

DON'T WAIT FOR
WASHINGTON



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HOW STATES CAN REFORM
HEALTH CARE TODAY

EDITED BY
BRIAN C. BLASE, PhD

Paragon Health Institute

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INTRODUCTION

Take Control

States Can Provide Remedies

Brian C. Blase, PhD

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 and CEO of the 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.

Demonstrate Leadership

Reform the State Employee Health Plan

Brian C. Blase, PhD

KEY TAKEAWAYS

- To obtain the dual benefit of lower costs for the state government as well as driving overall efficiencies in their health sector, states should introduce reforms into their state employee health plans.
- This chapter discusses six such reforms: (1) 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) prohibiting the use of facility fees in the state employee health plan if inpatient hospital-based care is not necessary, (5) incorporating reference-price and shared-savings payment structures, and (6) utilizing individual coverage health reimbursement arrangements.

PROBLEM

State and local governments are often the largest employers in the state, employing about 16.2 million full-time equivalent employees across the United States in 2014, including roughly 6.6 million working in elementary or secondary education and 2.1 million working in higher education.¹ Public employees and their dependents typically receive health benefits through

their employer, and local government employees, including schoolteachers and college employees, participate in the state employee health plan in nearly half the states.² Among state and local government workers, 89 percent are offered health benefits, and 78 percent of these workers enroll.³ Aside from reducing the costs to the state of the state employee health plan, better managing the plan provides the state with an opportunity to reform its entire health sector simply through reforms to its own employee health plan.

Montana's experience starting in 2015 shows the potential benefit of state action to reform state employee health plan contracts and vendor management. Montana renegotiated contracts with hospitals to pay prices slightly more than twice what Medicare pays and to reduce payment variation. Before the reforms, Montana paid hospitals 191–322 percent of Medicare rates for inpatient services and 239–611 percent of Medicare rates for outpatient services.⁴ Under the reform, Montana paid 220–225 percent of Medicare rates for inpatient services and 230–250 percent of Medicare rates for outpatient services.⁵

Montana also prohibited balance billing in its state employee health plan and tied annual hospital rate increases to Medicare payment growth. Moreover, Montana demanded a full accounting of pharmaceutical costs, including fees paid to various entities in the supply chain, and eliminated duplicate programs and many vendor contracts.

Before Montana initiated these reforms, its state health plan faced large projected deficits. Montana's reforms turned those projected deficits into large surpluses and succeeded in reducing what it paid for its employee health plan by about 8 percent in the first two years.⁶ Figure 1.1 contrasts the projected state employee health plan reserves before the reform with the actual results of the reform. According to an independent evaluation of the plan, Montana achieved savings of \$30.3 million for inpatient care and \$17.5 million for outpatient care in the first three years.⁷ As a testament to the reform's success, employer and employee premiums have not changed since 2016, and they are projected to remain flat through 2023.⁸ The Montana legislature passed two bills to allow employer premium holidays and to retain the funds—\$25.4 million in 2018 and \$27.9 million in 2021.

Other states could follow Montana's example. The recommendations in this chapter are less sweeping than what Montana did and thus should represent an easier political lift than setting all hospital rates in the state employee health plan as a percentage of Medicare rates. But effectively implementing the recommendations could lead to a significant drop in total spending

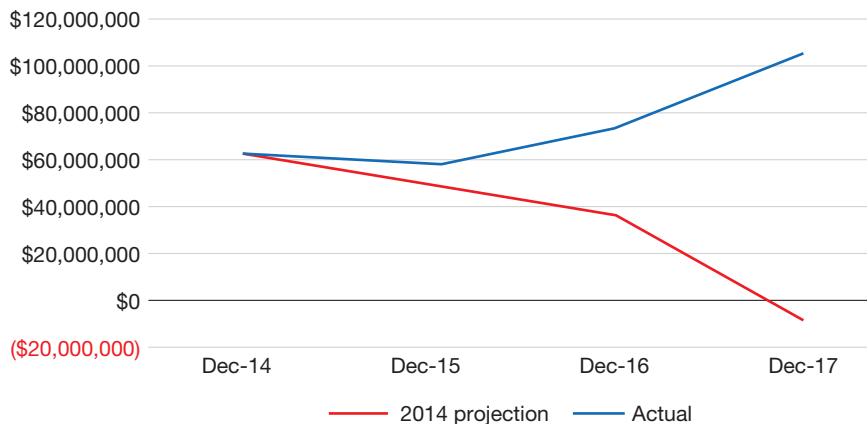


Figure 1.1 State health plan reserves.

on public employee health benefits. Moreover, because state employee health plans have many members, external benefits will likely accrue to private-sector employers and employees—both through lower health care prices that the reforms produce and by influencing private sector employer adoption of similar reforms.

OPTIONS FOR STATE EMPLOYEE HEALTH PLAN REFORM

States should only enter into agreements with third-party administrators (TPAs) that agree to transparency about the plan, including price and claims information

Writing in *Health Affairs* in 2019 about employer efforts to constrain health care prices, Gloria Sachdev, Chapin White, and Ge Bai note, “One reason for employers’ lack of success in health care cost containment efforts is their limited awareness of the prices they are paying providers. Just like consumers in other markets, employers need to know the prices that their insurance carriers have negotiated for them.”⁹ Perhaps surprisingly, many states have difficulty accessing this information for their state employee health plans. When limited data is analyzed, significant problems appear, such as overpayments by the third-party administrator (TPA) managing Tennessee’s state employee health plan.¹⁰ ClaimInformatics, which performed an analysis for Tennessee at no charge to the state, found \$17.6 million of overcharges on nearly 150,000 claims for professional services.¹¹

As an example of the power of transparency, a May 2019 report on hospital prices from the RAND Corporation found that Parkview hospital system based in Fort Wayne, Indiana, was among the highest-priced hospital systems in its study of hospital prices across 25 states.¹² These findings caused local employers to push for reform. According to Anthem, Parkview agreed to lower its prices for hospital services by more than 25 percent.¹³

States should consider permitting the state employee health plan to merge with group purchasing organizations to obtain better value for plan members

States should consider allowing employers within the state to join the state employee health plan to gain negotiating leverage with health systems. Many of Colorado's public employers have joined about a dozen other employers in the state to form the Colorado Purchasing Alliance.¹⁴ This purchasing alliance is using data to determine regional centers of excellence (facilities and providers with a favorable price-quality mix) and direct plan members to those facilities and providers for services and procedures that those facilities excel at providing. The alliance is also harnessing the increased purchasing power of its membership to obtain better prices for services, looking at local facilities and providers as well as those outside Colorado.

States should insist on bottom-up pricing and refuse to set any rates as discounts from billed charges

The "chargemaster rates" that hospitals and other health care providers bill are substantially inflated and do not resemble anything close to a market price, yet many contracts are negotiated for payment as a percentage discount off these "prices." After hospitals sign contracts with insurers or TPAs, they often increase these "prices," which ratchets up the payments they receive. Standard hospital contracts often also include an escalator clause, resulting in a guaranteed automatic increase every year. These payment structures are inherently inflationary. At a minimum, states should ensure that what they pay does not automatically increase when a hospital raises its chargemaster rates. The contract a state signs with a TPA must clearly state that a plan will not pay the additional amounts related to increased chargemaster rates or escalator clauses. The state should put a performance guarantee into the contract.

States should prohibit the use of facility fees in the state employee health plan if inpatient hospital-based care is not necessary

Many plans pay more for outpatient services performed in a hospital or its affiliated facilities than at an independent doctor's office. This is largely because hospitals and their affiliates charge "facility fees." A facility fee is a charge intended to compensate for the operational expenses of the hospital or health system, separate and distinct from the physician or medical provider's professional fee.

A bill for an office visit at a hospital-owned medical practice will often include a facility fee, meaning that the plan will pay much more for the same episode of care at a hospital-owned facility than at an independent doctor's office. Similar differential payments occur for medical procedures performed in a hospital outpatient department compared to lower-priced ambulatory surgical centers (ASCs) that are not owned by a hospital. These payment differentials raise state employer health plan expenditures. Moreover, they lead to more consolidated health care markets by incentivizing hospitals to purchase independent physician practices, imaging centers, and ASCs. The reduction in competition means higher prices and spending. Moreover, there is evidence that nonhospital facilities, such as ASCs, provide a higher quality of care and achieve better outcomes than hospitals.

Medicare has taken action to reduce the extra payments received by hospital-affiliated facilities for identical services that can be provided in physician offices. In a 2019 Medicare payment rule, the Centers for Medicare and Medicaid Services reduced government payments for evaluation and management services provided at off-campus hospital sites to what Medicare pays physicians for services delivered in their offices.¹⁵ Doing so saves taxpayers and beneficiaries money and reduces the incentive for hospital systems to acquire physician offices, which improves competition in local health care markets.

The National Academy for State Health Policy (NASHP) has proposed model legislation—patterned after Medicare payment policies—that prohibits the payment of facility fees for services located more than 250 yards from a hospital campus.¹⁶ It also prohibits facility fees for typical outpatient services that are billed using evaluation and management codes, even if those services are provided on a hospital campus. In other words, facility fees can only be charged for procedures and services provided on a hospital's campus, at a facility that includes a licensed hospital emergency department, or for emergency procedures or services at a freestanding emergency facility.¹⁷

The NASHP model legislation prohibits inappropriate facility fees across the board and may be, understandably, too sweeping for policymakers reluctant to interfere in private contracts. However, states should prohibit their state employee health plan from paying facility fees for all outpatient evaluation and management services, along with any other outpatient, diagnostic, or imaging services identified by states as inappropriate for facility fees, regardless of the location of the service. To effectuate this recommendation, states would put this requirement into their TPA contracts, along with conducting an audit of facility fees after each plan year.

States should utilize reference prices and shared savings for shoppable services

Reference pricing has demonstrated success in lowering health care prices and spending. Under reference pricing, the employer or insurer agrees to pay a set amount per procedure or service regardless of the provider chosen and the amount charged. The employee remains free to receive care from a provider that charges more, but the employee is then responsible for the difference between that provider's rate and what their plan pays (the reference price). Consumers thus retain broad choice among providers but have strong incentives to avoid high-priced ones.

Reference pricing is most applicable for "shoppable" and relatively standardized services such as laboratory tests, imaging, blood work, and orthopedic procedures such as knee and hip replacements. For reference pricing to be successful in producing overall savings and a more efficient health sector (by moving services from higher-priced providers to lower-priced providers and getting high-priced providers to reduce unnecessary costs), it needs to cause a shift in consumer behavior.

