Testimony of Dr. David Mitchell
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The Commonwealth Foundation for Public Policy Alternatives
Hearing on Health Care
Before Pennsylvania Senate Majority Policy Committee
The Honorable Daniel Laughlin, Chair
February 14, 2024

RE: Challenges Surrounding Rural Health Care in Pennsylvania

Chair Laughlin:

Thank you for the invitation to testify, and my thanks to the rest of the committee for your attention to this issue.

My name is David Mitchell. I'm a professor of economics at Ball State University and the director of the Institute for the Study of Political Economy. My testimony is at the request of the Commonwealth Foundation for Public Policy Alternatives, a free-market think tank that advances policy ideas and proposals to help all Pennsylvanians flourish.

Introduction

When it comes to health care, there are lots of myths. I want to give you some facts. I'm going to talk about access, quality, and cost.

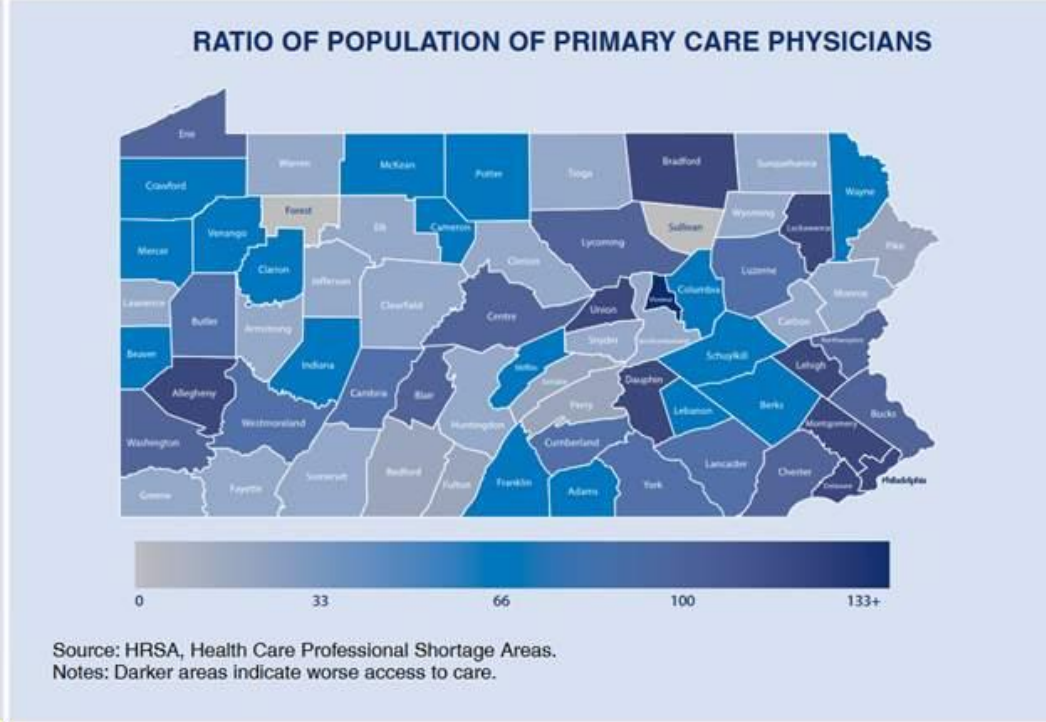
Pennsylvania ranks highly in many state health rankings. But health care isn't uniformly available. When Pennsylvanians get sick—especially those living in rural areas—there aren't enough primary health care providers. One cause of this primary care shortage is Pennsylvania's excessively restrictive medical regulation. Nurse practitioners (NPs) in Pennsylvania may not work independently. Yet, 26 other states have full practice authority.[1] These laws hinder qualified NPs from working independently to meet Pennsylvanians' needs.[2] The regulations add undue administrative burden.

