BREAKING BARRIERS

Improving Health Insurance Enrollment and Access to Health Care in Michigan

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In Michigan, Medicaid was not expanded until the initial enrollment period was over and we've learned some things from last year's enrollment process. This year, we were able to prescreen and interview people to determine eligibility before going through the formal enrollment process.

With a reported 272,539 enrollees at the conclusion of the first ACA enrollment period in April 2014, Michigan exceeded its initial enrollment projections and ranked eighth nationally in total enrollees.

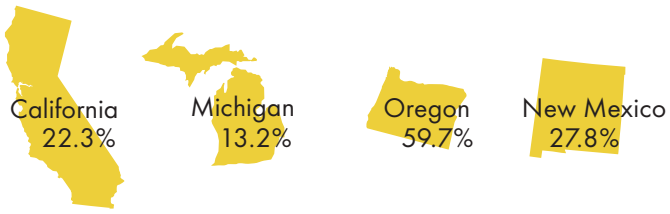
MICHIGAN'S RESIDENTS ARE NOT STRANGERS TO STANDARDIZED HEALTHCARE. But with the percentage of unionized workers shrinking from 18.8 percent of the workforce in 2008 to 14.5 percent in 2014, and the state becoming the 24th right-to-work state, more than 1.5 million workers and their families lost health coverage between 2000 and 2012.[1] Michigan was ripe for the ACA. With a reported 272,539 enrollees at the conclusion of the first ACA enrollment period in April 2014, Michigan exceeded its initial enrollment projections and ranked eighth nationally in total enrollees. And, Democrats and Republicans alike were not bashful about taking credit for the state's enrollment success. Eighteen months after a January 2013 speech in which he said he needed to do more research about putting 400,000 more people into a "primary care environment, as opposed to having them simply go to the ER,"[2] Governor Rick Snyder incorporated the success of the expansion into his reelection bid and took credit for the 63,000 more-than-projected low-income adults who had signed up for the program.[3]

Despite navigators' reliance on a federal exchange that was plagued by technical issues when it was launched in 2013, Michigan's enrollment success has continued. As of January 16, 2015, 299,750 Michiganders had chosen plans —8 percent more than the total who enrolled in 2014. Dizzy Warren, Statewide Program Manager for Enroll Michigan, credits targeted outreach as the key: "we worked with people who knew their population best. Navigators partnered with groups that know LGBT groups with unique interests and needs, who know and serve people with disabilities, who work with Native Americans. We approached people through people they know and worked with. There was no *one size fits all* approach."[4]

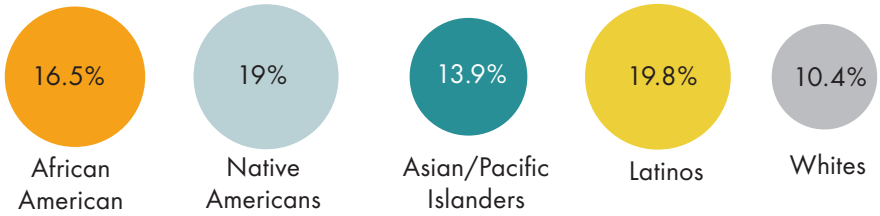
This report, part of a 10-state study, reviews Michigan's enrollment efforts and consumers' attempts to access health care in the state's low-income communities. The methodology includes key actor interviews with Michigan-based navigators, policy and health care professionals, and advocates, as well as 103 surveys in Spanish and English with low-income community residents at food pantries, health clinics, and homeless service centers. The report compares and contrasts the enrollment and "coverage-to-care" trends shown through the interviews and surveys to reported Michigan outcomes and, when appropriate, to national trends. Analyses of these results serve as the basis for the report's recommendations.