Like reference pricing, shared savings models provide employees with an incentive to use lower-priced providers. Through shared savings, employees receive a portion of the savings achieved when they choose a lower-priced provider. For example, if a reference price for a service is set at \$1,000 and the employee obtains the service for \$800, the employer might provide the employee with a portion of the \$200 savings. This could be utilized to reduce the patient deductible or could be provided as a cash payment to the individual.¹⁸ New Hampshire and Kentucky have had positive results with shared savings payment structures.¹⁹

There are two prominent examples that show the benefits of reference pricing. In 2011, the California Public Employee and Retiree System

(CalPERS) implemented reference pricing for several shoppable services, including orthopedic procedures and colonoscopies. Also in 2011, Safeway implemented reference pricing for laboratory tests and images for 492 procedures and services. In both cases, spending above the reference price did not count toward the member's deductible or out-of-pocket maximum.

The California experience shows that reference pricing incentivized employees to shop, caused high-priced providers to significantly lower prices, and led to large average price and spending reductions. According to a 2018 paper by the American Academy of Actuaries (AAA), "Evaluations of CalPERS' more expensive surgical services report consumer switching rates ranging from 9 percent to 29 percent; evaluations of Safeway's less expensive diagnostic services report switching rates of 9 percent to 25 percent."²⁰ Table 1.1 is reproduced from the AAA paper and summarizes the effects of reference pricing models for CalPERS and Safeway. Average savings of around 20 percent were achieved with the reference pricing payment system.

In a 2014 study, Chapin White and Megan Eguchi defined a set of 350 shoppable services that would be well suited to reference pricing.²¹

TABLE 1.1 Reference pricing in practice, impact on savings and behavior

System	Procedure(s)	Reference price percentile	Savings (%)	Consumers switching (%)	Reduction in high-priced provider prices (%)
CalPERS	cataract surgery	66th	17.9	8.6	NA
CalPERS	colonoscopy	66th	21.0	17.6	NA
CalPERS	hip and knee replacement	66th	20.2	28.5	34.3
CalPERS	arthroscopy: knee	66th	17.6	14.3	NA
CalPERS	arthroscopy: shoulder	66th	17.0	9.9	NA
Safeway	492 CPT codes, lab services	50th	20.8	12.0	NA
Safeway	diagnostic lab testing	60th	31.9	25.2	NA
Safeway	imaging: CT	60th	12.5	9.0	NA
Safeway	imaging: MRI	60th	10.5	16.6	NA

Note: NA means that the reduction in provider prices was not an aspect of the analysis.

Source: American Academy of Actuaries, "Estimating the Potential Health Care Savings of Reference Pricing," November 2018, <https://www.actuary.org/sites/default/files/files/publications/ReferencePricing11.2018.pdf>.

Assuming a reference price set at the 65th percentile of allowed amounts, with 30 percent of consumers switching from higher- to lower-priced providers, White and Eguchi estimated that spending on the 350 shoppable services could be reduced by 14 percent, equating to a total reduction in health care spending of 5 percent. The AAA, which estimated savings using a variety of assumptions and reference price thresholds, projected savings similar to those of White and Eguchi, with the impact on expenditures greater from providers lowering prices than from consumers switching providers.²²

Crucially, when evaluating CalPERS, economists Christopher Whaley and Timothy Brown found that about 75 percent of the price reductions spilled over to the non-CalPERS population, meaning that people benefited from the implementation of reference pricing even if they did not directly shop.²³ This happened because many providers lowered their prices across the board for these services. This demonstrates that a state's action to employ reference pricing for its public employee health plan will also provide benefits to many others outside the state.

Utilizing individual coverage HRAs

Since 2020, employers have been able to provide employees with contributions through health reimbursement arrangements (HRAs) allowing employees to purchase coverage in the individual health insurance market. These plans are comprehensive and must comply with Affordable Care Act requirements. In general, individual coverage HRAs provide employees with much greater choices of coverage and help employers by lessening their administrative burden along with providing greater cost predictability. Employees do not pay income or payroll taxes on the HRA contribution. One option for states is to transition state employees into the individual market by using an individual coverage HRA. A bonus with this policy is that it would almost certainly improve the state's individual health insurance market. Individual coverage HRAs should produce more engaged and cost-conscious consumers. By increasing choice and empowering more people to shop for health plans in the individual market, individual coverage HRAs should spur a more competitive individual market that drives health insurers to deliver better coverage options to consumers.

OVERCOMING OBSTACLES INSIDE AND OUTSIDE GOVERNMENT

While no states have taken the sweeping steps that Montana took to reduce expenditures in its state employee health plan, some states are acting. Public employees in Colorado are joining with local businesses to demand better deals and utilize regional centers of excellence. The state of Indiana insisted that the TPA managing its employee health plan, which it put out for bid, create a preferred tier of providers who have agreed to accept payments that are a percentage of Medicare rates.

The reforms outlined in this chapter do not represent an all-or-nothing approach, and states can implement them in stages. For instance, a state may wish to start with demanding transparency of the TPA that manages the state employee health plan, requiring access to their claims data in order to perform deep dive analytics and attempt to minimize unnecessary and wasteful expenses.

There are two main obstacles to state employee health plan reform: obstacles within the government and obstacles outside the government. First, state bureaucracies tend to avoid actions that might upset public employees. State action to reform the state employee health plan might be framed by opponents of such action as a reduction in benefits. State government leaders often lack incentives to pursue meaningful state employee health plan reform, so it often takes leaders who are intensely interested in being wise stewards of public resources. Hiring the right people in positions such as budget director and head of the office of state personnel is crucial.

Second, the health care industry has enormous political power, and the status quo generates large industry profits. Properly structured reform would reduce profits of both health insurers and hospital systems, particularly the higher-priced ones, in the state. These industries will resist reform. For example, hospitals will strongly resist the recommended prohibition on inappropriate facility fee charges in the state employee health plan.

There is also another more practical obstacle—restructured benefit designs may generate confusion if there is not sufficient education about the changes. For example, while reference pricing holds the promise of large savings, plan enrollees need to be properly educated about how the structure works. States should make an expert or a professional service available to work with employees and family members if they need help in choosing providers. There are many applications and benefits experts who will help

employers educate employees and make shopping as easy as possible for plan members.

CONCLUSION

State governments have significant influence over the health policy within their state. One underappreciated way that government can affect policy in their state is by the design of their employee health plan. By taking the steps discussed in this chapter, states can improve the efficiency of their employee health plan. Such steps will produce external benefits in the state through both lower prices and providing a model of feasible reforms for private employers.

ENDNOTES

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Manage Effectively

Make Medicaid More Accountable

Jonathan Ingram

KEY TAKEAWAYS

- Medicaid was designed as a safety net for the truly needy, but, over time, the program has gotten further away from that purpose, leading to skyrocketing enrollment and costs.
- In 2020, more than one in four dollars spent on Medicaid was improper. Improper enrollment largely results from the failure of states to properly verify income, citizenship, residence, incarceration status, and even whether people are still alive.
- States can help preserve resources for the truly needy by ensuring those enrolled in the program are eligible, including better screening on the front end, more frequent postenrollment reviews, rolling back optional exemptions, and improving enforcement.
- States should also prepare for the end of the COVID-19 public health emergency by beginning to conduct eligibility reviews throughout the year and performing a financial analysis of whether the 6.2 percent increase in federal matching funds is outweighed by the increased state costs from covering so many ineligible enrollees.

PROBLEM

Medicaid was designed as a safety net for the truly needy, including seniors, individuals with disabilities, and low-income children, but, over time, the program has gotten further and further away from that purpose, leading to

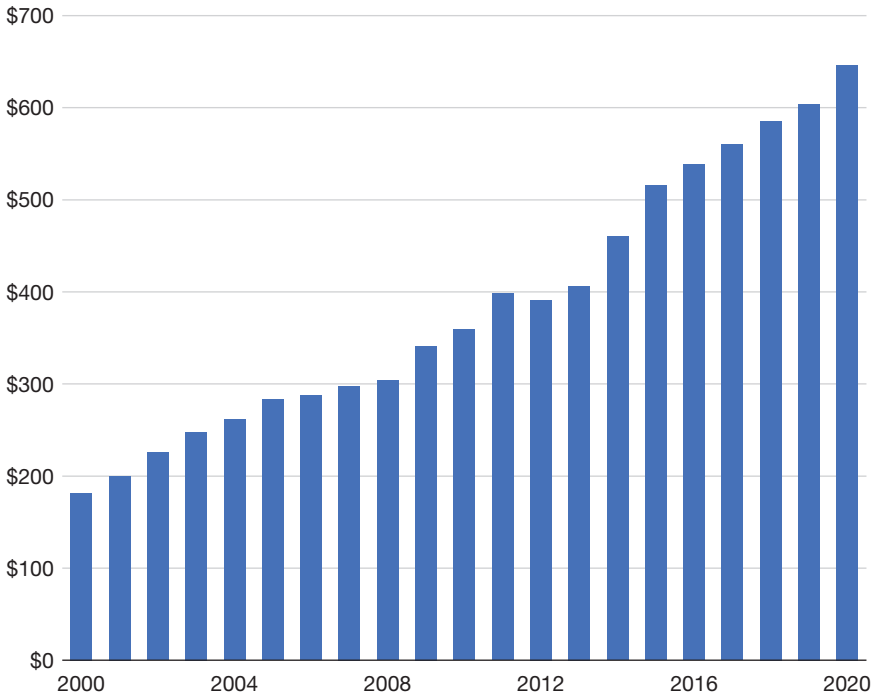


Figure 2.1 State and federal Medicaid spending by year (in billions). Medicaid spending has more than tripled since 2000.

