consideration in the US Congress amounts to a large expansion of the federal mandated benefit laws. Its features allowing patients to sue their health plans or their employers for medical malpractice committed by the plans' contracted health care providers would even more severely increase the cost of providing health insurance. Just the threat of lawsuits is enough to significantly raise premiums. The threat of litigation will cause health plans to practice "defensive medicine," i.e., lift most restrictions on tests and procedures desired by patients or their providers for fear of getting sued. The resultant increase in costs to the health plan leads to premium increases. Recognition and anticipation of the phenomenon of defensive medicine provides

¹⁷ John C. Goodman and Gerald L. Musgrave, "Freedom of Choice in Health Insurance," NCPA Policy Report No. 134 (Dallas: National Center for Policy Analysis, November 1988).

¹⁸ John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis*, (Washington, DC: Cato Institute, 1992), page 354.

¹⁹ "The Incidence of Mandated Maternity Benefits," by Jonathan Gruber, *American Economic Review*, Volume 84, Number 3, 1994: pages 622-41.

enough justification for insurers to raise premiums in states that have enacted “right to sue” laws, regardless of the amount of lawsuits actually taking place.

The premium increases resulting from “Patients Bill of Rights” legislation would serve to make it even more unaffordable for the uninsured to purchase health insurance. What’s more, many employers might decide to stop providing health insurance benefits to their employees, due to the increased cost of the insurance as well as fear added liability risks.

A study by the Employment Policy Foundation compared two “Patients’ Bill of Rights” proposals under consideration by Congress during the summer of 2001. One proposal (H.R.2315) allows for litigation, but is more restrictive than the second proposal (S. 1052). While it found that both bills would lead to an increase in the number of uninsured, the study found that 2 million fewer persons will be covered by insurance in 2010 as a result of the House bill, while there will 9 million more uninsured as a result of the Senate bill.²⁰

An actuarial analysis by the Health Insurance Association of America was more optimistic.²¹ It projects an increase of 6.5 million uninsured if the Senate version of the “Patients’ Bill of Rights” passes. The main reason, according to HIAA, is that the number of employers offering health insurance coverage in 2003 likely would decrease by a conservatively estimated 5 percent, compared to the number of employers likely to offer coverage in 2002. Some 6.5 million Americans would lose their employer-sponsored health insurance. Of these, 3.7 million would become uninsured, while many of the remaining 2.8 million would likely enroll in public programs, such as Medicaid or a state Child Health Insurance Program (“S-CHIP”) -- thereby increasing costs to taxpayers. The most severely affected would be low-income workers and their families.

Nearly half (46 percent) of employees with incomes under 200 percent of the federal poverty level working for employers who drop coverage would become uninsured, while only 7 percent of these workers would retain private coverage.

Tax Code Inequities

The federal income tax code has the unintended consequence of rewarding patients for seeking health insurance coverage through their employer, while punishing those who do not receive employer-provided health insurance. Employer-provided health insurance is not subject to income or payroll taxes, and is therefore a tax-exempt benefit. According to the Congressional Budget Office, this amounted

²⁰ NEWS RELEASE: " There's a Big Difference in the Patients' Rights Legislation Before Congress," July 12, 2001, and "Patients' Rights Legislation: The Triangle of Health Insurance: Quality, Cost and Access," Policy Backgrounder, June 20, 2001, both Employment Policy Foundation, Washington, DC

²¹ "A State-by-State Analysis of the Newly Uninsured," Health Insurance Association of America, July 18, 2001. For HIAA texts: <http://www.hiaa.org/news/newsstate/010718PressConference.htm>.

to more than \$74 billion in tax subsidies to corporate America in 1994 alone—at the same time, federal tax law prevented any of that subsidy from going directly to individuals.²²

Individuals wishing to purchase health insurance must do so with “after-tax” dollars. Therefore, the federal tax code has the perverse effect of punishing those who generally can least afford health insurance (those in the kinds of low-paying jobs where health insurance is not provided by the employer), by removing the favored tax status conferred upon those whose jobs provide health insurance.