The primary care shortage affects most of the state but is most severe in rural areas. The Kaiser Family Foundation, using data from Health Resources and Services Administration, shows that Pennsylvania has 153 designated Health Professional

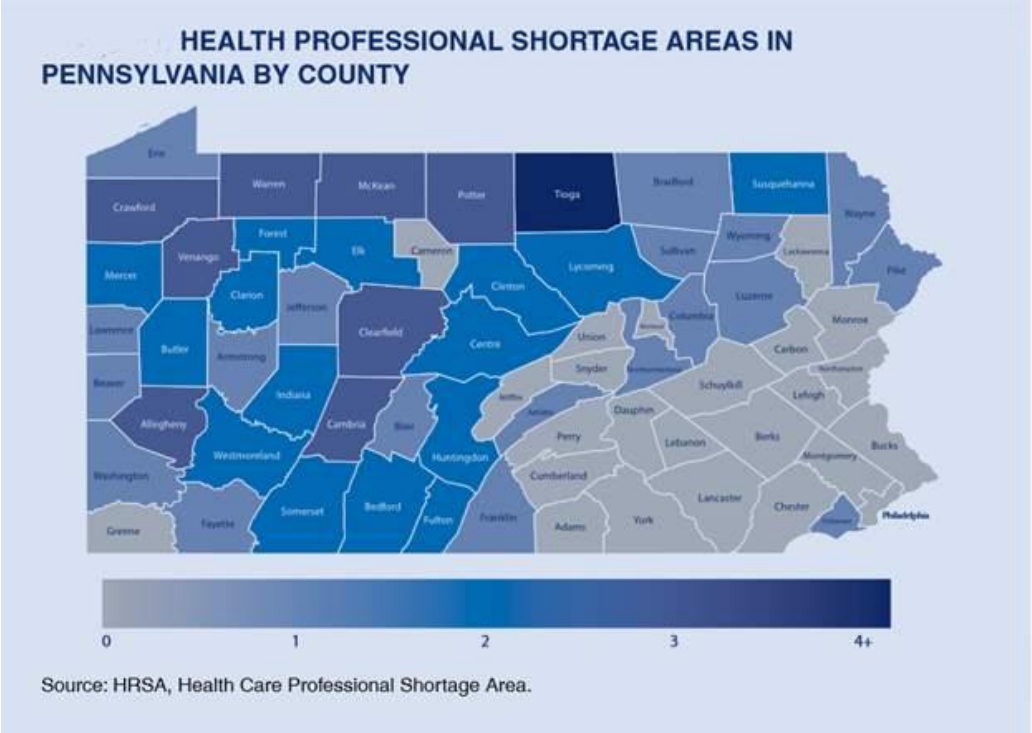
[1] Benjamin McMichael and Sara Markowitz,. "Toward a Uniform Classification of Nurse Practitioner Scope of Practice Laws," *Medical Care Research and Review* 80, No. 4 (August 2023), 444–54, https://doi.org/10.1177/10775587221126777.
[2] To "fully practice," means nurse practitioners (NPs) can diagnose patients, prescribe medicine, and treat people without physician oversight. The idea is that NPs should practice to the full extent of their training.

Shortage Areas (HPSA).[3] There are over 600,000 Pennsylvanians living in areas without enough providers. To catch up, the Keystone State would need 116 more primary care providers—and those providers would need to move to areas with shortages.

We can see the disparities in access to care from these two maps: "Ratio of Population to Primary Care Physicians" and "Health Professional Shortages by County."



[3] Primary Care Health Professional Shortage Areas (HPSAs). https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22pennsylvania%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D



Just because you have insurance doesn't mean you get care. Can you find a provider? And if you need complex care, you also need someone to get you into the system. We see from the maps, that in some places, patients struggle to get care.

Fortunately, NPs can help alleviate access to care issues in Pennsylvania. From 2009 to 2017, the number of NPs per 3,500 patients increased by 90.1 percent in rural U.S. counties. Meanwhile, Physicians increased only 14.3 percent.[4]

What about quality?

There is a broad consensus on the ability of NPs to provide great primary care.

We often hear that physicians train longer than NPs and those physicians incur tremendous costs to attend medical school. But we do not care about the actual inputs into health care. What we care about is patients getting quality care. What we care about is the evidence that NPs provide high-quality primary care. As far back as the year 2000, a randomized control trial published in *JAMA* found that NPs provide equivalent care to physicians.[5]

Remember, we must care about patient outcomes, not inputs by physicians.

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[4] E.H. Larson, C.H.A. Andrilla, and L.A. Garberson, Policy Brief 167: "Supply and Distribution of the Primary Care Workforce in Rural America: 2019," WWAMI Rural Health Research Center, University of Washington, June 2020, https://www.ruralhealthresearch.org/publications/1350.

