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Florida Statewide and Regional Physician Workforce Analysis: 2019 to 2035

2021 Update to Projections of Supply and Demand

Prepared for the Safety Net Hospital Alliance of Florida and the Florida Hospital Association

December 2021

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Executive Summary

To support workforce planning efforts and help ensure an adequate supply of healthcare providers in the future, The Safety Net Hospital Alliance of Florida and the Florida Hospital Association engaged IHS Markit to develop projections of future supply and demand for physicians, advanced practice registered nurses (APRNs), registered nurses (RNs), and licensed practical nurses (LPNs) in Florida. This report focuses on the physician workforce and projects supply and demand for physicians from 2019 through 2035. A companion report presents findings on the RN and LPN workforces. Less information is available on APRN supply and demand, but workforce projections for APRNs also are presented. This report updates a previous report (the "2015 Report") on the physician workforce prepared by IHS Markit. That study projected physician supply and demand starting in 2013, using the most current data available at that time. For this report, the baseline for data and modeling assumptions has been updated to 2019. The base year workforce adequacy can serve as a benchmark for Florida's progress towards addressing the workforce needs identified in the 2015 Report, while projected future adequacy provides insight into what resources may be needed in the future.

Using 2019 as a base year for modeling implies that the data sources used to derive physician workforce decisions and patient healthcare use patterns are pre-COVID-19. While the pandemic has had a large short-term impact on the population, demand for physician services, and the physician workforce, the ongoing nature of the pandemic and lags in data becoming available to researchers limits the degree to which long-term impacts on the physician workforce can be identified. This will likely be an area of ongoing research over the next several years. The pandemic has also increased awareness of the disparities that members of certain communities face in accessing high-quality care within the healthcare system. Given the heightened emphasis on this issue, a Reduced Barriers demand scenario was included in this report to provide an understanding of potential implications for the provider workforce demand assuming certain barriers to accessing healthcare services are removed for members of historically underserved populations.

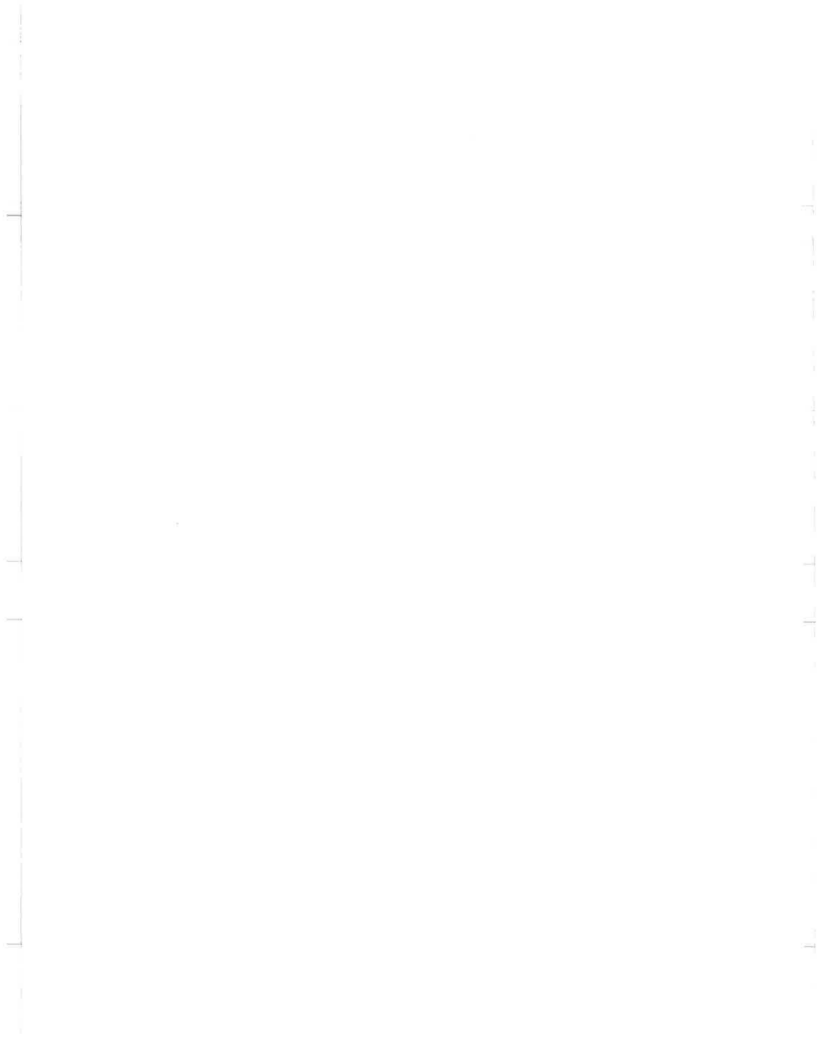
Physician supply and demand are expressed as full-time equivalents (FTEs), with an FTE defined as the estimated average hours worked by physicians working at least 8 hours per week. Hours worked per week varies by specialty, thus FTE definitions are slightly different across the specialties modeled. The Status Quo supply scenario models the continuation of base year numbers of new physicians trained and labor force participation patterns accounting for changing demographics of the physician workforce. The Status Quo demand scenario extrapolates national patterns of care use and delivery to Florida's current and projected future population accounting for demographics and prevalence of disease prevalence, health risk factors such as obesity and smoking, medical insurance coverage, household income levels, and metropolitan/nonmetropolitan residence location. Physician specialties were categorized into three specialty groupings: 1) traditional primary care, which includes family practice, general internal medicine, geriatric medicine, and pediatric medicine; 2) total primary care, which includes the four traditional primary care specialties plus emergency medicine, general surgery, and obstetrics & gynecology; and 3) non-primary care specialties, which includes the remaining 29 specialties modeled.