ENROLLMENT

Percent Medicaid Increase from 2013 Pre-Enrollment to August 2014 in Select Medicaid Expansion States[5]



Percent Uninsured 2011, by Race



Race/ethnicity	Percentage of state's population	Percentage of marketplace enrollees through April 2014[7]
African Americans	14.3%	13.0%
Native Americans	0.7%	0.4%
Asian/Pacific Islanders	2.7%	4.6%
Latinos	4.7%	2.4%
Whites	76.1%	78%

Medicaid data from the first enrollment period ending in March 2014 showed a 13.2 percent increase in enrollment, the smallest percentage increase in the Medicaid expansion states included in our study. However, the state's Medicaid expansion waiver was not approved until April of 2014, and although detailed data are not yet available for the enrollment period ending February 2015, the Department of Health and Human Services reports an increase of 251,405 people covered by Medicaid/CHIP from the pre-enrollment period of 2013 to August 2014.[8]

At 19.8 and 19 percent respectively, Latinos and Native Americans were most likely to be uninsured in Michigan, followed by African Americans (16.5 percent) and Asian-Pacific Islanders (13.9 percent); whites were uninsured at a rate of 10.4 percent. In terms of marketplace enrollment, whites were slightly overenrolled relative to both their percentage of the state's population (76 percent versus 78 percent of enrollees) and in terms of relative need—whites are a significantly lower percentage of uninsured people in the state. Latinos, on the other hand, with the highest uninsured rate, were under-enrolled

relative to their percentage of the population. Says Dizzy Warren, "Last year African Americans and Latinos were enrolled in the marketplace at lower percentages than they should have been. A lot of those we missed were at a very low income level. In the second year navigators from day one were focusing on the hardest to insure. Our biggest challenges have been in the Latino community."[9]

SURVEY RESPONSES[1]

CHART 1

Do you have medical coverage?

Race/ethnicity	Percent Yes
All Michigan respondents	85%
People of color	84%
White	86%

CHART 2

Enrolled within the last 12 months?

Percentage of those with coverage who are new enrollees

CHART 3

Did anybody help you enroll?

Percent Yes

CHART 4

Do you have Internet access at home?

Race/ethnicity	Percent Yes
People of color	73.3%
White	78.6%

1. Due to data limitations, survey responses are reported as either "white" or "people of color." Significant differences among people of color are noted in the text of the report.

CHART 5

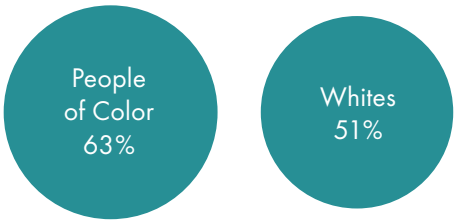
Did you find the enrollment process easy, somewhat difficult, or very difficult?

Percent very difficult

CHART 6
Knowledge of Plan Benefits

When you enrolled in a health plan, were you informed that financial support was available for low-income people?

Percent No



At 85 percent overall, Michigan survey respondents had the highest percentage of respondents surveyed who reported having medical coverage. However, less than 30 percent of white respondents and only 38.5 percent of respondents of color with insurance had gotten coverage within the last 12 months. Less than half of the new enrollees (36 percent of whites and 43 percent of people of color) had help with enrollment. With three-quarters of whites (78.6 percent) and respondents of color (73.3 percent) reporting Internet access at home, relatively small percentages of enrollees, 14 percent of people of color and 8 percent of whites, found the enrollment process "very difficult." Yet, 63 percent of people of color and 51 percent of whites were not informed about the availability of financial support.