Source: National Association of State Budget Officers.

skyrocketing enrollment and costs. State and federal spending on Medicaid has more than tripled since 2000 (see Figure 2.1), with able-bodied adults the fastest growing enrollment group, both before, but especially after, the Affordable Care Act (ACA) expanded eligibility to a new class of able-bodied adults.¹⁻³

Between 2013 and 2018, able-bodied adult enrollment nearly doubled, while enrollment in the rest of the Medicaid program grew by just 2 percent.⁴ In states that opted into the ACA expansion, more than twice as many able-bodied adults signed up for the program as states expected, with a much higher cost—nearly double the cost per person—than federal officials projected.⁵⁻⁶

In California, for example, state officials expected just 910,000 able-bodied adults would sign up for expansion by 2020.⁷ The state shattered those projections in less than a month.⁸ In 2021, more than 4.2 million

able-bodied adults in California were enrolled in Medicaid expansion, costing taxpayers billions of dollars more than anticipated.⁹⁻¹⁰ In fact, Medicaid expansion has cost significantly more than expected in every expansion state with available data.¹¹

Medicaid also plays a large role in why Americans are generally underprepared for long-term care, as the program has largely supplanted the private long-term care insurance market for upper- and middle-class families.¹² Long-term care costs now represent nearly a third of states' entire Medicaid budgets, with these costs making up more than half of all Medicaid expenditures in some states.¹³ Eligibility expansions, increased income and asset exemptions, and sophisticated "Medicaid planning" techniques have ensured that virtually anyone who chooses can become eligible for Medicaid long-term care benefits, including millionaires.¹⁴

As Medicaid enrollment and costs have continued to spiral out of control, and as accountability for the program has eroded, states have increasingly struggled to manage it effectively. More than one in four dollars spent on Medicaid today is improper.¹⁵ Before the ACA was implemented, improper payments accounted for 6–8 percent of Medicaid spending.¹⁶

While provider fraud often makes the headlines, the reality is that roughly 80 percent of improper payments are tied directly to eligibility errors (see Figure 2.2).¹⁷ Unfortunately, the Obama administration suspended its review of states' eligibility determinations in 2014, which stayed on pause until the Trump administration restarted it in 2018 (and as reflected in a 2019 report).¹⁸

In New York, for example, federal auditors projected that more than one million ineligible and potentially ineligible enrollees were in the program.¹⁹⁻²⁰ Nearly 100,000 ineligible or potentially ineligible expansion enrollees were estimated in Colorado, and more than 100,000 potentially ineligible enrollees were estimated in Kentucky.²¹⁻²³ In Ohio, a federal audit concluded that nearly 300,000 of the state's 481,000 expansion enrollees were ineligible or potentially ineligible, and federal auditors estimated nearly 1.2 million ineligible enrollees and another 3.2 million potentially ineligible enrollees in California's Medicaid program.²⁴⁻²⁶

Improper enrollment largely results from the failure of states to properly verify income, citizenship, residence, incarceration status, and even whether people are still alive. Some individuals have multiple enrollments in the same state or across states. Applicants may submit false information and fail to update key information, such as a large income change. Many individuals are

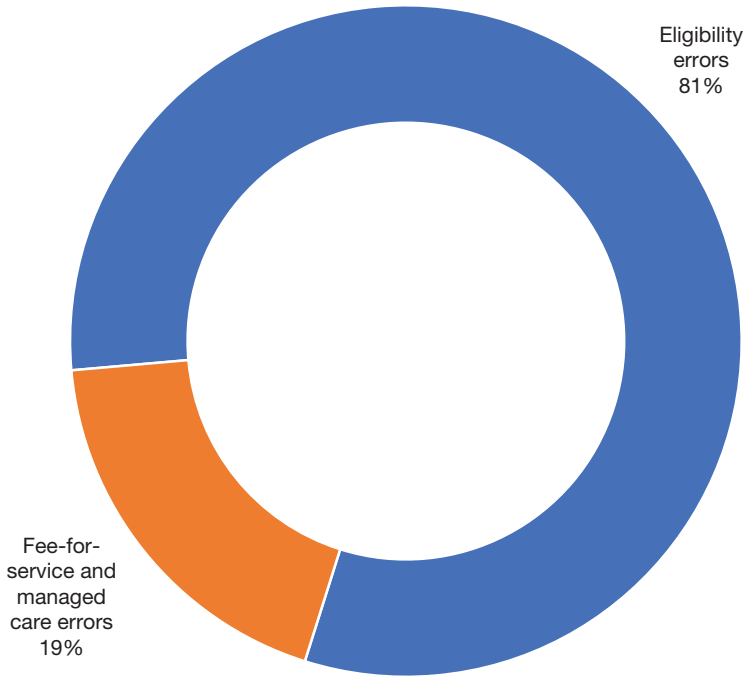


Figure 2.2 Source of improper Medicaid payments in 2020 PERM cycle. Eligibility errors cause most improper Medicaid payments.

Source: U.S. Department of Health and Human Services.

incorrectly determined eligible by HealthCare.gov, hospitals, or other providers using presumptive eligibility. Because managed care companies receive a flat monthly premium for every enrollee—regardless of whether the enrollee is actually eligible—the incentives align with improper enrollment. While some hope that managed care could reduce Medicaid’s cost growth, it could make costs spiral even further out of control. For example, some amount of state payments to insurers are for individuals who have died, moved out of state, are otherwise ineligible, or who utilize little, if any, health services.

Self-Attestation

One of the biggest program integrity issues in Medicaid is the acceptance of self-attested information. Many states accept applicants’ attestation for a

variety of information, including income, household size, household composition, and more. For example, all states accept self-attestation for household composition despite having access to tax return information and other relevant sources, 45 states accept self-attestation of residency, and at least 15 states accept self-attestation of income to some degree.²⁷ Once accepting this information, states may not verify it until months later and sometimes not at all.²⁸ A Louisiana audit, for example, found tens of thousands of ineligible individuals who were allowed to enroll in the program because the state did not verify self-attested information on household size, composition, or certain types of income.²⁹ New Jersey auditors identified thousands of enrollees with unreported six-figure incomes, including some earning as much as \$4.2 million per year.³⁰ In Minnesota, at least 15 percent of enrollees misreported their incomes to the Medicaid agency, with the average enrollee having nearly \$21,000 in underreported income.³¹ Several of these cases included individuals who self-attested to no income but who had income far above the eligibility limits.³²

Unreported Changes in Circumstances

Although individuals are legally required to report changes in their circumstances that may affect eligibility, few do. An Illinois audit of the state's passive redetermination processes discovered that more than 93 percent of all eligibility errors resulted from enrollees reporting incorrect information or failing to report changes in their income, household composition, and more.³³ New Jersey auditors identified a number of cases where individuals did not report changes as legally required, including one individual who had wages of nearly \$250,000—nearly 15 times the eligibility threshold.³⁴

Presumptive Eligibility

A growing Medicaid program integrity problem involves “presumptive” eligibility determinations—a process whereby Medicaid programs pay for expenses incurred by individuals before eligibility is verified. In a 2019 audit, the U.S. Department of Health and Human Services estimated that roughly 43 percent of sampled spending on presumptively eligible enrollees was improper.³⁵ Data from state Medicaid agencies reveals that such improper payments could be higher.³⁶

The problem may be growing worse since the ACA allowed hospitals to make presumptive eligibility determinations for all able-bodied adults regardless of whether states prefer to limit hospitals' ability to deem people eligible for Medicaid. Hospitals do not have incentives to ensure that people meet eligibility requirements, and they have done a poor job of assessing applicant eligibility before enrollment. Data provided by state Medicaid agencies reveals that just 30 percent of individuals that hospitals determined "presumptively eligible" were ultimately determined eligible for Medicaid by the state.³⁷ In California, for example, nearly 500,000 individuals were determined presumptively eligible by hospitals between April 2019 and March 2021, but the state enrolled only 155,000 after completing full eligibility reviews.³⁸ Under federal regulations, states also have no way to recoup their share of this improper spending.³⁹

Payments for the Deceased, Nonresidents, and Prisoners

State and federal audits have uncovered hundreds of millions of dollars in Medicaid funding spent on deceased individuals.⁴⁰⁻⁵⁴ In California, nearly a third of deceased individuals still enrolled in the program had been dead for more than a year.⁵⁵ Audits have also uncovered millions spent on individuals who had moved out of state or who may never have lived in the state in the first place. Missouri and Minnesota auditors identified thousands of Medicaid enrollees with out-of-state addresses.⁵⁶⁻⁵⁷ In Arkansas, nearly 43,000 out-of-state enrollees were discovered in the program.⁵⁸ To make matters worse, nearly 7,000 of those enrollees had no record of ever having lived in the state.⁵⁹

States have also discovered individuals enrolled in Medicaid while in state or federal prison, even though federal law generally prohibits states from using Medicaid funds to pay for inmates' medical care. In Missouri, for example, the Medicaid program paid managed care companies millions of dollars to cover individuals who were incarcerated and unable to utilize Medicaid services.⁶⁰ Similarly, Arkansas auditors identified more than 1,000 prisoners enrolled in Medicaid, many of whom were not expected to be released for five or more years.⁶¹

Double Enrollment

State and federal audits have also identified tens of thousands of individuals who enrolled multiple times in the same state.⁶²⁻⁶⁹ In some cases,

individuals had as many as seven different open Medicaid cases.⁷⁰ States then paid managed care companies multiple capitated premiums for the same individuals, costing taxpayers millions of dollars.^{71–76}

High-Risk Identities

In many cases, duplicate enrollment may result from identity fraud. In Arkansas, auditors discovered more than 20,000 enrollees with high-risk identities.⁷⁷ These included individuals with stolen or fraudulent Social Security numbers linked to multiple people.⁷⁸ A similar audit in New Jersey identified more than 18,000 enrollees with fake or duplicate Social Security numbers.⁷⁹

Faulty Exchange Determinations

Some states are adopting eligibility mistakes made by the federal government. States have the option to either assess the eligibility of individuals who have applied for coverage through HealthCare.gov or simply accept its determinations. Auditors have found a number of cases where HealthCare.gov's determinations were incorrect and where even cursory reviews of state data would have prevented eligibility errors.⁸⁰ States have reported thousands of cases of incorrect Medicaid determinations by HealthCare.gov.⁸¹

The Problematic Maintenance of Effort

States have been hamstrung in their abilities to address program integrity during the COVID-19 pandemic. As part of the Families First Coronavirus Response Act (FFCRA), states can increase federal taxpayers' share of traditional Medicaid funding by an additional 6.2 percent.⁸² In order to receive these funds, however, states must agree not to make changes to the eligibility or enrollment process and not remove ineligible enrollees.⁸³ States frequently report that 30 percent or more of cases reviewed at their annual redetermination are no longer eligible, meaning states are paying for millions of enrollees nationwide who are no longer eligible or who may never have been eligible.⁸⁴

In California, for example, Medicaid enrollment has spiked by more than 1.2 million people—nearly 10 percent—since March 2020, but a state enrollment review revealed that the entire *net* increase in enrollment was caused by federal rules prohibiting the state from removing people who were no longer

eligible.⁸⁵⁻⁸⁶ Likewise, Arizona’s Medicaid enrollment has increased by nearly 360,000, but Medicaid officials indicate that as many as 300,000 current enrollees are ineligible.⁸⁷