Key findings from the study include:

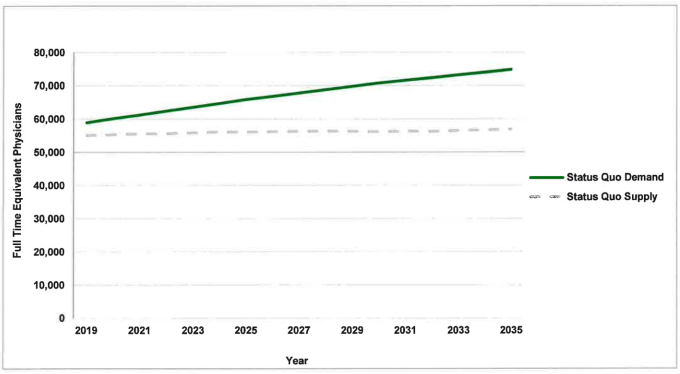
- Physician supply in 2019 was 55,083 FTEs and is projected to grow 3% (1,776 FTEs) and reach 56,859 FTEs by 2035. Supply growth varies by specialty, with supply for total primary care and traditional primary care physicians projected to increase by 3% and 4%, respectively, while non-primary care physician supply is projected to grow by 6%.
- Physician demand in 2019 is estimated at 58,918 FTEs, with demand projected to increase by 27% (15,866 FTEs), reaching 74,784 FTE physicians by 2035. This rapid increase in demand is driven largely

by population growth of 21%. The remaining 6% growth in demand is attributed to changing demographics, particularly population aging, under this modeled Status Quo scenario. The population age 65-74 is projected to increase by 32% and the population ages 75 and older is projected to increase by 74% over the projection period. This projected increase results in the population age 65 and above, which represents 20% of the state population in 2019, making up 26% of the state population by 2035. Consequently, demand growth is particularly high for specialties that predominately treat older patients.

- Estimated 2019 physician supply was approximately 3,835 FTEs lower than estimated demand, suggesting that supply in Florida was adequate to meet 93% of estimated demand relative to national averages. Supply adequacy varies by physician specialty. If current trends continue, projected 2035 supply and demand suggest a shortfall of about 17,924 FTE physicians (Exhibit ES-1) with supply sufficient to meet 77% of projected demand. Like with base year estimates, the projected shortfall varies by specialty and Florida Medicaid region.
    - **Primary Care Specialties:** Estimated demand for traditional primary care physicians in 2019 exceeded supply by 1,977 FTEs (an 88% estimated adequacy), driven by an estimated shortfall of 2,412 FTEs in family medicine with Florida having more general internists and pediatricians and fewer geriatricians relative to levels expected based on national averages. Total primary care had an estimate shortfall of 2,185 FTEs in 2019, a 91% estimated adequacy. Projected into the future, adequacy is expected to worsen across primary care specialties, with projected 2035 shortfalls totaling 7,872 FTEs (74% adequacy) for total primary care specialties, and 5,974 FTEs (72% adequacy) for traditional primary care specialties.
    - **Non-Primary Care Specialties:** Estimates for 2019 suggest that demand for non-primary care physicians exceeded supply by 1,650 FTEs, which translates to an adequacy of 95%. Supply appears more than adequate relative to the national average for radiology (134% adequacy; +869 FTEs), pathology (132% adequacy, +388 FTEs), and neurology (121% adequacy; +218 FTEs). Higher than national average supply of dermatologists (135% adequacy, +293 FTEs) could be due to higher levels of sun exposure in Florida which is not captured in the workforce model. Specialties where supply was substantially below levels based on estimated demand for services include: vascular surgery (69% adequacy, -113 FTEs, physical medicine and rehabilitation (70% adequacy; -316 FTEs), hematology and oncology (75% adequacy; -409 FTEs), and psychiatry (75% adequacy, -728 FTEs). Hospital medicine (69% adequacy; -794 FTEs) is also lower than expected, but this disparity might simply reflect data challenges with identifying hospitalists in licensure files. Projected to 2035, adequacy for the non-primary care specialty category is expected to decline to an overall 77% adequacy.