These responses point to a number of interesting trends: among the states studied, Michigan had the smallest racial digital divide but the highest percentages of people who where not informed about the availability of financial support. Interviews with service providers and advocates and conversations with survey respondents highlight a number of dynamics that may shed some light on obstacles to enrollment:

Literacy: The complexity of medical terminology as well as a lexicon of insurance terms (copayments, cost sharing, deductible) that are new to many can be daunting to navigate. Marjorie Mitchell of the Michigan Universal Healthcare Access Network pointed out: "People didn't understand what to look for when they're purchasing insurance. Then, they would find out that what they purchased wasn't necessarily what they wanted or needed."[10] "It's even confusing to those of us who are informed," says Chris Shea, executive director of Cherry St. Health Services in Grand Rapids. "And," he continued, "combined with the technology glitches on the exchange, many people tried to apply and then faded away."[11] In a conversation with one of our surveyors in Detroit, one

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MEDICAID "PERSONAL RESPONSIBILITY" IN MICHIGAN

Michigan is one of five states that have instituted an "alternative Medicaid expansion model" wherein enrollees are charged various combinations of premiums and copayments, with charges sometimes reduced if they participate in "healthy behavior practices"; enrollees may be required to contribute to health savings accounts. In Michigan, most newly eligible recipients will face copays – typically from $1 to $3 for most outpatient health services (but not for preventive services). Those with incomes between 100 percent ($11,670) and 138 percent ($16,105) of the federal poverty level will also pay a premium of 2 percent of their income. Both premiums and copayments are to be made to a health savings account. The amount that must be deposited for co-pays will be based on a person's average co-payments over the previous six months.

If people fill out and discuss with their doctor a "health risk assessment" form their premiums will be cut in half, i.e. to 1 percent of income. They can retain the reduced premium by doing the health assessment annually and committing to taking action on specified health goals. The assessment focuses on exercise, eating habits, smoking, alcohol use, regular tests (e.g. blood pressure), getting flu shots, and substance use. People with incomes below 100 percent of the federal poverty level are not charged premiums or copays; they receive a $50 gift card for doing the health assessment.

If people do not pay into the health savings account they'll remain eligible for Medicaid as the state may not terminate their coverage. However, the state is considering imposing liens on tax refunds.[17]

respondent reported that he's been "glad to get health insurance," but hadn't been to a doctor because, "I am really not sure how much it's going to cost."[12]

Culture and Language: For many new enrollees, particularly those with origins in another country of origin, the intricacies of health insurance coverage add layers of both cultural and financial complication. "Back home people just walk into doctor's office. They don't need to make an appointment. If the doctor says you need some procedure, it's not your responsibility to find out if insurance covers it," says Madiha Tariq, Public Health Manager with ACCESS (the Arab Community Center for Economic and Social Services). "People are confused why this law exists since nothing like this exists where they come from. They are also nervous about putting personal information into a website."[13] Last year ACCESS, in collaboration with a number of other organizations, participated in a Muslim Enrollment Weekend to promote the ACA. This year the organization is working with a local Hindu temple on enrollment. Says Tariq, "a lot of attendees had legal status but didn't know if they'd qualify. They figured enrollment was only for Americans."

Immigration Status: Undocumented immigrants are not eligible for Medicaid or ACA enrollment. However, many families have "mixed status," i.e., some family members have legal status while others are undocumented. In our interviews with advocates, one noted that "fear is an issue for some Latinos with mixed status families; that's why you have lower Latino participation."[14] In addition to fear of discovery, the exclusion of undocumented families from the ACA has other implications. As Chris Shea points out, "Really, there is very little available to undocumented families. To some degree they're being squeezed out. If a provider was accepting uninsured undocumented patients before, they're saying 'now we can serve people on Healthy Michigan.' So, because we don't exclude anyone, clinics like ours are seeing an increase in undocumented patients."[15]

Costs: With the third highest unemployment rate in the country in 2014, that insurance premium costs are a substantial obstacle for many is not surprising. Of the 14 percent of survey respondents who did not have coverage, over half cited premium costs as the major barrier. Even among the majority of respondents who had insurance, premium costs, co-payments, and deductibles were key areas of consumer dissatisfaction. Marjorie Mitchell observes that "affordability is a major issue. We still don't have good products that are really affordable and we have a lot of advocacy work to do on that."[16]

COVERAGE TO CARE

BEYOND THE ENROLLMENT QUESTION, however, insurance coverage does not necessarily translate into quality care, which includes access to providers, a relationship with a personal doctor, and access to both medication and other forms of treatment. Although the ACA infrastructure is still developing, in this section we examine some key issues related to access and treatment.