The current tax code, by encouraging employer-provided health insurance, has additional deleterious effects: it allows employers—not consumers—to select health care benefits; it is a principal cause of “job-lock,” wherein an employee becomes “trapped” in an unwanted job for fear of loss of health insurance.

Policy Prescriptions

Policy reforms that serve to decrease the number of uninsured patients in Arizona will also serve to mitigate the rate of uncompensated care. This will have the dual effect of enhancing access to health care for all Arizonans, and creating a more friendly and attractive market for health care providers—thus, hopefully, alleviating the physician shortage.

Experience has taught us that centralized, “command-and-control” approaches to public policy have unintended consequences—and those unintended consequences are often of unequal distribution. Many of the problems faced by Arizona’s patients and health care providers are the direct result of centralized, “one-size-fits-all” public policy. An old adage states that when one finds oneself dug into a deep hole, the first thing to do is stop digging. With this in mind, we offer the following policy prescriptions.

Repeal the Emergency Medical Treatment and Labor Act (EMTALA)

Repeal of EMTALA would help to end Arizona’s role as an “escape valve” health care provider for people living in Mexico. This, in turn, would go a long way towards attacking the problem of uncompensated care. In addition, by removing the financial burdens (not to mention the real fear of federal criminal sanctions) EMTALA imposes on hospitals and doctors, repeal would improve market conditions for both.

Hospitals and doctors have a long tradition of providing charity care to those unable to pay for their services. But, over the years, various healthcare communities have worked out their own solutions—each solution best suited to the

²² “Restoring Health Freedom: The Case For a Universal Tax Credit for Health Insurance,” by Sue A. Blevins, Policy Analysis 290, December 12, 1997, Cato Institute, Washington, DC.

individual community, and always voluntary—to the problem of providing care to the uninsured. The experience of the past century has taught all but the most intransigent of policy makers that spontaneous solutions, arrived at by civil society, specific to the individual community's context, always work best. Without EMTALA, the uninsured will still get care—as they did before EMTALA. But communities will be able to develop less burdensome methods for providing this care when free from the centralized mandates of EMTALA.

End or Phase Out Mandated Benefits Laws

Mandated benefits laws have been shown to increase the cost of health insurance and consequently increase the number of uninsured. Mandated benefits laws, by increasing the cost of health insurance, erect a large barrier for those with marginal incomes who wish to purchase individual insurance.

Many individuals would be very well served by simple, catastrophic insurance policies that meet their specific health care needs. But mandated benefit laws require them to purchase insurance that provides many benefits they don't need and don't wish to purchase. So they go without insurance.

Repeal of mandated benefits laws will make it easier for those who do not receive health insurance as an employment benefit to purchase health insurance on their own—especially since they are forced to do so with “after-tax” dollars.

At the very minimum, no new mandated benefit laws should be enacted.

Expand and Remove Restrictions from Medical Savings Accounts

When tax-preferred medical savings accounts (MSAs) were allowed to be created by the Health Insurance Portability and Accountability Act of 1996, strict limitations were placed on the amount of policies that could be sold. In addition, rigid requirements were imposed on the deductibility limits of the catastrophic insurance component of MSAs, as well as on who can contribute (and how much) to an MSA in any given year. This has resulted a very small segment of the population (roughly 100,000) establishing health insurance coverage through medical savings accounts.

Despite this fact, MSAs are a very sensible and promising way of providing low cost coverage to those who can't afford health insurance premiums. US Treasury figures for 2000 revealed that of the nearly 100,000 Americans who purchased MSAs since the pilot program began in January 1997, more than a third were previously uninsured.²³

²³ “MSAs Deserve a Healthy Boost,” Senator Robert Torricelli, *Wall Street Journal*, op-ed column, July 28, 2000.

Experience in South Africa, where MSAs were introduced under Nelson Mandela in the 1990s, have been very encouraging. Currently, more than half of those who have private health insurance in South Africa have it in the form of an MSA. Since the South African government never passed a law dictating MSA design, MSAs developed in a relatively free market. They are less restrictive and, in some ways, more attractive than the American version.²⁴

Congress should enact legislation making MSAs available to everyone, allowing MSAs to be combined with any health plan, and allowing more flexibility in deductibles and contributions. MSAs can serve an important function in decreasing the number of uninsured.

