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HOW STATES CAN REFORM HEALTH CARE TODAY

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INTRODUCTION

Take Control

States Can Provide Remedies

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Some aspects of the U.S. health care system, such as pharmaceutical innovation and cancer care, are the best in the world. However, the problems with the U.S. health care sector are legion. Chief among these, patients have too little control over their health spending, and they lack information, incentives, and opportunities to make the best decisions for their health care. This is partly why Americans spend large amounts of money on many services that provide little or no health benefit.

The federal government heavily influences the health sector through the Medicare and Medicaid programs, the Affordable Care Act (ACA), and the tax exclusion for employer-provided health insurance. Moreover, policies of bureaucracies such as the Food and Drug Administration and the Centers for Medicare and Medicaid Services also significantly affect the practice of medicine.

State policy also plays an important role in the functioning of the health sector. State legislators and policymakers can take actions that create a more transparent and competitive market or one with greater restrictions and special-interest carveouts. States can be more effective stewards of taxpayer dollars, or they can waste taxpayer resources by mismanaging health programs—especially Medicaid.

State policy reform could create models for federal health reform efforts. For example, welfare reform in Wisconsin in the early 1990s spurred major federal welfare reform in the mid-1990s. This book, which outlines many specific reforms, is the ideal resource for enterprising state leaders who want to

make a real difference and improve health policy in their state and ultimately expand access, lower health care prices, and enhance the quality of care.

States are at different places with respect to their health policies. With regard to Medicaid, some state programs are better managed than others. With regard to the supply of health care services, including medical professionals' ability to practice, certificate of need (CON) requirements, and telehealth services, some states have only light restrictions, whereas other states have severe ones. Regarding health coverage options such as short-term plans, some states permit a wider variety of coverage, whereas other states restrict such options.

This book sets out an agenda for state health reform for the year 2022 and beyond. The eight chapters that follow detail specific, common problems with state health policy and provide recommendations for states to improve those policies. If states pursue the recommended reforms in this book, they will empower patients to have greater control over their health care. These reforms will expand access and reduce costs—both to patients and to taxpayers—and will significantly increase the number of people who obtain the right care, at the right time, at prices they can afford. The reforms will encourage the development of innovative care models to better serve patients—innovations such as the health clinics established by Walmart, Walgreens, and CVS Health.

The reforms will be especially valuable to people in areas of the country where health care access is a significant challenge—in rural areas and inner cities, for example. Expanding telehealth and removing certificate of need restrictions and scope-of-practice limitations will increase the ability of patients in these areas to obtain accessible and affordable care. Many of the recommendations involve states codifying commonsense actions they took during the pandemic to expand the supply of lower-cost and more convenient health care services. The book contains thorough citations so state policymakers can understand the evidence underlying the recommended policy reforms.

In chapter 1, I discuss how states can improve their health care sectors by using their leverage as a large, and often the largest, employer in the state. Instituting reforms in their state employee health plans can increase beneficial competitive forces in the state, save taxpayer resources, and provide private-sector employers a model for reform. I discuss beneficial policy changes to state employee health plans made by California and Montana, and I offer states a menu of options for introducing reforms to their state

employee health plans. These include (1) providing greater transparency about the plan, (2) permitting the plan to merge with group purchasing organizations to obtain better value for plan members, (3) insisting on bottom-up pricing and avoiding inflationary pricing structures such as discounts from billed charges, (4) moving toward site-neutral reimbursement by prohibiting the use of facility fees in the state employee health plan if inpatient hospital-based care is not necessary, (5) utilizing reference-price and shared-savings payment structures, and (6) employing individual coverage health reimbursement arrangements.

In chapter 2, Jonathan Ingram discusses many of the problems with Medicaid—the largest state budget item—and provides recommendations for how states can better run their programs. Partially because of the ACA's expansion of Medicaid, enrollment and spending in the program have soared. Unfortunately, improper payments now account for more than one in four federal dollars expended through Medicaid—a cost that exceeds $100 billion annually. Many of the problems result from eligibility issues. Millions who are enrolled in the ACA Medicaid expansion are not legally eligible for the program. Many states abdicated review of applicant information as applications soared with the ACA's Medicaid expansion. Compounding this problem is a maintenance-of-effort (MOE) provision in legislation enacted by Congress in February 2020 that effectively prevented states from disenrolling people who no longer met eligibility requirements. Moreover, current eligibility requirements make it too easy to access Medicaid long-term care, which discourages responsible financial planning.