CHART 7

Do you have one or more medical conditions that have affected you for more than 3 months?

Race/ethnicity	Percent with chronic conditions by race
People of color	38.7%
Whites	36.2%

Chronic diseases cause seven of every 10 deaths. In addition, health care costs for an individual with one or more chronic diseases are five times those for an individual without chronic disease.[18] According to rankings by the United Health Foundation, Michigan has high levels of obesity and cardiovascular deaths.[19] Thirty-nine percent of survey respondents of color and 36 percent of whites indicated that they had one or more chronic illnesses.

CHART 8

A personal doctor (also called primary care provider) is the one you would regularly see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?

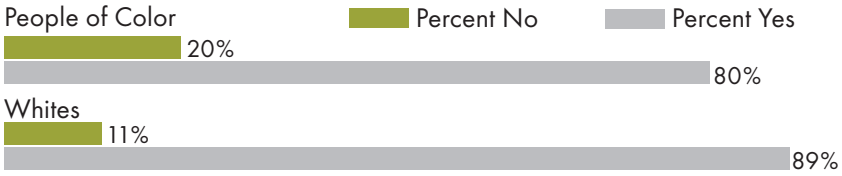


CHART 9

Is your doctor in your network now? (Respondents who had a personal doctor before they got health coverage)

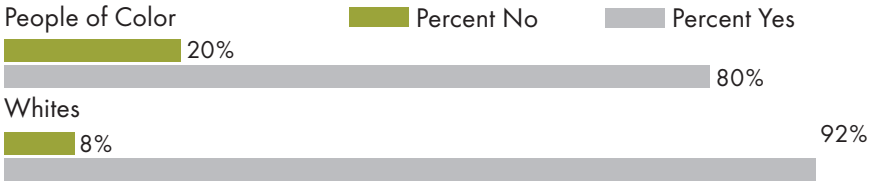
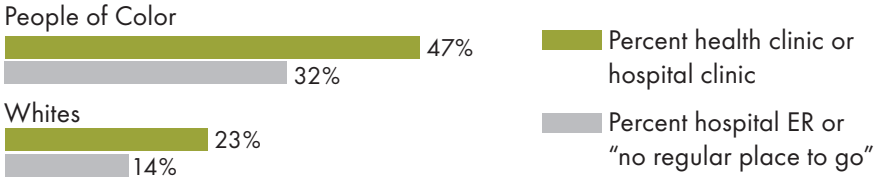


CHART 10

Where do you go for your primary health care needs? Percent individual physician

CHART 11

Where do you go for your primary health care needs?



A greater percentage of white respondents (89 percent) than people of color (80 percent) have a personal doctor. This nine point gap gets three percentage points larger when respondents are asked if the doctor they had before they were covered is in their current health network: 92 percent of white respondents had access to their previous doctor versus only 80 percent of people of color. The gap widens even more when respondents were asked where they go for their primary health needs. Three times as many whites (64 percent) regularly visited an individual doctor as did people of color, at only 21 percent. Significantly, 32 percent of people of color, more than double the percentage of whites (14 percent), either use a hospital emergency room for their health needs or have "no regular place to go."

CHART 12

In the last 6 months, did a doctor or other health provider order a blood test, x-ray, or other test for you?

Race/ethnicity	Percent yes
People of color	58.3%
White	65.5%

CHART 13

In the last 6 months, how often did a doctor or other health provider talk with you about non-medical things like diet, exercise, meditation, or chiropractic care to treat or prevent illness?