ES-1. Projected Total Supply and Demand for Physicians, 2019-2035



- Adequacy of Florida's physician supply varies across the state's 11 Medicaid Regions. Demand is calculated based on where the population resides. In Regions 10 and 11, for example, 2019 supply exceeds projected demand by 448 FTEs (109% adequacy) and 2,123 FTEs (137% adequacy) respectively. On a total FTE basis, Region 3 (-1,558 FTEs, 73% adequacy) and Region 8 (-1,412 FTEs, 76% adequacy) face the largest base year shortfall. Region 2 faces the largest shortage on a relative basis (-603 FTEs, 69% adequacy). Projected demand exceeds supply in 2035 in all but Region 11, suggesting that many people in Florida might need to travel substantial distances to receive care.
- Alternative supply scenarios were modeled to provide sensitivity analysis for estimates and assumptions regarding physician workforce participation (more or fewer hours worked per week, early or delayed retirement, increased and decreased numbers of annual new entrants). These modeled supply scenarios did not materially change the projected 2035 physician shortfall.
- A hypothetical demand scenario addressing healthcare utilization equity modeled the implications if barriers to accessing care were reduced for populations that traditionally have faced such barriers (i.e., people who are uninsured, residing in non-metropolitan areas, and racial and ethnic minority populations). If barriers to accessing healthcare services could be reduced, demand for physicians would rise and by 2035 there would be a shortfall of approximately 26,026 FTE physicians, which includes a shortfall of 10,594 FTEs in total primary care specialties and 15,432 FTEs in non-primary care specialties.
- Estimated 2019 supply of APRNs in Florida was 29,311 FTEs. This number is projected to nearly double over the projection period, reaching 57,780 FTEs (28,469 FTE or 97% growth) by 2035. While the 31% 2019-2035 projected APRN demand growth is well above the 21% rate of projected population growth, it

is significantly below the projected supply growth. In 2019 the supply of APRNs was an estimated 6,446 FTEs below the level that would be expected based on national average levels of care use and delivery. Due to the rapid growth in APRN supply, by 2035 there will be an estimated 10,765 FTEs beyond what is needed to maintain current national average physician-to-APRN staffing ratios.

This study updates key components of the workforce models compared to the 2015 Report. Key differences in model inputs and projections include the following:

- The 2015 Report projected that, starting from a 2013 supply of 42,610 FTEs, if the current (as of 2013) number of physicians entering Florida's workforce each year (2,230) remained unchanged, FTE physician supply would reach nearly 47,000 by 2019. This updated study found that the number of new entrants to Florida's workforce has been increasing over time, with about 2,324 now entering the workforce each year, and actual FTE supply in 2019 was 55,083. Thus, while 2013-2019 supply in the 2015 Report was projected to grow by about 4,400 FTEs absent policy intervention, actual supply growth over the time period was about 12,473 FTEs.
- Florida's population grew faster than the population projections used for the 2015 Report. Extrapolating a 2013 national average level of care (care use and delivery) to Florida's *projected* population in 2019 (20.9 million), the 2015 Report projected demand for 53,710 FTE physicians in 2019. Extrapolating a 2019 national average level of care to the *actual* population in 2019 (21.5 million), this updated study estimates demand for 58,918 FTEs. The higher population counts and updated national average level of care each contributed to the 5,208 FTE increase in estimated 2019 demand between the 2015 Report and this updated report. Another contributing factor is that the *actual* 2013-2019 projected growth in the population age 65-74 and 75 and older (31% and 27%, respectively) was larger than the *projected* 2013-2019 growth for the age cohorts (25% and 15%, respectively) used in the 2015 Report.
- Although the 2015 Report and this updated study use different benchmarks to estimate demand for physicians in Florida (i.e., 2013 national average versus 2019 national average level of care), the updated estimate of a shortfall of physicians in Florida (3,835 FTEs) is smaller than what was projected for 2019 in the 2015 Report (5,933 FTEs). The supply adequacy updates vary by Medicaid region.