Ingram makes recommendations that would help ensure that program funds are allocated in lawful and responsible ways. So only eligible recipients are enrolled in Medicaid, Ingram suggests that states stop accepting self-attestation for income and other household attributes, utilize all available data sources for verification of applicant information, take steps to ensure that hospitals are not enrolling ineligible residents in Medicaid, and perform more frequent eligibility reviews. Perhaps most importantly, given the high number of improper Medicaid enrollees, Ingram recommends that states prepare for the end of the coronavirus public health emergency by restarting redeterminations. To limit public resources financing long-term care services for people with significant assets, Ingram recommends that states use the standard home equity exemption and improve their efforts to recover taxpayer costs from the estates of deceased enrollees who used

Medicaid to finance their long-term care. Finally, Ingram suggests that states conduct full-scale audits of their Medicaid programs to better understand whether program expenditures comply with the law and yield acceptable outcomes.

In chapter 3, Charles Miller carefully documents evidence of how the ACA's insurance regulation removed affordable and flexible coverage options from millions of Americans—particularly those who earn middle income or higher. Fortunately, states can make alternative, lower-priced, high-quality coverage available to their residents. Miller discusses the benefits of short-term health insurance plans, which are not subject to ACA rules. He recommends that states make them available for terms up to 364 days, with renewals for up to three years, and that states consider certain safeguards to improve these plans for longer-term use.

Miller also discusses the advantages of health benefit plans purchased through Farm Bureaus. These plans use underwriting at the time of issuance, with nine out of ten applicants offered coverage. After the initial underwriting, the plans are guaranteed renewable, meaning that if the individual remains a member of the association, they are protected both from loss of coverage and from premium increases if their health deteriorates. For several decades, Tennessee citizens have been able to purchase Farm Bureau plans. These plans are also now allowed in the states of Iowa, Indiana, Kansas and, most recently, South Dakota and Texas. Having worked to enact Farm Bureau plans in Texas, Miller concludes his chapter with effective responses to false claims that opponents of expanded coverage options may present.

In chapter 4, Matt Mitchell extensively documents the history of CON laws as well as evidence of how CON works. These laws are state regulations that require health care providers to obtain permission from a government board to increase the availability of health care services. They exist for many types of services, including hospital-based care and imaging technologies. The evidence overwhelmingly demonstrates that CON reduces access, reduces competition, reduces quality, and increases costs. In effect, CON has contributed to the problem of monopolized health care markets. Mitchell details how CON is especially harmful to rural patients, diminishing their access to hospitals and ambulatory surgical centers and forcing them to travel longer distances to receive care. Such laws have also contributed to disparities in access between white and black state residents.

While Mitchell recommends that states eliminate their CON requirements, he recognizes that there are powerful political interest groups—chiefly incumbent providers—who benefit from the ability to have government restrict their competition. Thus, he also offers a menu of reforms, including repealing CON requirements at a future date, requiring that the CON authority approve a greater number of applications over time, and eliminating CON requirements that harm vulnerable populations, such as the CONs for drug and alcohol rehabilitation and psychiatric services. He also offers the commonsense recommendations that employees of incumbent providers should be barred from serving on CON boards and that no CON application should be rejected on the basis that entry would create a duplication of services in a region. Lastly, Mitchell discusses how several states, including Florida and Montana, were able to enact CON reforms over the past few years.

In chapter 5, Robert Graboyes and Darcy Nikol Bryan, MD, assess state laws that limit medical professionals from practicing at the top of their license. They discuss the problems with state licensure laws, such as rules that raise costs for out-of-state professionals and effectively prohibit them from offering their services. Other problems include mandatory collaborative practice agreements that restrict non-MDs, such as nurses, physician assistants, and dental therapists, from offering services independent of physician or dentist oversight. These types of restrictions reduce access to care for patients, raise patients' financial costs, and are associated with poorer quality of care. Such restrictions are particularly problematic in rural areas and poor urban areas, where people suffer from a dearth of health care professionals to care for them.

Graboyes and Bryan offer a variety of recommendations for states to allow all medical professionals to practice at the top of their license and for non-MDs to practice without mandatory collaborative practice agreements, pointing to several state reforms as models. These include having states join the Interstate Medical Licensure Compact and Arizona's 2019 legislation that enables licensed professionals from other states to begin practicing as soon as they move to Arizona. Graboyes and Bryan also propose simplifying the process for international medical graduates to obtain licenses, thereby easing doctor shortages in the United States.

Consistent with the themes of chapters 4 and 5, in chapter 6, Naomi Lopez considers why states should make permanent many of the telehealth reforms they enacted to ease patients' access to their providers during the COVID

pandemic. At the start of the pandemic, both the federal government and states relaxed many rules that limited the availability of telehealth. For example, many states allowed out-of-state providers to offer telehealth services, eliminated requirements for a provider-patient relationship prior to initiating telehealth, suspended the requirement that a patient be physically present in a medical facility to obtain evaluation via telehealth, and permitted both audio and telehealth options. These policy changes permitted many patients to receive care, including remote monitoring, who otherwise would have been without any convenient options for such care. Lopez discusses the importance of telehealth expansion, including better meeting patients' needs and preferences, increasing access for people who live in rural areas, permitting flexibility for hospital redesign, and encouraging innovation in insurance design.