Race/ethnicity	Percent Never
All Michigan respondents	**34%**
People of color	41%
Whites	30%

CHART 14

If your doctor discussed non-medical methods and strategies, which ones did he/she mention?

Race/ethnicity	Of those whose doctors discussed non-medical methods, percent who discussed only diet and/or exercise
All Michigan respondents	**59%**
People of color	64%
White	57%

Despite reporting a slightly higher percentage of chronic diseases, over the last six months survey respondents of color (58 percent) were less likely than whites (65 percent) to be scheduled for a medical test or x-ray. In addition, although the ACA makes provision for insurance networks to include alternative modalities, 30 percent of white respondents and 41 percent of respondents of color reported that their health provider never discussed non-medical modalities like acupuncture, chiropractic care, meditation, diet, or exercise. Of the respondents who reported their providers did mentioned alternative modalities, almost 60 percent (64 percent people of color and 57 percent of whites) said their providers limited their mention of alternative medical modalities to the two most common "self-care" practices: diet and exercise.

CHART 15

In the last 6 months, did you have an illness, injury or condition that needed care right away?

Percent Yes

CHART 16

In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed it?

Percent sometimes or never

A quarter of respondents of color reported a need for urgent care in the last six months, a rate slightly lower than the 28 percent reported by whites. However, 31 percent of respondents of color reported that they "sometimes or never" received urgent care when they thought they need it, in contrast to 20 percent of white respondents.

In addition to the results from our survey respondents, advocates pointed to one other significant factor that could influence future access to care: the availability of physicians. Research reports indicate that by 2020, the number of Michigan residents eligible for Medicare will increase by 36 percent. At the same time, the Michigan Association of Family Physicians estimates that 45 percent of Michigan's 5,400 family physicians will retire within the next ten years and that the state will experience a shortage of physicians as early as 2020.[20] Ricardo Guzman of the Michigan Primary Care Association says that in general provider participants are handling the load well. "Long-term we'll see what happens regarding lack of available providers. We are not seeing any problem yet but do anticipate that they will arise."[21] Marjorie Mitchell of the Michigan Universal Health Access Network views the problem as more immediate, pointing out that "network adequacy and the availability of specialists is a problem right now."[22]

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SUMMARY OF FINDINGS

MICHIGAN'S INITIAL ENROLLMENT EFFORTS REFLECTED SMALL RACIAL DISPARITIES with an over-enrollment of whites and under-enrollment in the Latino, Native American, African-American, and Asian-Pacific Islander communities. In part, some of the initial enrollment gaps may have been due to applicants falling into the Medicaid coverage gap. However, both advocates and survey respondents pointed to enrollment obstacles that included literacy, culture and language, immigration status, and insurance premium costs.

In terms of access to care we found the following:

Racial disparities were more apparent in the arena of coverage to care. There was a 9 percent gap between whites (89 percent of whom reported having a personal doctor) and people of color (80 percent of whom reported having a personal doctor). This gap widens when respondents were asked where they go for regular health care. The gap widens even more when respondents were asked where they go for their primary health needs. Three times as many whites (64 percent) regularly visited an individual doctor than did people of color at only 21 percent. In addition, only 14 percent of whites, in contrast to 32 percent of people of color, either use a hospital emergency room for their health needs or have "no regular place to go."

Although they reported a slightly higher incidence of chronic disease, people of color are less likely than whites to be scheduled for medical tests or x-rays. In terms of exposure to alternative medical modalities, one-third of survey respondents said their health care providers did not discuss non-medical health interventions. Of survey respondents who had discussed alternative health practices with their doctor, for 57 percent of whites and 64 percent of people of color the discussion was limited to the self care practices of diet and exercise.

A quarter of respondents of color and 28 percent of whites reported needing urgent care in the last six months; 31 percent of respondents of color reported that they "sometimes or never" received urgent care when they thought they needed it, in contrast to 20 percent of white respondents.