Harming the Truly Needy

Nearly 820,000 individuals nationwide are on waiting lists for home- and community-based services and support.⁸⁸ The average wait time for individuals with intellectual or developmental disabilities—who make up the vast majority of those waiting for needed services—is nearly six years.⁸⁹ In some states, the average wait can be as long as 14 years.⁹⁰ Since the ACA’s Medicaid expansion began, at least 22,000 individuals on Medicaid waiting lists have died.⁹¹

Crowding Out Other State Priorities

Medicaid is the largest and the fastest-growing program in state budgets and is crowding out funding for other priorities (see Figure 2.3). In 2000,

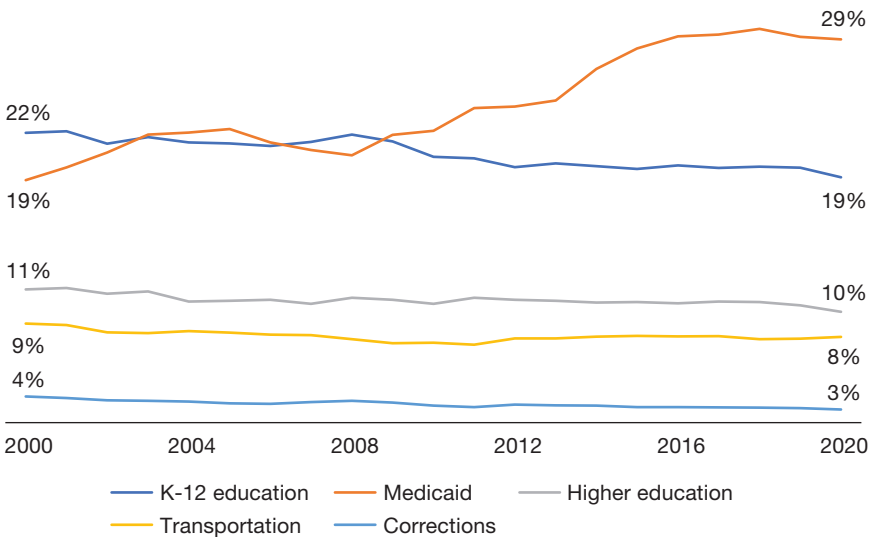


Figure 2.3 Medicaid’s share of total state budgets by year, showing that it is consuming more and more of states’ budgets.

Source: National Association of State Budget Officers.

Medicaid spending accounted for roughly one in five dollars in states' budgets.⁹² By 2020, that figure had reached nearly one in three.⁹³ In some states, Medicaid consumes nearly 40 percent of the state budget.⁹⁴ Because Medicaid spending is growing nearly three times as fast as state tax revenues, more and more funding must be diverted from other areas, such as education, infrastructure, and public safety.⁹⁵⁻⁹⁶

PROPOSAL—GREATER ACCOUNTABILITY IN MEDICAID

While Washington policies push Medicaid further and further from its core purpose, states can improve the program for those who truly need it and be better stewards of taxpayer dollars. This starts with ensuring that those enrolled in the program are eligible. States can take action now, regardless of federal government policy.

Prepare for the End of the COVID-19 Emergency

In response to the Maintenance of Effort (MOE) restrictions imposed by FFCRA, many states stopped conducting eligibility reviews altogether. When the government declares the public health emergency over, these states will face a massive backlog of overdue redeterminations. States should begin to prepare now by commencing eligibility reviews throughout the year. For those states that have paused redeterminations, that means restarting the reviews immediately. This will ensure that states are prepared to remove ineligible enrollees as soon as the emergency ends. As part of that preparation, states should also conduct a financial analysis of whether the 6.2 percent increase in federal matching funds is outweighed by the increased state costs from being unable to remove ineligible enrollees, as the number of ineligible enrollees will continue to grow throughout the declared public health emergency. As states prepare for these changes, they should ensure better verification on the front end, increase data matching processes on an ongoing basis, roll back optional exemptions, and improve enforcement.

Audit of the Medicaid Program

States should also conduct a full-scale audit of the Medicaid program, including eligibility verification processes, utilization rates, managed care rates,

duration of individuals enrolled through retroactive or presumptive eligibility, and more. These audits are justified by the high, pre-COVID, improper payment rate in the program, as well as the dramatic program changes that have occurred during the public health emergency. The audits should provide valuable information for states as they seek to introduce reforms into their programs.

Better Verification on the Front End

States must perform better initial verification of Medicaid eligibility. Instead of accepting self-attestation for income, household size, and household composition or only conducting postenrollment verification months later, states should once again verify this information before enrolling applicants. States already have access to a variety of data that can help verify eligibility, including employers' quarterly wage reports, state tax filings, and commercial databases already in use for other purposes. Medicaid agencies should set up data-sharing arrangements with other state agencies to begin using this data.

States should also stop accepting eligibility determinations from HealthCare.gov, as the federal exchange lacks important data that states maintain and has a history of significant errors. Instead, they should assess the eligibility of applicants submitted through HealthCare.gov, just as they do all other applications.

States should improve their performance benchmarks for hospitals and other providers that incorrectly determine someone is presumptively eligible for Medicaid. Maine, for example, instituted a commonsense "three strikes" policy for presumptive eligibility.⁹⁷ Under this policy, all hospitals making presumptive eligibility determinations in Maine were given extensive training on the determination process.⁹⁸ After the first strike—where a hospital incorrectly determined an individual was presumptively eligible—the Medicaid agency sent a notice explaining which standards the hospital failed to meet and warned that a second incorrect determination would require additional training.⁹⁹ After the second strike, the agency sent another notice and warned that the third strike would result in the hospital no longer being authorized to perform presumptive eligibility determinations.¹⁰⁰ After the third strike, the agency sent a notice of which standards were not met and confirmed that the hospital could no longer make presumptive eligibility determinations.¹⁰¹

More Ongoing Reviews

Most states only perform eligibility reviews once per year, even though many, if not most, individuals experience life changes, such as finding a new job, a change in salary, moving to a new state, getting married, or even death, during the year. States already receive reports from employers when they make new hires as well as receiving quarterly wage reports. The Medicaid agency should be crosschecking this data as it receives it, ensuring that it knows when enrollees' circumstances change, rather than waiting a year to check.

States also maintain death records for their residents and have access to federal and commercial death registry data. The Medicaid agency should be reviewing this data monthly, removing dead enrollees from the program to avoid paying managed care companies for individuals who are dead.

States also have access to a variety of data to ensure that those in the program still reside in their state. More active participation and use of data-sharing arrangements with other states—such as the Public Assistance Reporting Information System and the National Accuracy Clearinghouse—would provide additional notice when enrollees apply for benefits in other states, but data sharing between welfare programs would improve program integrity even more. For those Medicaid enrollees also receiving food stamps or cash welfare, states could review monthly out-of-state food stamp transactions to identify individuals who have likely moved out of state.

States must then do a full eligibility redetermination when changes in enrollees' circumstances suggest the enrollee is no longer eligible. Collectively, these reforms have produced hundreds of millions of dollars in savings, their administrative costs have been accommodated within existing resources, and the potential savings far exceed implementation costs.^{102–104}

Roll Back Optional Exemptions and Improve Enforcement

States should also take action to minimize the ease with which relatively affluent people can have their long-term care expenses paid by Medicaid. For example, under federal law, states must exempt up to \$603,000 in home equity from their resource limits when determining eligibility for Medicaid long-term care, but states can extend that exemption beyond the federal minimum, and many have done so.^{105–106} In most states that have extended

the exemption, individuals can exempt up to \$906,000 in home equity from the asset limits.¹⁰⁷ In some states, such as California, applicants can exempt an unlimited amount of home equity.¹⁰⁸ In order to preserve resources for the truly needy, states should immediately return to the federal standards for home equity exemptions for all new long-term care applicants, as Illinois did in 2012.¹⁰⁹ While additional changes are needed at the federal level to return the program to its intended purpose, this will help states begin charting that path.¹¹⁰

States should also improve enforcement of their estate recovery efforts. Although federal law requires that states recover Medicaid enrollees' long-term care costs from their estates, there is wide variation in the kinds of costs states try to recoup and even whether states try to recover funds at all.¹¹¹ When states fail to meaningfully engage in estate recovery, heirs can receive large inheritances while taxpayers are left covering those expenses.

CONCLUSION

Irrespective of federal policy and whether states adopted the ACA Medicaid expansion, states should responsibly manage their Medicaid programs. With a federal Medicaid improper payment rate above 25 percent, there is a lot of work to do. Unfortunately, many of the institutions that are financially benefiting from these improper payments or benefit politically from higher welfare enrollment are likely to oppose commonsense program oversight and accountability, but Medicaid does not exist to funnel unlawful payments to hospitals and insurance companies, where funds meant for the truly needy are instead siphoned away through waste, fraud, and abuse.

ABOUT THE AUTHOR

Jonathan Ingram is vice president of policy and research at the Foundation for Government Accountability (FGA), where he leads a team that develops and advances policy solutions to help millions of people achieve the American Dream. Prior to joining FGA, he served as the director of health policy and pension reform at the Illinois Policy Institute and as editor-in-chief at the *Journal of Legal Medicine*. He holds a BA in history and English, an executive MBA, and a JD. His passion for reducing dependency resulted in Illinois governor Bruce Rauner appointing him to serve on the Illinois Health Facilities and Services Review Board in 2016. He has

testified before numerous state legislative committees, and his research and commentary has earned coverage from the *Wall Street Journal*, the *Chicago Tribune*, *Crain's Chicago Business*, *Forbes*, *USA Today*, and Fox News, among other media outlets.

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Maximize Choice

Open Up Coverage Options

Charles Miller

KEY TAKEAWAYS

- Affordable Care Act plans do not meet the needs of many Americans because of one-size-fits-all requirements and unaffordable premiums.
- States can add more affordable and flexible options for their residents, including Farm Bureau plans and short-term plans.
- These options have a proven track record and do not disrupt the existing insurance market or increase costs for existing enrollees.

PROBLEM

Health insurance offered on the Health Insurance Marketplace exchanges under the Affordable Care Act (ACA) are failing to meet many families' needs, even as their cost to taxpayers explodes. Nearly 30 million Americans remain uninsured, but the lack of affordable options also impacts those who remain in jobs solely to keep their employer-sponsored insurance.