ROBERT GRAHAM CENTER

Florida: Projecting Primary Care Physician Workforce

Background

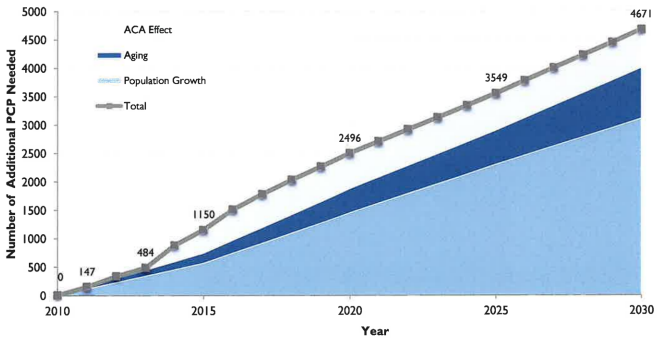
Primary care physicians (PCP) workforce shortages challenge the long term viability of U.S. primary care, a foundation of the Triple Aim for U.S. health care. The Triple Aim envisions primary care as an integrating component working across its three goals of improving the quality of care, improving health of populations, and reducing per capita health care costs.[1] Studies of the future need for primary care providers indicate that demographic and policy trends will only strain a workforce already struggling to meet national needs.[2] Other analyses document geographic maldistribution of PCPs, within states as well as across states.[3] Addressing both physician shortages and maldistribution requires analysis and action on the state level.

Methods. The Robert Graham Center projected the Florida PCP workforce necessary to maintain current primary care utilization rates, accounting for increased demand due to aging, population growth, and an increasingly insured population due to the Affordable Care Act (ACA). Primary care use was estimated with 2010 Medical Expenditure Panel Survey (MEPS) data. Current active PCPs within Florida were identified using the 2010 American Medical Association (AMA) Masterfile, adjusting for retirees and physicians with a primary care specialty but not practicing in primary care settings. Florida population projections are from those produced by the state based on the 2010 Census.[4]

Workforce Projections 2010-2030

To maintain current rates of utilization, Florida will need an additional 4,671 primary care physicians by 2030, a 38% increase compared to the state's current (as of 2010) 12,228 PCP workforce.

Florida Projected Primary Care Physicians Need



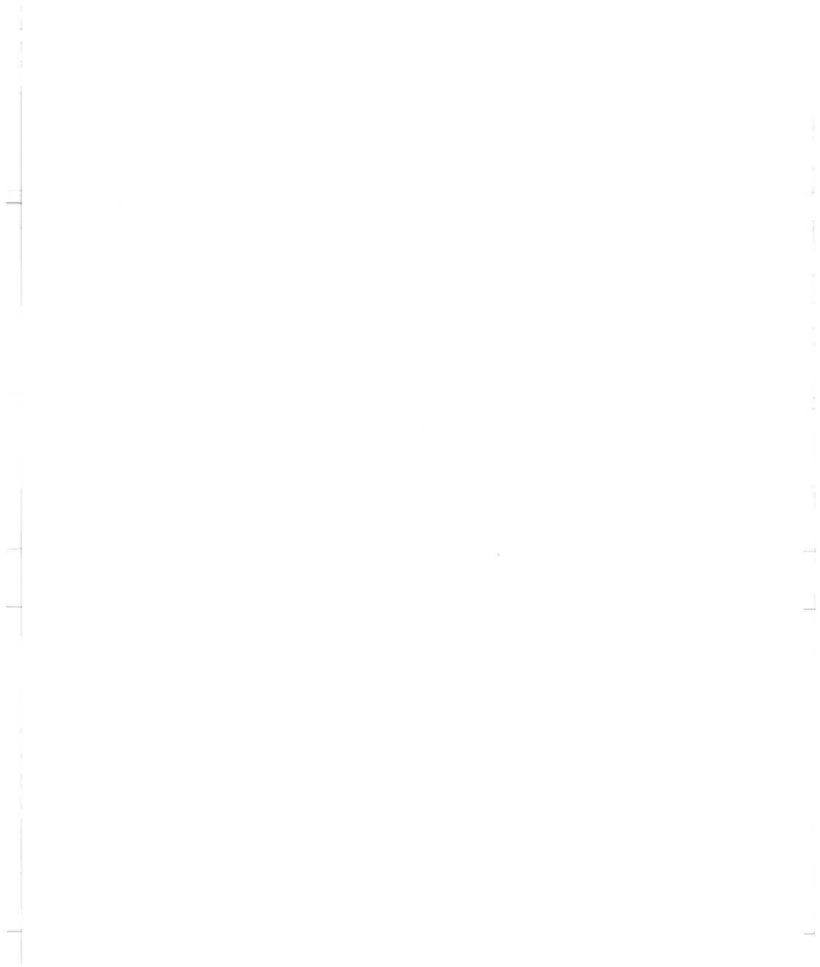
Suggested citation: Petterson, Stephen M; Cai, Angela; Moore, Miranda; Bazemore, Andrew. State-level projections of primary care workforce, 2010-2030. September 2013, Robert Graham Center, Washington, D.C.