In order to improve enrollment and care options, we recommend the following:

I. SAFEGUARDING ACCESS TO HEALTH INSURANCE

Target for enrollment low-income residents already enrolled in income-based programs. Immediately increase low-income health insurance enrollment by automatically enrolling in Medicaid people who already receive need-based benefits like SNAP (food stamps), Supplemental Security Income (SSI), WIC, or free or reduced-price school meals, as well as people released from incarceration with no immediate source of income or assets.

Improve language access. Latinos and Native Americans have uninsured rates that are significantly higher than whites in Michigan, and culturally appropriate language access is still not an everyday reality. Complete multilingual application materials and website access are not readily available. To address these issues, Michigan should establish a right to enroll in health coverage in the enrollee's primary language. The state should require plans

to give enrollees notice of their right to language services, as California does (Cal. Code Regs. tit. 10 § 2538.3), and regularly assess plans' compliance with language access requirements, as New York mandates (N.Y. Pub. Health Law § 4403). Michigan should expand its pool of interpreters and require plans to continually update information about which providers are in their networks. Provider directories must be available in multiple languages and list addresses, phone numbers, languages spoken, hospital affiliations, and specialties.

Simplify the insurance-shopping experience. The state should simplify multilingual print and electronic descriptions of plans and benefits, especially deductibles, co-pays, preventive services available at no cost, and the significance of providers being in- or out-of-network, making costs transparent and ensuring easy comparison of services available with no co-pay.

Keep provider information current. The state should require plans to continually update information about which providers are in their networks; provider directories must be available in multiple languages and list addresses, phone numbers, languages spoken, hospital affiliations, and specialties.

Make faster decisions on enrollment applications. The state should require decisions on ACA and Medicaid applications within two weeks of filing.

II. MOVING CONSUMERS FROM COVERAGE TO CARE

Expand and extend the role of navigators. Many enrollees are new to health insurance coverage. Not only are they unfamiliar with medical terminology, they have had little interaction with the medical system or the insurance system and may need both an introduction and an acclimation. Navigators are in an ideal position to perform this role. Michigan should extend the role of navigators to encompass teaching new enrollees how to use insurance coverage and recruiting enrollees to participate in marketplace-sponsored evening and weekend clinics focusing on health education, specific mobile services (exams, immunizations, etc.), and access to different medical modalities (e.g., acupuncture, chiropractic care).

Address racial health disparities. Michigan should enforce ACA statutory provisions that require insurers to act to reduce racial disparities and continually monitor implementation of insurers' disparity-reduction plans and programs, especially outreach and outcomes. The state should impose penalties, including exclusion from exchanges, against plans that do not succeed in reducing disparities within targeted timeframes.

Require plans to include in their networks at least one full-time primary care provider for every 2,000 patients and ensure that enrollees are able to make appointments with their primary care providers within 10 business days of seeking an appointment, as do California and Washington.

Require that new enrollees have the opportunity for a free physical exam and appropriate screening tests within 60 days of enrollment.

Reinforce the ACA-mandated women's right to no-cost "well-woman preventive" care by ensuring that all plans available through the marketplace include reproductive health care services, including all FDA-approved forms of contraception.

Expand and standardize preventive services, ensuring that non-grandfathered plans offer preventive services (yearly check-ups, immunizations, counseling, and screenings) at *no out-of-pocket cost* and penalize plans in which fewer than 70 percent of enrollees receive these services.

Require plans to track health outcomes, disaggregated by race, ethnicity, primary language, gender, disability, and sexual orientation.

III. BUILDING AN INFRASTRUCTURE TO PROMOTE PREVENTIVE HEALTH CARE

Offer incentives to plans that adopt a broad view of health benefits and tackle underlying social determinants of health. Michigan is a state with 16.8 percent of its residents living in poverty. Insurance is one step towards better health but in order to address the prevalence of chronic diseases, the state must encourage innovation and experimentation to address the underlying causes of poor health.