If current trends continue, America's economic strength will be negatively impacted by the increased drag of the cost of health care and health insurance as it results in less money in workers' paychecks, and fewer jobs as employers divert money away from new hiring to paying the benefits of current workers. Even worse is that as costs go up, patients put off medically

necessary care, and their health may suffer. Both those with insurance and those that are uninsured need more affordable options.

Who Are the Uninsured?

The uninsured in America come from all walks of life (see Figure 3.1). Of the nearly 29 million uninsured Americans in 2019,¹ only about 21 percent were below the federal poverty line (FPL), but a similar amount—about 17 percent—were earning more than 400 percent of the FPL (for a family of four, that is about \$106,000 annually). The overwhelming majority (73 percent) live in households with at least one full-time worker.

As an illustration, in Texas there were nearly five million uninsured residents as of 2018 (see Figure 3.2). If Texas were to expand Medicaid, only about 16 percent of the uninsured would be newly eligible for coverage. By comparison, there are nearly 1.2 million uninsured Texans not eligible for any government assistance.² Even more already qualify for some form of government assistance, yet do not sign up because of concerns over cost or quality.

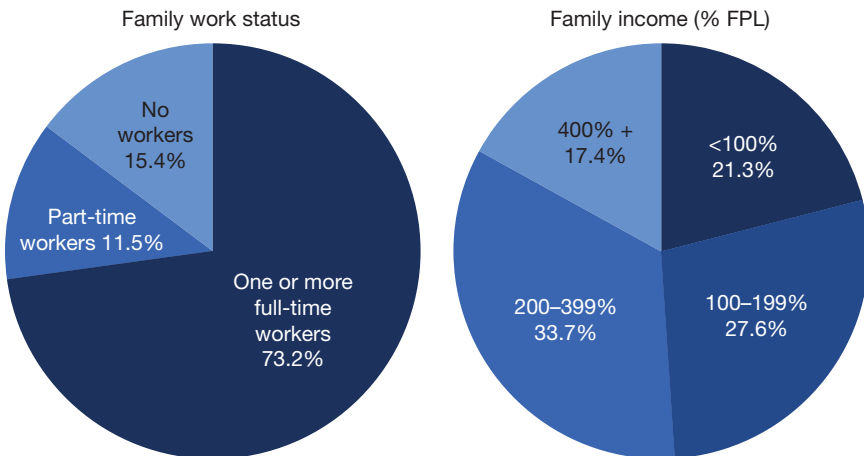


Figure 3.1 Uninsured by work status and income level.

Source: Graphic reproduced from Kaiser Family Foundation, <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/>.

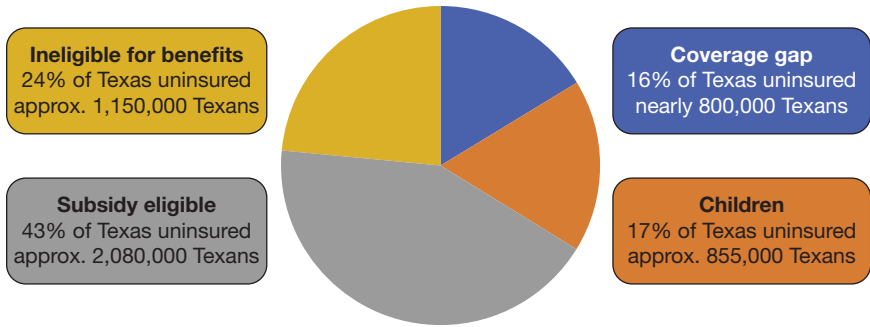


Figure 3.2 Breakdown of nearly five million uninsured Texans in 2018.

Health Insurance Is Increasingly Unaffordable

For those who are not eligible for any financial assistance, the cost of obtaining individual ACA coverage can be prohibitively expensive. As a result of the ACA, nationwide-average premiums for the individual market increased 105 percent from 2013 to 2017³ and soared another 30 percent in 2018 before stabilizing since then.⁴

The average annual ACA premium was over \$7,100 in 2020.⁵ The average deductible for single individual coverage was \$4,364,⁶ and the out-of-pocket limit for ACA plans was \$8,150.⁷ This means that an average individual was looking at paying over \$11,000 before their insurance started.

For those who are eligible for subsidies but have not chosen to sign up, the reasons could be a combination of both affordability and the quality of the insurance. Under the ACA, subsidies phase out as one's income increases and are smaller for younger individuals. For example, a Kaiser Family Foundation analysis estimates that the average monthly subsidy for a 27-year-old earning \$51,000 a year would only be \$9 a month, which when applied to an average silver-level plan premium of \$370 per month is only mildly helpful in making the plan more affordable.⁸ Because the premiums are so high, in many cases the amount of subsidy available—especially for younger and healthier Americans—is not enough to make ACA coverage a good value.

Price Is Not the Only Factor in Picking Coverage

The value of coverage is determined by both quality and price. Avalere found that 72 percent of the 2019 ACA market was comprised of “narrow network” plans, defined as health maintenance organizations (HMOs) and exclusive provider organizations (EPOs),⁹ and that the percentage of narrow network plans has grown over time.¹⁰ These narrow networks mean that patients often have a limited choice of providers, and the plans may not include a patient’s current provider or health systems when seeking care.

Michael Cannon has explained that “Obamacare’s preexisting conditions provisions are creating a race to the bottom because these provisions still penalize high-quality coverage for the sick, reward insurers who slash coverage for the sick, and leave patients unable to obtain adequate insurance.”¹¹ Unable to charge actuarially sound premiums, the evidence suggests that insurers attempt to screen out the sickest patients by offering poor-quality coverage for certain expensive conditions.¹² For example, John Goodman found that not a single plan on the individual market in Texas included MD Anderson’s cancer center in-network, and similarly, the world-renowned Mayo Clinic in Minnesota was not in-network in any plans offered in that state.¹³

The lack of good options for individual coverage may also contribute to job lock, where individuals remain in a job to maintain their health insurance benefits. This prevents people from doing what they otherwise think is best for their life, such as changing jobs, starting a business of their own, reducing hours to take care of family members, or even retiring early.¹⁴

In sum, the combination of high premiums and narrow network products has resulted in ACA exchange enrollment that is only about 40 percent of what was projected.¹⁵ The overwhelming majority of exchange enrollees are lower income and qualify for enormous subsidies to purchase coverage. Middle-income households, particularly if the household is relatively young, have been priced out of the market through a combination of rising premiums and decreasing quality. These trends are leading to a growing population that is uninsured or seeking alternative coverage options.

PROPOSAL—ALLOWING MORE OPTIONS HELPS CONSUMERS

States should permit additional coverage options for their residents. These options, such as Farm Bureau plans and short-term health insurance plans (STPs), are permitted by the federal government and do not have to comply with all the regulatory barriers that have led to unattractive products in the individual market. These options help millions of Americans who have been left behind by the ACA.

By authorizing alternative health benefit plans, states can allow many consumers to access less costly coverage, with greater choice over what services to insure. Some consumers may not wish to insure relatively small expenses such as primary care visits, or want access to direct primary care or more team-based care models. These alternative health benefit plans allow such innovation and customization. Alternative benefit plans offer many consumers better value because they are not bound by ACA rules that create perverse incentives and that have led to a sicker risk pool and high premiums and deductibles for coverage.

Farm Bureau Style Plans

A Farm Bureau style plan is a type of alternative health benefit plan that is offered by a dues-paying member-based nonprofit professional or trade association. Tennessee's Farm Bureau has been offering coverage since the 1940s, and in 1993, the state exempted Farm Bureau plans from state insurance regulation.¹⁶ Over the past several years, Indiana, Iowa, Kansas, South Dakota, and Texas have authorized their Farm Bureaus to sell coverage that is not subject to state insurance regulation. The ACA only regulates plans that are defined as health insurance by the state and regulated as such by state insurance commissioners. Therefore, Farm Bureau plans, which are not considered insurance by the state and regulated by the state as such, are exempt from federal health insurance regulation, including the ACA. Of note is that the reinsurers of the coverage remain subject to regulation.

These plans utilize underwriting at the time of issuance, although nine out of ten applicants are offered coverage. After the initial underwriting, the plans are guaranteed renewable without premium increases if the individual gets sick, and the coverage can be kept as long as the individual remains a member of the association. In general, network access is extremely broad.

In Tennessee, the plans are popular with both consumers and regulators,¹⁷ with the Farm Bureau plans retaining 98 percent of members.¹⁸ The prices are far better than for ACA plans. Thirty-seven-year-old Jason Lindsey would have paid at least \$1,500 per month for a plan to cover his wife and two kids with an \$11,300 family deductible under the ACA. Through the Farm Bureau, his family is covered for \$480 per month. Jason's experience is similar to those of thousands of other families in Tennessee. Average savings for a family of four have been over \$800 per month for these plans.¹⁹

It is not just in Tennessee either. The Indiana Farm Bureau, which began offering plans in 2020, released the results of a survey of members in May 2021. Seventy-five percent of respondents said the health plan is less expensive than their previous coverage, with average savings of over \$350 per month. Ninety-six percent of respondents said they would recommend their Farm Bureau plan to others.²⁰ By comparison, a 2018 survey by America's Health Insurance Plans (AHIP) found that only 71 percent of respondents were satisfied with their employer-sponsored health insurance.²¹

Short-Term Plans

Short-term plans are exempt from the ACA's requirements, so they can cover all ACA benefits or just some of them. The Trump administration reversed Obama administration restrictions on short-term plans in 2018. This had the effect of permitting states to have more control over the length of the plans, allowing individuals to purchase them for initial coverage up to one year, renewable up to a total of three years. About half the states allow this full flexibility, and about half have shorter timelines or prohibit the sale of STPs. Moreover, insurers can combine short-term plans with separate option contracts that would allow an individual to obtain the equivalent of "guaranteed renewability" through STPs.

The wide networks, unique benefits, and cost savings make such plans especially valuable for individuals who think they might only need insurance for a short period of time, such as individuals who are between jobs, starting new companies, taking time off from school, or looking to retire early and "bridge" to Medicare.²² Despite critics' concerns about short-term plans, recent work has shown that trends in the ACA individual market are better in states that fully permit short-term plans than in those that restrict them.²³

Short-term plans can make smart financial sense and be the difference between having coverage or having no coverage at all. For example, Mike

Pirner had emergency gallbladder surgery two months after buying a short-term plan for about \$150 per month. The total costs associated with the procedure were near \$100,000, but Mike only had to pay his \$2,500 deductible, which was also his out-of-pocket maximum.