[5] M.O. Mundinger et al., "Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians: A Randomized Trial," *Journal of the American Medical Association 283*, No. 1 (January 2000), 59-68, https://doi.org/10.1001/jama.283.1.59.

NPs are great health care providers.

NPs are registered nurses who have earned a master's degree or a doctorate in nursing practice. They take graduate courses and complete clinical hours. They pass national board certification and are licensed in their state. Most NPs choose primary care, which is comprehensive treatment for ailments not requiring a specialist. That is just what Pennsylvania needs. Moreover, research by the Kaiser Family Foundation found that NPs could perform 80 to 90 percent of the primary care that physicians provide.[6]

My own work in the *Journal of Rural Health* found that full practice authority is great for rural residents with chronic disease.[7] We found that there were 219.4 fewer foot debridements per 10,000 enrollees ($P < .001$) in rural counties. Remember, that about 11% of Americans have diabetes. Interestingly, we found the impact occurred the year after states adopted full scope of practice. So right away.

Although there are many medical procedures that NPs do not perform, a large body of research indicates that for most primary care purposes, NPs are great substitutes for physicians. Research in the journal *Health Services Research*[8] found that "patients reassigned to NPs experienced similar outcomes and incurred less utilization at comparable cost relative to MD patients."[9] Other research shows *better* health outcomes in primary care patients when NPs can practice to the full extent of their training.[10]

Research on mortality finds "Analyzing deaths in the United States between 2005 and 2019, I find that relaxing NP scope-of-practice laws reduces health care amenable deaths by 12 per 100,000 individuals and that relaxing PA scope-of-practice laws reduces these deaths by 10 per 100,000, with larger reductions in rural areas."[11]

From kids to grandparents, NPs are great health care providers. My colleague Moiz Bhai and I found that full scope of practice improves the health of children.[12] Last October, research published in the *Annals of Internal Medicine* which analyzed the prescribing

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[6] Tapping Nurse Practitioners to Meet Rising Demand for Primary Care: https://www.kff.org/medicaid/issue-brief/tapping-nurse-practitioners-to-meet-rising-demand-for-primary-care/

[7] Danny R. Hughes, Candice Filar, and David T. Mitchell, "Nurse Practitioner Scope of Practice and the Prevention of Foot Complications in Rural Diabetes Patients,". *The Journal of Rural Health* 38, No. 4 (September 2022), 994–98, https://doi.org/10.1111/jrh.12599.

[8] Liu, C. F., Hebert, P. L., Douglas, J. H., Neely, E. L., Sulc, C. A., Reddy, A., ... & Wong, E. S. (2020). Outcomes of primary care delivery by nurse practitioners: Utilization, cost, and quality of care. *Health services research*, *55*(2), 178-189.

[9] Chuan-Fen Liu et al., "Outcomes of Primary Care Delivery by Nurse Practitioners: Utilization, Cost, and Quality of Care," *Health Services Research* 55 (January 2020), https://doi.org/10.1111/1475-6773.13246.

[10] Bhai, M., & Mitchell, D. T. (2022). The effects of occupational licensing reform for nurse practitioners on children's health. *Southern Economic Journal*.

[11] Benjamin J. McMichael, "Supply-Side Health Policy: The Impact of Scope-of-Practice Laws on Mortality," *Journal of Public Economics* 222, No. 3 (June 2023), http://dx.doi.org/10.1016/j.jpubeco.2023.104901.

[12] Moiz Bhai and David T. Mitchell, "The Effects of Occupational Licensing Reform for Nurse Practitioners on Children's Health," *Southern Economic Journal* (July 2022), https://doi.org/10.1002/soej.12592.

patterns of 73,000 primary care physicians and NPs showed NPs are no more likely to prescribe inappropriately to Medicare patients.[13]

We hear horror stories from the other side, but if nurse NPs were truly inferior, then their mistakes would show up in malpractice payouts and adverse action reports against NPs. But recent research finds no evidence of that.[14]

Full Scope of Practice for NPs reduces costs.

When NPs practice to the full extent of their training, costs go down for several reasons. First, NPs receive reimbursements for their services at a lower rate than physicians. Secondly, and perhaps more importantly, increased access to care means treating problems sooner when it is cheaper.

Recall that a collaborative practice agreement with a physician is costly in terms of time and money for NPs, and it is time-consuming for physicians who must review NPs' charts.