Defined Contribution Alternatives to Health Insurance

An intriguing and under-utilized portion of section 106 of the IRS Code allows an employer to extend the advantages of tax exclusion to employer defined contribution plans. The employer may choose to reimburse employees for some or all of the health insurance premium expenses they incur when the latter select other health plans that are not sponsored by the employer. This fixed reimbursement under a defined contribution approach remains tax-advantaged only if the employer makes those premium reimbursements directly to the employee's insurer, without the money passing through the employees hands.

This allows employees to purchase individually owned insurance while avoiding the negative tax consequences of such a move. It also allows employers to provide insurance to employees at less cost and risk.

Congress should further clarify the tax treatment of employers' defined contribution payments and remove other regulatory uncertainties. This would accelerate the move to an environment in which workers more directly control their health care benefits and insurance choices. It would promote economic forces aimed at lowering the cost of health insurance coverage.

Facilitate Association-Based Insurance

Employees covered by the health insurance plans of large corporations not only benefit from being part of a large insurance pool, but they receive advantages under federal law and the tax code that are not afforded to those who do not have employer-provided insurance. One advantage is that they are covered by the Employee Retirement Income Security Act, or ERISA.

Among other provisions, ERISA exempts corporate health plans from expensive state mandates. It also protects employers from certain law suits,

²⁴ "MSAs for Everyone, Part I," by John C. Goodman, Brief Analysis 318, March 31, 2000, National Center for Policy Analysis, Dallas.

although that protection will be weakened if the patients' bill of rights is passed by Congress.

The disadvantage of employer-provided insurance is that it makes employees dependent on their employers for medical care. A change in employment status results in a change in insurance status.

While it can be argued that under federalism the federal government should not interfere with state prerogatives in regulating health insurance, the reality is that ERISA and other federal legislation and regulations are not going to be rescinded. Therefore, it is only fair that ERISA-like protection be given to those who are not covered by employer plans.

Specifically, that protection should be extended to association-based plans as a way of facilitating the development of such plans. An association-based plan is a group plan offered by a fraternal, religious, professional or charitable organization to its members. Such insurance would stay in effect for as long as the insured individual remains a member of the association. And since most associations are nonprofit organizations, association-based insurance would not have what some see as the conflict of interest between profits and patient care.

Association-based insurance has great potential for addressing the health insurance needs of Mexican immigrants in Arizona. Since the majority are devout Catholics, their association of choice would undoubtedly be their local parish or diocese, if the Catholic Church were to offer group health insurance. Given the Church's mission of helping the sick and the poor, that would seem to be a natural role that the Church would want to play, as long as it would have ERISA-like protections. The Church would not have to be in the insurance business and carry the risk, just as many corporations do not carry the risk. The corporations are intermediaries who use their group purchasing power to buy insurance from insurance companies, who both underwrite and administer claims.

Enact a Universal Tax Credit for Health Insurance

A good way to reverse the inequities in the existing tax code while making insurance more affordable to all, is to enact a universal tax credit for health insurance.²⁵ Unlike current tax exemptions, a universal tax credit neither discriminates against those who purchase health insurance individually, nor rewards those who paid for health care services through insurance rather than directly out of pocket.

The credit amount should be a flat amount for all taxpayers. Capping the total amount of the tax credit minimizes the amount of distortion caused by granting a tax preference to health care as opposed to other goods or services. It

²⁵ Blevins, "Restoring Health Freedom," pages 17-20.

could be made budget neutral by eliminating the tax exempt status (in effect, a tax subsidy) conferred upon employer-provided health insurance.

The tax credit would go directly to the individual, for the individual to use for the purchase of health insurance and other health care services that best suit that individual. The tax credit can be designed as a refundable tax credit for those whose income tax liability is such that they wouldn't otherwise qualify for a tax credit.