If Mike had been on a standard ACA plan, he would have paid an \$8,550 deductible, assuming the surgery was at a facility that was covered by his plan. Prior to purchasing a short-term plan, he had researched ACA plans and found the cost of the plans most similar to his short-term plan was above \$500 per month. The annual combined out-of-pocket costs plus the premium for an ACA plan would be near \$15,000—compared to about \$4,000 for his short-term plan. “An Obamacare plan was simply not an option,” he says, “For a time, I considered having no insurance at all, until I realized short-term plans made sense for my situation.”²⁴

OVERCOMING OPPOSITION

In 2021, the Texas legislature enacted legislation authorizing Texas Mutual and the Texas Farm Bureau to offer health benefits without those benefits being subject to insurance regulation. In general, opponents—special-interest groups and existing health plans—made three criticisms that serve as a helpful preview of what you should expect to see as arguments against giving residents more coverage options:

1. Allowing these plans would remove protections for people with pre-existing conditions (see Figure 3.3).
2. These plans would “cherry-pick” the healthiest people from ACA plans, making ACA plans more expensive.
3. These plans are unregulated “junk plans” that do not protect people.



AARP Texas  @AARPTX · Apr 22

#HB3924 and #HB3752 would return Texas to a time when you could be charged more or denied coverage based on your health status.

#txlege

Figure 3.3 Example of opposition messaging to bills authorizing alternative benefit plans.

Myth—These plans will harm people with preexisting conditions / Truth—People with preexisting conditions will continue to have exactly the same access to ACA plans

Individuals with preexisting conditions will continue to be able to purchase ACA-compliant plans just as before, with guaranteed issue and community rating provisions. Alternative health benefit plans do not remove those rules and do nothing to impact anyone’s access to ACA plans. Moreover, for the vast majority of people who purchase ACA plans, their share of the premiums would be unaffected since the subsidy structure limits the amount a household has to pay to a certain amount of premium—regardless of the total premium size.

Myth—Alternative health plans will “cherry-pick” the healthy members away from ACA plans, making ACA plans more expensive / Truth—There are very few “cherries” left to pick, and even if there were a large number, the vast majority of ACA enrollees are subsidized, so their net premiums would not increase

The current makeup of the ACA market makes it highly unlikely that this concern has merit. In short, there are not many “cherries”—low-risk individuals who are not heavily subsidized—left in the ACA for alternative health plans to “pick.” For the most part, these individuals never signed up for the ACA in large numbers.

The makeup of the uninsured compared to the makeup of those who enrolled in ACA plans is illustrative (see Figure 3.4). In Texas, for example, early enrollees in the ACA exchanges were disproportionately old compared to the uninsured population. While 18–34-year-olds represented 43 percent of the Texas uninsured population, they only represented 29 percent of ACA enrollees.²⁵ Meanwhile, those over 55 represented only 10 percent of uninsured Texans but 22 percent of ACA enrollees. As of the December 2020 open enrollment period, those figures had become even more skewed, with 18–34-year-olds representing about 25 percent of enrollees, while those over 55 comprising 27 percent.²⁶

Since their rocky start, the ACA exchanges have stabilized.²⁷ At this point, almost all enrollees are getting a subsidy²⁸ and therefore are unlikely to leave the exchange, since the subsidies are only available for exchange plans.

Both Farm Bureau and short-term plans mainly benefit those who are not currently purchasing ACA plans. In Iowa, an estimated 83 percent of Farm Bureau plan enrollees would have been uninsured in the absence of the

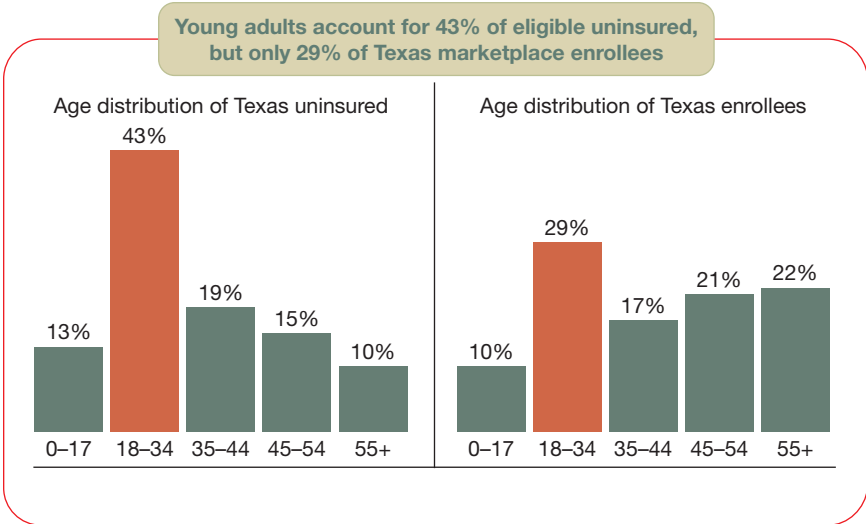


Figure 3.4 Comparison of age distribution of eligible uninsured population in Texas (2013) and average ACA enrollment population in Texas (2014–2016 OEPs).

Source: Graphic reproduced from Robiel Abraha, Shao-Chee Sim, and Elena Marks, “A Closer Look at ACA Marketplace Enrollment in Texas, October 2013–February 2016: Key Highlight and Future Implications,” Episcopal Health Foundation, October 31, 2016, <https://www.episcopalhealth.org/research-report/closer-look-aca-marketplace-enrollment-texas-oct-2013-feb-2016-key-highlights-and-future-implications/>.

Farm Bureau plan.²⁹ Most current ACA enrollees are likely to be either sick enough or have a low enough income (and thus high enough subsidies) to make the ACA a good value. Neither group is a “cherry” ripe for picking for alternative health plans.

Similarly, critics of short-term plans asserted that the short-term plans expanded by the Trump administration would lead to adverse selection in the individual market. However, contrary to those concerns, average exchange premiums declined after the expansion of STPs, decreasing more in states that fully permitted the expansion compared to states that restricted them. Benchmark plan premiums in states that fully permitted STPs decreased 7.9 percent between 2018 and 2021, compared to only a 3.2 percent decrease in states that restricted them.³⁰ As Brian Blase summarized his study’s findings, “Actual experience shows that states that fully permit short-term plans have experienced improvements in their individual markets compared to states that

restrict short-term plans on every dimension—enrollment, choice of plans, and premiums.”³¹

Even if the critics are correct that cherry-picking would raise gross premiums, few enrollees would experience any change in cost. Assuming that these plans would trigger additional adverse selection in the ACA market, that point is only true for *gross* premiums. Enrollees eligible for subsidies will not see any increase in their *net* premiums. As of the December 2020 open enrollment period, 85 percent of ACA enrollees nationwide were subsidized and thus insensitive to price changes.³² In many states—including Wyoming, Utah, Texas, South Dakota, Oklahoma, Nebraska, North Carolina, Mississippi, Florida, and Alabama—subsidized enrollment exceeded 90 percent of total enrollment. Even if authorizing alternative health benefit plans would increase *gross* premiums for the ACA plans, these subsidized enrollees would see no difference in their *net* premiums.

Myth—The enhanced federal subsidies in the American Rescue Plan Act make alternative plans unnecessary / Truth—The enhanced subsidies are only scheduled to be temporary, are financially inefficient, and are ineffective at reducing the number of uninsured

The American Rescue Plan Act temporarily increased the amount of subsidies that individuals are eligible for as well as removing the “benefit cliff” that capped eligibility for subsidies at 400 percent of the federal poverty line. This temporary boost is for 2021 and 2022, although President Biden and many congressional Democrats have proposed to extend it further. The Congressional Budget Office projected that the enhanced subsidies would only lead to a reduction in the uninsured of about 1.3 million nationwide, at a cost to the federal government of about \$35 billion over two years. That works out to a cost of nearly \$27,000 per additional insured.³³ Thus, there would still be many uninsured who could benefit from alternative plans, including the hypothetical single 27-year-old earning \$51,000 discussed earlier, who would qualify for just a \$9 per month subsidy, leaving a remaining monthly premium of \$361 for a benchmark plan.

The enhanced federal subsidies decrease the number of market enrollees who are not receiving a subsidy. This only makes the response to the cherry-picking critique even stronger, since having more subsidized enrollees further decreases the number of enrollees who might hypothetically be impacted by the cherry-picking effect.

Ultimately, there is little harm to the ACA market by permitting alternative coverage options, even less so with the enhanced subsidies, but restricting these options would inflict great harm to the individuals who could have benefited from them.

Myth—Alternative plans create an unlevel playing field for insurers with different rules / Truth—If it is not fair, it is because alternative benefit plans are not eligible for massive federal subsidies

Alternative health benefit plans are not generally competing against ACA plans for the same customers, but to the extent there is an unfair playing field, it is because ACA plans are eligible for generous subsidies, while alternative benefit plans have to demonstrate their full value to consumers in order to get them to purchase these plans and keep them as members.

Myth—Alternative benefit plans are unregulated, “junk” plans / Truth—The Farm Bureau is a trusted, member-driven, long-run-oriented, well-known entity, with no history of bad faith actions in other states, and states remain free to regulate STPs as they see fit

Despite that five states have already authorized Farm Bureau plans, opponents have been unable to find a single individual who had a coverage complaint.³⁴ The lack of controversy over Farm Bureau plans may be partially because of the nature of the Farm Bureau. The Farm Bureau is a member-run, nonprofit organization whose purpose is to create products of benefit to its membership. This structure and the desire of the Farm Bureau to maintain a sterling reputation is a key consumer protection. As *Stat News* describes it, the Farm Bureau “doesn’t kick any of its members out once they get sick. They can always renew their coverage, even if they develop a costly condition. . . . The benefits themselves are pretty robust too.”³⁵ Their reporters spent two weeks talking with consumer advocates, health insurance brokers, and other state officials and could not find anyone who complained about the coverage.

In addition, organizations that are authorized to offer alternative health benefit plans depend on the legislature for this authorization and know that if they engage in deceptive or unfair practices, the legislature can rescind this authorization. Tennessee Farm Bureau’s general counsel has alluded to the ultimate reason that states should not be concerned about allowing the company to start offering plans: “The legislature has an opportunity every year to say no, we don’t want this setup to continue, and yet every year

since 1993 they've allowed this to continue because we're trusted, because we're doing what we told them we would do. It's not a loophole. It's not an accident."³⁶

Unlike Farm Bureau plans, short-term plans may be fully regulated by the state. While imposing ACA-style regulations such as community rating and benefit mandates would weaken this market and harm consumers, states should consider improvements, including a guaranteed renewable option with the coverage so people can be permanently protected from going through underwriting in the future. States should also consider prohibiting "post-claims underwriting," in which the insurer sells the customer a plan without engaging in underwriting at the front end, only performing the underwriting after a claim is submitted. States should also be clear that inappropriate rescissions, whereby a policy is retroactively canceled based on minor or immaterial inaccuracies on the application, will not be tolerated.