These joint protocols mean NPs cannot open their own medical clinic, and they require physicians to spend time overseeing NPs—taking time away from these doctors to attend their own patients. In addition, these protocols require NPs to pay costly monthly payments to a doctor, and physicians can cancel these agreements at any time. The result is fewer patients receiving care.[15]

Decreasing supply leads to higher health costs. For example, a study from the University of Chicago found that insurance providers paid 3 to 16 percent more for well-child visits in states like Pennsylvania that restrict NPs.[16]

If NPs are less able to handle complex primary care, one could assume that increased scope of practice would lead to expensive emergency department visits or hospital admissions. However, research published in *Health Affairs* found the opposite. Care from NPs led to lower costs.[17] That's because nurse practitioners are less costly than doctors, and increased primary care saves money by detecting and treating medical

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[13] Johnny Huynh, Sahil A. Alim, David C. Chan, and David Studdert, "Inappropriate Prescribing to Older Patients by Nurse Practitioners and Primary Care Physicians," *Annals of Internal Medicine* 176, No. 11 (October 2023), 1448–55, https://doi.org/10.7326/M23-0827.

[14] Sara Markowitz and Andrew J. Smith, "Nurse Practitioner Scope of Practice and Patient Harm: Evidence from Medical Malpractice Payouts and Adverse Action Reports," *Journal of Policy Analysis and Management* (July 2023), https://doi.org/10.1002/pam.22507.

[15] Brendan Martin and Maryann Alexander, "The Economic Burden and Practice Restrictions Associated with Collaborative Practice Agreements: A National Survey of Advanced Practice Registered Nurses," *Journal of Nursing Regulation* 9, No. 4 (January 2019), 22–30, https://doi.org/10.1016/S2155-8256(19)30012-2.

[16] Morris M. Kleiner, Allison Marier, Kyoung Won Park, and Coady Wing, "Relaxing Occupational Licensing Requirements: Analyzing Wages and Prices for a Medical Service," *Journal of Law and Economics* 59, No. 2 (May 2026), https://doi.org/10.1086/688093.

[17] Perri A. Morgan et al., "Impact of Physicians, Nurse Practitioners, and Physician Assistants on Utilization and Costs for Complex Patients," *Health Affairs* 38, No. 6 (June 2019), https://doi.org/10.1377/hlthaff.2019.00014.

problems early. Pennsylvania residents pay *more* money for health care due to the burdensome restrictions on NPs.

The administrative burden reduces time spent with patients.

Full practice authority for Pennsylvania NPs would increase the amount of time NPs can see patients by about 45 minutes each week.

- This translates into almost one more week of patient access per NP per year, or approximately an additional 109 patients per NP each year.
- This is a conservative estimate given the calculation excludes patients likely seen by new NPs and other efficiency gains.

Full practice authority trends towards higher rates of NP self-employment and indicates a greater shift to full-time work for the full year for both physicians and NPs.

- Full practice authority results in a statistically significant increase in NP earnings of $3,535 (approximately 4 percent), while physician earnings show no statistically significant change.[18]

Conclusion

Pennsylvania has many excellent higher education institutions including 111 nurse practitioner programs. A study in the *Journal of Labor Research*[19] found that NPs were far more likely to move to full-practice states than restricted-practice states. Nearby states such as New York, Delaware, and Maryland do not require collaborative practice agreements, making it tempting for Pennsylvania NPs to locate elsewhere. Pennsylvania wants NPs moving to the state not away from it.

Most health initiatives put forward by lawmakers are expensive to implement but changing the scope of practice laws costs taxpayers nothing. Changing these restrictive laws will allow Pennsylvania's NPs to work independently, will provide greater access to health care, *and* will save the health care system money.

Full scope of practice alone won't move you all the way to complete access to care. But this is something you can do to improve health care and reduce costs.

Again, thank you. I would be happy to address any questions you may have.

Sincerely,

David Mitchell

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[18] Moiz Bhai and David T. Mitchell, "Health Care Access: The Easy Way," Commonwealth Foundation, May 9, 2023, https://www.commonwealthfoundation.org/research/expanding-health-care-nurse-practitioners/.

[19] Shakya, S., & Plemmons, A. (2020). Does scope of practice affect mobility of nurse practitioners serving medicare beneficiaries?. *Journal of Labor Research*, *41*, 421-434.