[1] Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The triple aim: care, health, and cost. *Health Affairs, 27*(3), 759–69. doi:10.1377/hlthaff.27.3.759

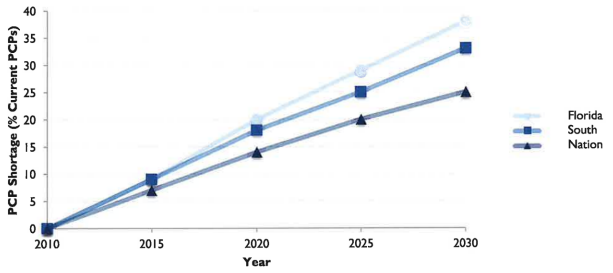
[2] Petterson, S. M., Liaw, W. R., Phillips, R. L., Rabin, D. L., Meyers, D. S., & Bazemore, A. W. (2012). Projecting US Primary Care Physician Workforce Needs : physician supply meet demands of an increasing and aging population? *Health Affairs, 27*(3), w232–w241. Also see Colwill, J., Cultice, J., & Kruse, R. (2008). Will generalist physician supply meet demands of an increasing and aging population? *Health Affairs, 27*(3), w232–w241.

[3] *Council on Graduate Medical Education Tenth Report: Physician Distribution and Health Care Challenges in Rural and Inner-city Areas.* (1998). Washington, D.C.

[4] http://edr.state.fl.us/Content/population-demographics/data/index.cfm. For full description of the methodology, see http://www.graham-center.org/tools-resources/state-projections.htm.



Physician Demand Comparison – State, Region, Nation



Implications for Florida

To maintain the status quo, Florida will require an additional 4,671 primary care physicians by 2030, a 38% increase of the state's current (as of 2010) 12,228 practicing PCPs. The current population to PCP ratio of 1537:1 is greater than the national average of 1463:1. The 2030 projection stands above the South overall and above the nation overall. Components of Florida's increased need for PCPs include 19% (894 PCPs) from increased utilization due to aging, 66% (3,100 PCPs) due to population growth, and 14% (677 PCPs) due to a greater insured population following the Affordable Care Act (ACA).

Pressures from a growing, aging, increasingly insured population call on Florida to address current and growing demand for PCPs to adequately meet health care needs. Policymakers in Florida should consider strategies to bolster the primary care pipeline including reimbursement reform, dedicated funding for primary care Graduate Medical Education (GME), increased funding for primary care training and medical school debt relief.

Highlights: Florida's Projected Primary Care Physician Demand

Additional PCPs Required by 2030
4,671
Or, **38%** of current workforce, due to an aging, growing and increasingly insured population.

Current Primary Care Physician Workforce
12,228

The state's PCP ratio of 1537:1 is greater than the national average of 1463:1.

Potential Solutions –

Bolster the Primary Care Pipeline

- Physician reimbursement reform
- Dedicated funding for primary care Graduate Medical Education (GME)
- Increased funding for primary care training (Title VII, Section 747)
- Medical school student debt relief

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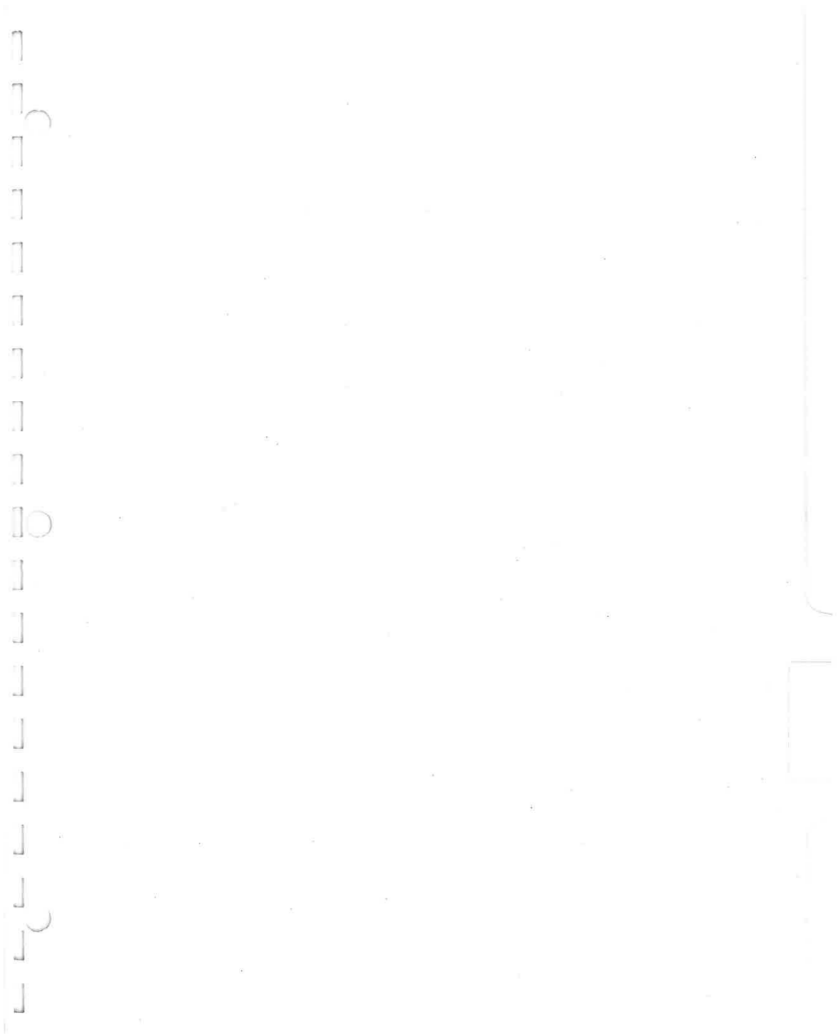


FAMILY AND MEDICAL ETHICS DEFENSE ACT

Section 1. Definitions.