Expand medical-legal partnerships as an avenue toward the broad array of issues that lead to poor health in low-income communities (e.g., mold in housing, domestic violence). While three-quarters of states have at least one such partnership, through which medical and legal professionals collaborate to look holistically at barriers to health and wellness and work jointly to remove the barriers, the partnerships already in place cannot begin to meet the need.

Invest in non-traditional services. Because health status is determined more by factors outside the clinical setting than by the nature of health care services, pursuant to Sections 2703 and 4108 of the ACA (42 U.S.C. § 1396w-4) states should direct Medicaid dollars toward non-traditional services like care coordination and community support for high-risk individuals with chronic disease.

Invest in school-based health centers. Seek funds from HHS' Health Resources and Services Administration or use state funds to expand school-based health centers, especially in medically-underserved communities (where 10.8 percent percent of state residents reside), to mitigate the lack of other health care options (Section 4101 of the ACA, 42 U.S.C. § 280h-4).

ENDNOTES

1. Hudson, Jan, 1.5 Million Lose Health Insurance in Michigan (Nov. 14, 2013), accessed at: http://www.mlpp.org/1-5-million-lose-health-insurance-in-michigan#more-19035.

2. Neher, Jake, Michigan Leaders Still Weighing Expansion of Medicaid (Jan. 29, 2013), Michigan Radio, accessed at: http://michiganradio.org/post/michigan-leaders-still-weighing-expansion-medicaid.

3. Snyder Touts Michigan's Successful Medicaid Expansion in Re-election Bid; Schauer Notes Delay, Associated Press (Sept. 16, 2014), accessed at: http://www.mlive.com/lansingnews/index.ssf/2014/09/snyder_touts_expanded_medicaid.html.

4. Interview with AJS staff, January 2015.

5. "Medicaid & CHIP: August 2014 Monthly Applications, Eligibility Determinations and Enrollment Report," U.S. Department of Health & Human Services (Oct. 17, 2014), accessed at: http://medicaid.gov/medicaid-chip-program-information/program-information/downloads/august-2014-enrollment-report.pdf.

6. Health Care Reform: Tracking Tribal, Federal, and State Implementation (May 20, 2011), Table 5 p. 12, accessed at: https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/CMSHealthCareReform5202011.pdf.

7. Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period (May 1, 2014), table c3 (unknown/other excluded), accessed at: http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf.

8. Medicaid and CHIP: August 2014 Monthly Applications, Eligibility Determinations and Enrollment Report, Table 1 (Oct. 17, 2014), accessed at: http://medicaid.gov/medicaid-chip-program-information/program-information/downloads/august-2014-enrollment-report.pdf.

9. Interview with AJS staff, January 2015.

10. Interview with AJS staff, January 2015.

11. Interview with AJS staff, January 2015.

12. Conversation with AJS surveyor, July 2015.

13. Interview with AJS staff, January 2015.

14. Interview with AJS staff, January 2015.

15. Interview with AJS staff, January 2015.

16. Interview with AJS staff, January 2015.

17. Michigan To Reward Medicaid Enrollees Who Take "Personal Responsibility," accessed at: http://kaiserhealthnews.org/news/michigan-to-reward-medicaid-...

18. "The Impact of Chronic Diseases on Healthcare," Partnership for Solutions, accessed at: http://www.forahealthieramerica.com/ds/impact-of-chronic-disease.html.

19. America's Health Rankings, United Health Foundation, accessed at: http://www.americashealthrankings.org/MI.

20. Sidorowicz, Josh, The Doctor is out, Facing the Nation's Physician Shortage (May 1, 2014), WILX.com, accessed at: http://www.wilx.com/topstories/headlines/SPECIAL-REPORT-The-Doctor-Is-Out-Facing-the-Nations-Physician-Shortage-257384891.html.

21. Interview with AJS staff, January 2015.

22. Interview with AJS staff, January 2015.