CONCLUSION

For tens of millions of Americans, the ACA has failed to live up to its promise of providing affordable health insurance. They have seen premiums skyrocket, deductibles increase, networks narrow, and the price of care escalate. They want new options to pick from.

Because alternative benefit plans do not have to comply with the ACA's requirements, they can provide an attractive option to individuals who have been harmed by the ACA's one-size-fits-all nature. Legislatures that make these options available to their residents will take a firm step toward reducing the uninsured rate by meeting the diverse needs of their residents while not disrupting the existing insurance marketplace.

ABOUT THE AUTHOR

Charles Miller is a senior policy advisor for Texas 2036, a non-profit public policy organization committed to implementing data-driven policies that ensure Texas remains the best state to work and live by its bicentennial in 2036. Charles joined Texas 2036 after serving as a budget and policy advisor for Governor Greg Abbott, where he advised on a broad range of issues, including health care, insurance, workforce development, elections, information resources, cybersecurity, first amendment issues, and civil law. Previously, Charles practiced

law, primarily involved in insurance defense litigation. He received his JD from the University of Texas at Austin, and his BA in history from the University of Notre Dame. He lives in Austin with his wife and two daughters.

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Welcome Competition

Scale Back Certificate of Need Laws

Matthew D. Mitchell, PhD

KEY TAKEAWAYS

- In much of the country, state regulations have monopolized local health care markets.
- Certificate of need (CON) laws have been widely studied, and the evidence is overwhelming that they reduce access, limit competition, and increase costs.
- State legislators could improve health care quality, lower prices, and—above all—make it easier for millions of Americans to obtain care by repealing CON laws.

PROBLEM

The Origins of CON

Much like today, federal lawmakers of a half century ago were worried about skyrocketing health care expenditures, so, in 1975, Congress passed, and President Ford signed, the National Health Planning and Resources Development Act (NHPRDA). Congress lamented the “massive infusion of Federal funds into the existing health care system [that] has contributed to inflationary increases in the cost of health care and failed to produce an adequate supply or distribution of health resources, and consequently has not made possible equal access for everyone to such resources.”¹ The solution, they believed, lay in a regulation pioneered by New York about a decade earlier.²

The regulation requires a “certificate of need” (CON), meaning that providers that wish to open or expand their facilities must first prove to a regulator that their community “needs” the service in question. Congress threatened to withdraw federal health care funds from any state that refused to enact such a program. Because of repeated postponement, it was a threat that never actually materialized.³ Nevertheless, by the early 1980s, nearly every state in the country had created at least one CON program.

The Rationale(s) for CON

Unlike other varieties of regulation, the CON process is not supposed to assess a provider’s qualifications, safety record, or the adequacy of their facility. Instead, the entire process is geared toward second-guessing the provider’s belief that their community would benefit from the service they would like to offer.

Certificate of need is an unusual regulation. In most other industries, need is assessed by the entrepreneur, based on his or her expectation of profitability. Since providers are either risking their own capital or capital that they have promised to repay, they have a strong incentive to carefully weigh the financial viability of the venture. But given the third-party payer problem in health care, lawmakers worried that patients could be induced to agree to expensive hospital stays and unneeded procedures.

In encouraging CON, lawmakers hoped hospitals would acquire fewer beds, fill them with fewer patients, and spend less money. The main purpose of CON was therefore to reduce health care expenditures by rationing care. The authors of the NHPRDA also thought that they could reduce health care costs by encouraging “the use of appropriate alternative levels of health care, and for the substitution of ambulatory and intermediate care.”⁴

Beyond costs and expenditures, the authors of the NHPRDA also hoped to ensure an adequate supply of care, especially for “underserved populations,” including “those which are located in rural or economically depressed areas.”⁵ Finally, they hoped to “achieve needed improvements in the quality of health services.”⁶

These goals—cost containment, adequate and equitable access, and quality improvement—remain widely shared aims of health policy and are laudable goals. The preponderance of evidence suggests that CON fails to achieve them. In fact, CON likely increases costs, limits access, and undermines quality.

CON's Evolution

Early research suggested that CON did not work. One study found that hospitals anticipated CON and actually increased their investments before it took effect.⁷ Another found that while the regulation did change the composition of investments, “retarding expansion in bed supplies but increasing investment in new services and equipment,” it had no effect on the total dollar volume of investment.⁸ As a result, early evaluations found that limited CON programs had no effect on total expenditures per patient, while comprehensive programs were associated with higher spending.⁹

As this evidence was emerging, Congress was also making important changes to Medicare reimbursement. Medicare had originally reimbursed hospitals on a “retrospective” and “cost-plus” basis. “Under this system,” explained health care researchers Stuart Guterman and Allen Dobson in 1986, “hospitals were paid whatever they spent; there was little incentive to control costs, because higher costs brought about higher levels of reimbursement.”¹⁰ Recognizing the problem, Congress switched to “prospective” reimbursement in 1983.¹¹

Mark Botti of the Antitrust Division of the Department of Justice noted the implications of this change in testimony before the Georgia State Assembly in 2007, saying, “In addition to the fact that CON laws have been ineffective in serving their original purpose, CON laws should be reexamined because the reimbursement methodologies that may in theory have justified them initially have changed significantly since the 1970s. The federal government no longer reimburses on a cost-plus basis.”¹²

Indeed, three years after Congress switched from retrospective to prospective reimbursement, it elected to do away with the CON mandate.¹³ Almost immediately, 12 states eliminated their CON programs. Representative Roy Rowland (D-Ga.), a physician representing the largely rural center of Georgia, captured the sentiment of his colleagues, noting a few years after repeal that, “At first glance, the idea [of certificate of need] may have looked pretty good. In practice, however, the effect of certificate-of-need on health care costs has been dubious, at best. And the program has certainly been insensitive in many instances to the true needs of our communities.”¹⁴ Representative Rowland urged his colleagues to go further, asserting that “it’s now time to abolish it throughout the nation.”¹⁵

He did not get his wish. Still, without the federal incentive, 15 states have eliminated CONs for most or all aspects of health care as of 2021.¹⁶ The most

recent full repeal was in New Hampshire in 2016. Several other states, however, have pared back their programs. Florida, for example, enacted significant reforms in 2019, eliminating CONs for most technologies and investments.¹⁷ For reasons that are not entirely clear, nursing home CONs seem to be particularly difficult to eliminate, so states like Florida that enact sweeping reforms often leave these CONs untouched.¹⁸

The global COVID pandemic touched off keen interest in eliminating barriers to health care and, as evidence mounted that these rules were associated with projected bed shortages and higher mortality, 24 states eased or suspended their CON regulations.¹⁹ In 2021, CON reform or repeal was considered in 18 states. Modest reforms were passed in Tennessee, Washington, and Virginia, while Montana eliminated every CON except that for nursing homes.

CON Today

A survey in 2020 found that among 35 CON-regulated services, the most common CON requirements are for nursing homes (34 states), psychiatric services (31 states), and hospitals (29 states).²⁰ Hawaii regulates the most services at 28, with North Carolina (27 services) and the District of Columbia (25 services) falling close behind. Meanwhile, Indiana and Ohio each regulate just one service (nursing homes). With its reforms, Montana will soon join this group. Arizona and New Mexico have only ambulance service CON requirements (which, to my knowledge, have not been studied).

It is common for states to require CONs for expenditures above a certain threshold, although these thresholds vary across states. In New York, for example, projects undertaken by general hospitals in excess of \$30 million necessitate a CON, while in Iowa projects in excess of just \$1.5 million require a CON.²¹ In a reflection of the political power of hospital associations, the thresholds that trigger a CON review are typically lower for non-hospital providers than for hospitals. In Maine, for example, hospitals must obtain a CON when they undertake capital expenditures in excess of \$12.365 million, while ambulatory surgery centers must obtain a CON for expenditures in excess of \$3 million.²²

Application fees also vary, ranging from \$100 in Arizona to \$250,000 in Maine, though some states structure fees as a percentage of the proposed capital expenditures.²³ There is no systematic data on compliance costs, but we know that providers can spend months or years preparing their applications

and waiting to hear from the regulator. Because the process can be cumbersome, providers often hire boutique consulting firms to help them navigate it. Employees of existing hospitals and other incumbent providers typically sit on CON boards, and in all but five CON states, incumbent providers are allowed to object to a CON application of a would-be competitor.²⁴ In some states, Mississippi and Oklahoma, for example, competitors are allowed to appeal a CON decision after it has been made, further dragging out the process.²⁵

These compliance costs and the revenue providers forgo as they await the verdict can amount to tens or even hundreds of thousands of dollars.²⁶ In many states, a CON can be denied if a regulator believes that the new service will duplicate an existing service, all but ensuring a local monopoly. There is, again, no systematic data on approval rates. Available data, however, suggests that approval is far from guaranteed. From early 2014 to early 2017, for example, about 55 percent of Florida CON applications were rejected.²⁷

DOES CON WORK AS ADVERTISED?

The stated goals of CON regulation are to contain costs, ensure adequate and equitable access to care, and improve quality. The evidence shows CON fails to achieve these laudable goals and is an expensive barrier to entry.