A. "***Disclosure***" means a formal or informal communication or transmission, but does not include a communication or transmission concerning policy decisions that lawfully exercise discretionary authority unless the medical practitioner providing the disclosure or transmission reasonably believes that the disclosure or transmission evinces:

1. Any violation of any law, rule, or regulation;
2. Any violation of any ethical guidelines for the provision of any healthcare service; or
3. Gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health or safety.

B. "***Healthcare service***" means medical research or medical care provided to any patient at any time over the entire course of treatment. This includes, but is not limited to, testing; diagnosis; referral; dispensing and/or administering any drug, medication, or device; psychological therapy or counseling; research; prognosis; therapy; record making procedures; notes related to treatment; set up or performance of a surgery or procedure; or any other care or services performed or provided by any medical practitioner including, but not limited to, physicians, nurses, allied health professionals, paraprofessionals, contractors, or employees of healthcare institutions.

C. "***Healthcare institution***" means any organization, corporation, partnership, association, agency, network, sole proprietorship, joint venture, or other entity that provides healthcare services. The term includes, but is not limited to, any public or private hospital, clinic, medical center, physician organization, professional association, ambulatory surgical center, private physician's office, pharmacy, nursing home, medical school, nursing school, medical training facility, or any other entity or location in which healthcare services are performed.

D. "***Healthcare payer***" means any employer, health plan, health maintenance organization, insurance company, management services organization, or any other entity that pays for—or arranges for the payment of—any healthcare service provided to any patient, whether that payment is made in whole or in part.

E. "***Medical practitioner***" means any person or individual who may be or is asked to participate in any way in any healthcare service. This includes, but is not limited to, doctors, nurse practitioners, physician's assistants, nurses, nurses' aides, allied health professionals, medical assistants, hospital employees, clinic employees, nursing home employees, pharmacists, pharmacy technicians and employees, medical school faculty and students, nursing school faculty and students, psychology and counseling faculty and students, medical researchers, laboratory technicians, psychologists, psychiatrists, counselors, mental health professionals, social workers, or any other person who facilitates or participates in the provision of healthcare services to any person.

F. "***Participate***" in a healthcare service means to provide, perform, assist with, facilitate, refer for, counsel for, advise with regard to, admit for the purposes of providing, or take part in any way in providing, any health care service or any form of such service.

Section 2. Rights of Conscience

A. **Freedom of Conscience**. A medical practitioner, healthcare institution, or healthcare payer has the freedom not to participate in or pay for any healthcare service which violates his, her, or its

conscience as informed by ethical, moral, or religious beliefs or principles.

B. **Limitations.** The exercise of the right of conscience is limited to conscience-based objections to a particular healthcare service. This section may not be construed to waive or modify any duty a health care practitioner, health care institution, or health care payer may have to provide other medical services that do not violate the practitioner's, institution's, or payer's conscience.

C. **Discrimination Prohibited**. No medical practitioner, healthcare institution, or healthcare payer shall be discriminated against or suffer any adverse action as a result of declining to participate in or pay for a healthcare service on the basis of conscience. No medical practitioner, healthcare institution, or healthcare payer shall be civilly, criminally, or administratively liable for exercising the right of conscience by declining to participate in or pay for a healthcare service. No healthcare institution shall be civilly, criminally, or administratively liable because a medical practitioner employed, contracted, or granted admitting privileges by the healthcare institution exercise the conscience rights by declining to participate in a healthcare service.

D. **Emergency Medical Treatments**. Nothing herein shall be construed to override the requirement to provide emergency medical treatment to all patients set forth in 42 U.S.C. § 1395dd or any other federal law governing emergency medical treatments.

Section 3. Speech and Whistleblower Protection.

A. No medical practitioner shall be discriminated against in any manner because the medical practitioner:

1. Provided, caused to be provided, or is about to provide or cause to be provided to his or her employer, the Attorney General of Florida, Florida Department of Health, any other state agency charged with protecting health care rights of conscience, the U.S. Department of Health and Human Services, Office of Civil Rights, or any other federal agency charged with protecting health care rights of conscience information relating to any violation of, or any act or omission the medical practitioner reasonably believes to be a violation of, any provision of this Act;
2. Testified or is about to testify in a proceeding concerning such violation; or
3. Assisted or participated, or is about to assist or participate, in such a proceeding.