Lopez highlights legislation that Arizona enacted in 2021 to demonstrate why states should make permanent the changes they enacted during the pandemic. Arizona's law permits remote patient monitoring and telehealth in real time, as well as asynchronous applications that enable services such as sending a patient's x-rays to a surgeon for immediate evaluation. One caution with Arizona's legislation is that it requires that insurers reimburse providers at no less than the in-person rate for the same service unless the telehealth services are conducted through an insurer's platform. States should be wary of parity requirements and avoid them whenever possible, as they impose additional market distortions and may increase the potential for abuse and inflated spending. If parity of rates is required for providers to cover costs associated with implementing telehealth technologies, the requirement should phase out over time.

After three chapters of recommendations for how states can free providers to best meet patient needs, chapter 7 focuses on what states can do to help patients manage their health, specifically around prescriptions. In this chapter, Jeffrey Singer, MD, considers what states should do to conform to a new federal rule that permits patients to access and share their electronic health records via smartphone apps. The rule change, which takes effect in 2022, also permits patients to use their personal prescription information to shop for prescription drugs, thereby allowing them to find the pharmacy that provides the best price, supply duration, convenience, and overall experience. According to Singer, the benefits from the federal rule change will not flow to patients unless states remove pharmacy and health information transfer

regulations. Most state regulations make it difficult for patients to electronically move prescriptions between pharmacies that are not within the same company.

Singer's recommendations that states remove regulatory obstacles to patients' control of their prescriptions should be uncontroversial. Specifically, he recommends that states remove regulations that limit the electronic transfer of prescriptions between pharmacies as well as requirements that such transfers must only be conducted between pharmacists or pharmacy interns. He further advises states to pass legislation requiring that health care providers electronically transfer a patient's current medication history to a provider designated by the patient. By permitting patients to own their prescription history and control where to receive their medications, these reforms will stimulate patient shopping and increase competition, which should lower prices, improve convenience, and potentially increase medication adherence.

In chapter 8, Heidi Overton, MD, recommends that states make Medicaid claims data public to increase patients' knowledge of their providers and to improve the appropriateness of medical care received by state residents. Medicaid enrollees typically have poorer health outcomes than people with private insurance, even after controlling for numerous patient characteristics. Overton recommends that states make Medicaid data available so that provider practice pattern metrics, particularly for certain care identified as high cost and low quality, can be developed. She discusses the utility of appropriateness measures that recognize the diversity in provider practices and are developed through provider consensus. She has firsthand expertise in the development of such measures and highlights the importance of having provider input.

To demonstrate the need for her recommendations, Overton uses a case study of Cesarean section (C-section), a procedure of particular importance to the Medicaid program and its patients since Medicaid paid for more than 42 percent of all U.S. births in 2019. She argues that patients should know providers' low-risk C-section rates and that the state should ensure that providers are aware of their own rates compared to those of other providers. Such transparency would help patients have more control over, and awareness of, the quality of care they receive as well as increase providers' awareness of the appropriateness of their own practices.

While aspects of the U.S. health care system are the best in the world, much of our health care spending delivers little, if any, benefit for patients. And

government policy often restricts consumers' ability to access lower-cost alternatives. Reforms are unquestionably needed to address causes of these skyrocketing costs, and patients—including those in rural regions—need to be empowered to have more choice and control over their own health care.

This book is a crucial resource for state legislators who wish to improve both their constituents' well-being and their state's financial health. The reforms included in this book are commonsense, innovative solutions to achieve those goals. The book's authors share their own experiences to help readers anticipate and counter opposition with effective responses and evidence, such as statistics and examples of other states' successes. States that implement these practical solutions may help not only their own constituents but also citizens nationwide by inspiring reforms in other states and even at the federal level. It is urgent that state leaders not wait for solutions from Washington and instead use the power that they have to improve their health sectors.

ABOUT THE AUTHOR

Brian C. Blase, PhD, is the president of Paragon Health Institute. He is also a senior research fellow at the Galen Institute and a visiting fellow at the Foundation of Government Accountability. In addition, he is CEO of Blase Policy Strategies. From 2017 through 2019, he was a special assistant to the president at the White House's National Economic Council. He has a PhD in economics from George Mason University and publishes regularly in outlets such as the *Wall Street Journal*, *New York Post*, *The Hill*, *Health Affairs*, and *Forbes*. He lives in northern Florida with his wife and five children.