In this way, nearly anyone who wants insurance coverage can get it. But a centralized, "command-and-control" approach to health insurance coverage is avoided. The insurance coverage is individually-owned, customized to the needs of the consumer, and provided by the private sector. Furthermore, the insurance coverage will be the choice of the patient, not the employer or the government. And it will not be tied to the job.

Reform Immigration

Although immigration is good for the economy in the long-run, it does have short-term costs. Many of those costs are borne by Arizona's health care providers, including physicians, who are not compensated for treating the high percentage of uninsured among recent immigrants, especially undocumented immigrants.

For example, the Yuma Regional Medical Center, a relatively small hospital near the Mexican border, estimates that its uncompensated care for undocumented Mexicans was at least \$2 million last year.²⁶ The total for the state is unknown, since hospitals do not ask for proof of citizenship, and no agency is estimating what the statewide cost might be.

The hidden economy of undocumented immigrants not only results in hidden costs for health care providers but also forces the immigrants to live in an underground world where their options for obtaining medical insurance are limited. Denying that the problem exists does not make it go away.

Reforms are needed to bring the hidden economy to the surface, where the short-term problems associated with immigration can be addressed by policy makers on both sides of the border. One reform might be a guest worker program, in which Mexican workers could freely cross the border for jobs in the United States, yet stay eligible for Mexico's national health care system and return home for non-emergency treatment. Alternatively, once the workers have a legal standing—once they are integrated into the legitimate, mainstream economy—they could participate in the medical insurance market to the same extent as American citizens.

²⁶ Based upon conversation between Craig J. Cantoni and the Chief Financial Officer of Yuma Regional Medical Center.

It is not within the scope of this report to provide detailed policy prescriptions for reforming immigration, but it is clear that the problems of the uninsured and uncompensated care in Arizona will not be solved unless immigration policy is reformed.

Summary and Conclusions

Arizona has developed a shortage of physicians relative to its population requirements. This shortage has developed over the last ten years.

Arizona's physician shortage is caused by several factors:

- 60 years of misguided government policies have kept a consumer-led free market in medical insurance from developing. Thus the costs of health care and health insurance are greater than they would otherwise be. This ultimately increases the amount of people who are without health insurance coverage and seek uncompensated care.
- Regulations and government price controls have forced physicians to often provide care for less than the cost of the service and many times for free.
- The federal government's immigration policies have created a hidden economy and forced recent immigrants to seek free health care, the hidden cost of which is borne by physicians and other health care providers.
- Compulsory uncompensated care amounts to a real, albeit hidden, added tax on health care providers—and taxation of an activity is a clear disincentive to engaging in that activity.

These factors have combined to make Arizona less economically attractive to health care providers.

Furthermore, since a considerable portion of the uninsured population receives medical care from physicians in hospital emergency rooms instead of private physician offices, there are fewer private physician practices than there would otherwise be in the state. That in turn results in fewer physicians being attracted to the state to staff those practices. In other words, health care and immigration policy have created a disequilibrium in the supply and demand of physicians.

In the past, these problems have been addressed in a way that has made the problems worse. The problems have worsened because the past practice of providing free insurance and uncompensated care to the uninsured does nothing to address the underlying root problem. The root problem can only be solved by making medical insurance more affordable and available through free market reforms. And

those reforms have to be coupled with immigration reforms, especially in border states like Arizona.

The Authors

Jeffrey A. Singer

Jeffrey A. Singer is a general surgeon in private practice in Phoenix, Arizona. He writes and lectures on regional and national public policy issues, and has published in major national journals and newspapers on issues ranging from health care reform, to tax policy, to drug policy reform. He is a member of the Board of Directors of the Goldwater Institute, and also serves on the Board of Directors of the Maricopa County Medical Society. He received his Doctor of Medicine from New York Medical College, and is a Fellow of the American College of Surgeons.

Craig J. Cantoni

Craig J. Cantoni is president of a human resources consulting firm and a former human resources executive with some of the largest companies in America. He has been active in health insurance reform for five years. He is an author and columnist, and has published many articles on insurance reform in leading publications, including *The Wall Street Journal*. He holds a Masters in Business Administration from St. Mary's University.