B. Unless the disclosure is specifically prohibited by law, no medical practitioner shall be discriminated against in any manner because the medical practitioner disclosed any information that the medical practitioner reasonably believes evinces

1. Any violation of any law, rule, or regulation;
2. Any violation of any ethical guidelines for the provision of any healthcare service; or
3. Gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health or safety.

C. A board, or the Department of Health if there is no board, may not reprimand, sanction, or revoke or threaten to revoke a license, certificate, or registration of a health care practitioner for engaging in speech or expressive activity protected under the First Amendment to the U.S. Constitution, unless the board or the Department of Health, as applicable, demonstrates beyond a reasonable doubt that the practitioner's speech was the direct cause of physical harm to a person with whom the health care practitioner had a practitioner-patient relationship within the 3 years

immediately preceding the incident of physical harm.

(3) The board, or the Department of Health if there is no board, must provide a medical practitioner with any complaints it has received which may result in the revocation of the medical practitioner's license, certification, or registration, within 7 days after receipt of the complaint. The board, or the department if there is no board, must pay the medical practitioner an administrative penalty of $500 for each day the complaint is not provided to the medical practitioner after the specified 7 days.

Section 4. Civil Action for Violation of Right of Conscience. A civil action for damages, injunctive relief, or any other appropriate relief, including attorneys' fees, may be brought by any medical practitioner, health care institution, or health care payer for any violation of this Act.


10

FREQUENTLY ASKED QUESTIONS

Medical Ethics & Diversity Act

ALLIANCE DEFENDING FREEDOM
FOR FAITH. FOR JUSTICE

QUESTION 1

Why is this bill needed?

It protects diversity of belief within the medical profession and benefits patients by protecting the supply of physicians and other medical providers within the healthcare system. In a 2019 survey of 1732 members of faith-based medical associations:

- 23% of respondents reported personally experiencing discrimination.
- 36% of respondents reported having faced pressure or discrimination from med school administrators or faculty based on their beliefs.
- 20% of respondents said they decided not to pursue a career in certain fields due to a lack of tolerance for their moral, ethical, or religious beliefs. (80% of these respondents had chosen not to pursue a specialty in OB-GYN).
- 91% of respondents reported that they "would rather stop practicing medicine altogether than be forced to violate [their] conscience."[1]

Medical practitioners should not be forced to choose between their ethical, moral, or religious values and their life's calling. Diversity among medical providers is important—81 percent of Americans surveyed said it was important that their medical providers shared their moral beliefs.[2]

QUESTION 2

Does this bill allow providers to refuse to provide general care to a patient or kick a patient out of their practice?

No. This bill simply protects providers who gladly serve everyone in their particular field of medicine from being required to perform a specific medical procedure if doing so would violate their conscience. It is not legal permission to refuse to provide general medical care. In fact, federal law already prohibits providers who participate in Medicaid, Medicare, or other federal programs from discriminating on the basis of race, color, or national origin. This bill would not supersede those protections or provide any other legal justification for a provider to dismiss a patient from his or her practice.

[1] Christian Medical Association survey (2019), available at: freedom2care.org/polling.
[2] United States Conference of Catholic Bishops survey (2019), available at: https://24168d49-d5cc-4260-ae1a-a97a91740a06.filesusr.com/ugd/7d505d_e082159d7e1932d99ebc7cb03588ce7.pdf.

QUESTION 3

Will this bill impede the ability of patients to receive proper emergency care?

No. The best avenue for emergency care is usually a patient visit to a hospital. Under a federal law known as the Emergency Medical Treatment and Active Labor Act (EMTALA), hospitals and hospital-affiliated stand-alone emergency departments are required to provide examinations and treatments to anyone with an emergency medical condition. This bill would not conflict with or supersede the EMTALA.

QUESTION 4

Are there any limits on what can be included under "conscience"?

Yes. Federal law, including the Emergency Medical Treatment and Active Labor Act, mandates treatment or appropriate transfers of emergency conditions. In addition, there have been no cases involving medical providers seeking the right to refuse emergency treatments required to prevent death or imminent and severe physical harm. Rather, the current conscience issues involve objections concerning lifestyle and elective procedures and treatments, including assisted suicide, dispensing marijuana and mind-altering drugs, gene-editing and other genetic manipulation on children in-utero, prescription or provision of abortifacients, abortion procedures, and surgeries that remove otherwise healthy body parts or that result in permanent sterilization as part of gender identity procedures.

QUESTION 5

Does this bill require providers or institutions to offer certain services?

No. This bill simply protects providers or institutions from being compelled to perform specific procedures to which they have a conscientious objection.

QUESTION 6

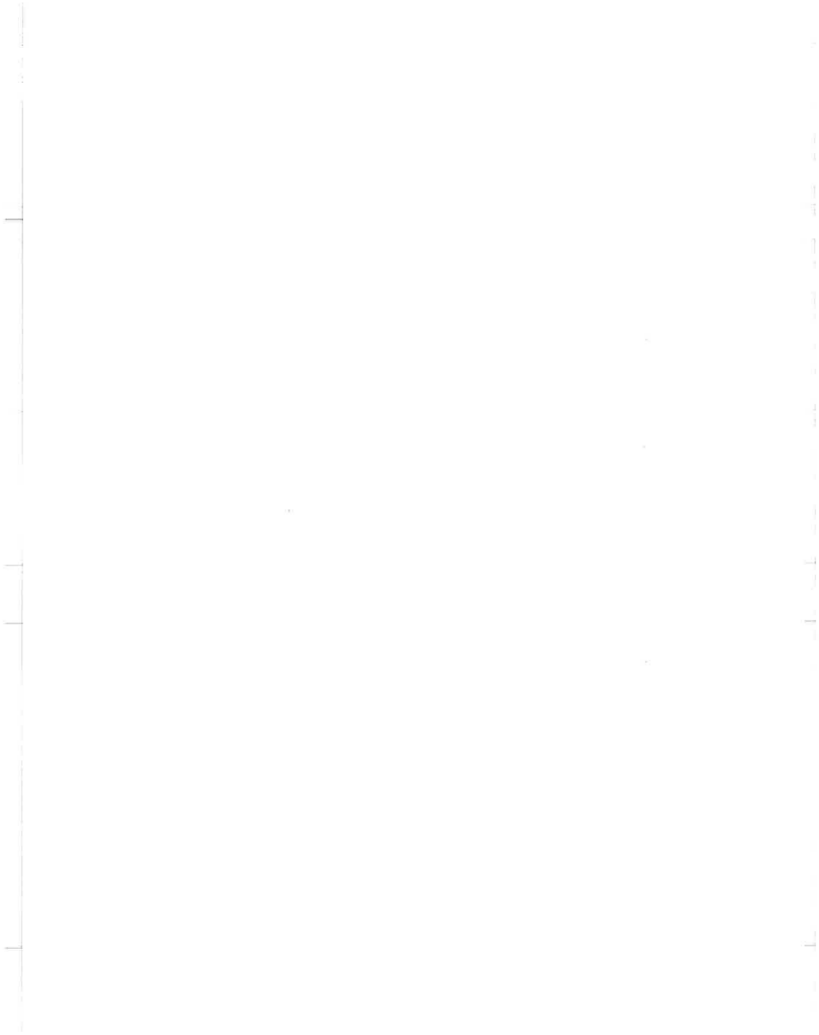
Does this bill establish a right for providers or institutions to offer any services they wish?

No. This bill does not create an affirmative right to perform a medical procedure or offer medical services that are unethical or prohibited under state or federal law. Rather, it protects the right NOT to perform a specific procedure that is unethical or to which a conscientious objection applies.

QUESTION 7

Can a medical provider or institution decline to serve a patient due to race or other protected characteristic?

No. This bill does not permit providers, institutions, or payers to decline to serve a person based upon their race, color, sex, or any other protected characteristic. This bill simply protects providers from being required to perform specific procedures.



QUESTION 8

Does the whistleblower section mean that an employer can't fire someone who is a habitual complainer or who files false complaints?

No. Whistleblowers are only safeguarded when making specific, legally protected reports that are necessary to disclose unethical practices or violations of the law. Employees who are filing false reports or merely harassing their employer are not protected under this bill. In addition, the bill includes specific language indicating that reports "concerning policy decisions that lawfully exercise discretionary authority" are generally not protected under this bill.

QUESTION 9

Why is it important to protect healthcare payers?

Some organizations, especially non-profits and religious organizations, self-insure and are healthcare payers themselves rather than relying on an insurance company. In addition, all employers who help provide healthcare for their employees are payers. Institutions do not act alone, but rather through people—as the U.S. Supreme Court noted in Burwell v. Hobby Lobby Stores, Inc. In the case's majority opinion, Justice Alito recognized that "protecting the free-exercise rights of closely held corporations thus protects the religious liberty of the humans who own and control them." In the same way that we don't require taxpayers to fund abortions, we should not require these organizations and closely held family businesses to pay for specific medical procedures that they find objectionable. Their values and beliefs must be respected when accommodating medical conscience.

QUESTION 10

Could insurance companies use this to avoid paying for costly medical treatments by claiming that some treatment costs are unconscionable?

No. This bill only allows an assertion that certain procedures are unconscionable in themselves based upon the nature of the procedure itself. Nothing in this bill allows the cost of the procedure to factor into the consideration of conscience. In addition, neither federal law nor case law support finding a right to medical conscience based upon the cost of a procedure. This premise is unsupported in American law.

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FOR FAITH. FOR JUSTICE.

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