CON Increases Costs

Given the potentially anticompetitive effects of the regulation, it may give providers some degree of pricing power, insulate them from the incentive to contain costs, and encourage wasteful efforts to seek and maintain the privilege.²⁸

In a 2016 survey of 20 peer-reviewed studies, I conclude that “the overwhelming weight of evidence suggests that CON laws are associated with both higher per unit costs and higher total expenditures.”²⁹

CON Reduces Access

The theoretical prediction that CON will backfire regarding health care access is stronger. The most straightforward expectation is that a supply restraint will limit quantity supplied, and the evidence is abundant that CON does just that. Controlling for other factors, researchers find that the average patient in a CON state has access to fewer hospitals,³⁰ fewer hospice care facilities,³¹

fewer dialysis clinics,³² and fewer ambulatory surgery centers (ASCs).³³ There are fewer beds per patient in these states³⁴ and fewer medical imaging devices.³⁵

Nor does CON seem to distribute care where it is most lacking. The average rural patient has access to fewer rural hospitals and fewer rural ASCs in CON states,³⁶ and patients must travel farther for care and are more likely to leave their states for care.³⁷ Despite the hope that CON regulators might condition approval on the provision of care to vulnerable populations, there is no greater incidence of charity care in CON states relative to non-CON states.³⁸ Repeal of CON can increase equity as disparities among racial groups in the provision of care disappear when CON is eliminated.³⁹

CON Reduces Quality

Theory suggests that competition will tend to enhance quality, though it is possible that in some settings (surgery, for example) high-volume providers may be able to offer better care through mastery of their craft. Early studies tended to focus on specific procedures and offered mixed results.⁴⁰ The most recent research, however, suggests that patients in CON states have higher mortality rates following heart attacks, heart failure, and pneumonia.⁴¹ Moreover, patients in states with four or more CON requirements have higher readmission rates following heart attack and heart failure, more post-surgery complications, and lower patient satisfaction levels.⁴² Certificate of need laws appear to have no statistically significant effect on all-cause mortality, though point estimates suggest that, if anything, they may increase it.⁴³

PROPOSAL

State legislators should repeal their CON requirements. Short of full and immediate CON repeal, reform-minded legislators have several options.⁴⁴ Policymakers could schedule repeal to take effect at some future date (perhaps calibrated to give CON holders time to recover their costs on long-lived assets), or they might phase in repeal by requiring that the CON authority approve an ever-larger percentage of applications over time.

Alternatively, policymakers could eliminate specific CON requirements, such as those that restrict access to facilities and services used by vulnerable populations. Prime candidates include CONs for drug and alcohol rehabilitation, for psychiatric services, and for intermediate care facilities serving

those with intellectual disabilities. Policymakers could also take steps to ease the administrative and financial costs of applying for a CON.

Alternatively, they might mitigate the most egregiously anticompetitive aspects of CON. For example, they could bar employees of incumbent providers from serving on CON boards or, following Indiana, Louisiana, Michigan, Nebraska, and New York, they could no longer solicit and consider the objections of a competitor when a provider applies for a CON. Furthermore, no CON should be rejected on the basis that entry would create a duplication of services, as this guarantees an incumbent a local monopoly.

These and other steps could permit more Americans, especially vulnerable populations, greater access to lower-cost and higher-quality care. We know this because researchers have spent decades studying outcomes in states where policymakers have already done away with these anticompetitive rules.

ABOUT THE AUTHOR

Matthew D. Mitchell, PhD, is a senior research fellow and director of the Equal Liberty Initiative at the Mercatus Center at George Mason University. He received his PhD and MA in economics from George Mason University and his BA in political science and BS in economics from Arizona State University.

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Unshackle Providers

Don't Waste Their Training

Robert F. Graboyes, PhD, and Darcy Nikol Bryan, MD

KEY TAKEAWAYS

- Arbitrary restraints on America's health care workforce diminish access to care—especially in rural areas, lower-income urban neighborhoods, and minority communities.
- State licensure laws obstruct providers wishing to offer services across state lines and international medical graduates wishing to practice here.
- Scope-of-practice laws prevent advanced practice registered nurses (APRNs) and other health care providers from offering services for which they are trained and competent.
- Mandatory collaborative practice agreements foist unnecessary costs on, and restrict the mobility of, APRNs and other health care providers.

PROBLEM

America's supply of health care resources is artificially constrained by a maze of laws and regulations. In 2020, *USA Today* reported that 218 U.S. counties have no doctors at all.¹ In some areas, physicians are present but patients must wait weeks to secure an appointment.² Many regions are critically short on specialists.^{3,4} Scope-of-practice laws prohibit classes of health care professionals from offering services for which they are fully qualified,⁵

and such limitations often rest on political considerations rather than on professionals' competency, qualifications, and training.⁶

Rural health care is deteriorating at an alarming rate as hospitals close and health care providers leave communities or retire, most often without replacement. The majority of primary care Health Professional Shortage Areas (HPSAs) are in rural areas.⁷ The poor in urban areas as well as those in rural communities suffer poor health outcomes, in part from an inability to access affordable health care in a timely manner.⁸ Minorities account for more than half the uninsured population⁹ and are disproportionately impacted by poor access to health care.¹⁰

Obtaining affordable, quality health care is a problem for many in the United States. The problem is even more frustrating because ballooning health care costs and poor access are self-inflicted by a regulatory apparatus that hinders competition and fosters monopolies. It is increasingly evident that the most vulnerable in our population are paying the price of health care provider scarcity brought about by regulatory barriers involving licensure, scope of practice, and collaborative practice agreement (CPA) mandates.

LICENSURE RESTRICTIONS

While federalism and state sovereignty play an important role in American governance, state licensure laws often amount to government-enforced protectionism for established licensees.¹¹ One result is excessive limitations on health care providers' ability to migrate, permanently or temporarily, across state lines in order to respond to shifting demand patterns among patients.¹²

The need for international medical graduates (IMGs) is forecast to increase considerably in the coming decades. Already, nearly 25 percent of the physicians practicing in the United States received their training elsewhere.¹³ In 2020, the American Association of Medical Colleges issued a paper forecasting that "the United States could see an estimated shortage of between 54,100 and 139,000 physicians, including shortfalls in both primary and specialty care, by 2033."¹⁴

The historical evolution of medical licensure places control with states, while national credentialing bodies, such as specialty boards, and licensing exams seek uniform competence across state lines. All states require passing the medical licensing exams called the United States Medical Licensing Examination for medical students or the Comprehensive Osteopathic

Medical Licensing Examination of the United States of America for osteopathic students.

Each state asks a licensing applicant similar questions during the application process, which takes several hours to complete. State licensing perversely ensures an immobile, slow-to-respond, fragmentary health care workforce. With the development of telemedicine, restricting health care provision within state boundaries seems increasingly arbitrary. For example, there are no medical reasons for preventing a psychiatrist in Oregon from counseling a patient in Nebraska. It is difficult to justify requiring the psychiatrist to pay for a separate license—and endure a repetitive application process—in each state where he or she provides care.

Many providers will not bear these redundant costs, further exacerbating access issues for patients in need. For an applicant seeking a license in a new state, the wait time for approval can range from two to nine months.¹⁵ Fees for individual state applications range from \$35 to \$1,425 per state.¹⁶

Many states waived their medical licensure requirements in response to the COVID-19 crisis, provided the practitioner held a license in another U.S. state. This was sensible, as there are no real differences in screening processes among states. While federalism has many virtues, the promising evolution of telemedicine, care to the underserved, and the ability to respond to health emergencies will only be hindered by antiquated state-by-state licensing requirements. The success of telehealth during the COVID outbreak has led to calls to make cross-state licensing and other liberalization permanent.^{17,18}

SCOPE-OF-PRACTICE LIMITATIONS

Physicians are granted the privilege to practice medicine as defined by a particular state's medical board, with practical limitations determined mostly by credentialing bodies, including specialty boards and hospitals. For non-MDs, scope-of-practice laws and regulations legally define the extent of permissible practice privileges. All too often, scope-of-practice laws forbid a health care provider, such as a nurse practitioner (NP) or physician assistant (PA), from performing a service he or she was trained to do.

Although aligned, professional competence and legal scope of practice are different. Legal scope of practice is highly variable between states and is often arbitrary. For example, dental hygienists are routinely trained to administer local anesthesia, but some states forbid them from providing this service.¹⁹

In North Carolina, dental hygienists were prohibited from performing teeth-whitening procedures until the U.S. Supreme Court ended that prohibition in 2015.²⁰ Monica O'Reilly-Jacob and Jennifer Perloff called for permanent revision of NP laws, considering the experience during the pandemic.²¹

Non-MD providers often lack the political power to reform scope-of-practice laws. Physicians provide far more in political contributions than nonphysician providers.²²

MANDATORY COLLABORATIVE PRACTICE AGREEMENTS

Many states mandate physician supervision of non-MDs. This constricts the supply of care and increases its cost. These agreements purport to ensure quality by allowing a non-MD health professional to practice beyond their state-defined scope by requiring oversight from a supervisory physician, but evidence contradicts the notion that such supervision is necessary to uphold quality standards.

Christopher H. Stucky, William J. Brown, and Michelle G. Stucky argue that NPs have a unique role in health care and that “antiquated job titles pervasive in the workplace for NPs such as ‘midlevel provider,’ ‘physician extender,’ or ‘nonphysician provider’ are misleading and do not fully capture the importance of nursing.” They argue that the hierarchical aspects of medicine lead to higher costs and redundancy.²³

Policies that eliminate mandates for physician supervision of non-MD health professionals while supporting non-MD health educational and training standards would expand the available health care workforce capable of providing quality, affordable care. For example, an independently practicing nurse practitioner, midwife, pharmacist, optometrist, or dental hygienist would be able to work in communities that have no doctor or dentist at the full capacity of their training—an obvious win for the underserved. Many states already grant autonomy to non-MD health professionals.²⁴ The opportunity to become an independent non-MD health practitioner, without the restrictions of scope-of-practice laws or CPAs, may inspire minorities in challenged communities to continue their educations and gain the skills needed to serve as non-MD providers, thereby increasing diversity in the health care workforce and access in places where people have difficulty obtaining care when they need it.

Judith Ortiz and colleagues found “strong indications that the quality of patient outcomes is not reduced when the scope of practice is expanded.”²⁵

Similarly, Bo Kyum Yang and colleagues found “expanded state NP practice regulations were associated with greater NP supply and improved access to care among rural and underserved populations without decreasing care quality.”²⁶ Edward J. Timmons found that “permitting nurse practitioners to practice autonomously is associated with patients receiving more care without increasing cost” and “an 8 percent increase in the amount of care that Medicaid patients receive once nurse practitioners are granted autonomy and full practice authority.”²⁷ A Veterans Affairs (VA) study showed that “patients reassigned to NPs experienced similar outcomes and incurred less utilization at comparable cost relative to MD patients.”²⁸ Gina M. Oliver and colleagues found that “states with full practice of nurse practitioners have lower hospitalization rates in all examined groups and improved health outcomes in their communities. Results indicate that obstacles to full scope of APRN practice have the potential to negatively impact our nation’s health.”²⁹

If a professional is fully trained and certified to provide a service, requiring the contractual mechanism of a collaborative agreement essentially gives a competing professional a piece of their practice and profit. This supervision, enforced via CPAs, adds to the cost of health care, with two practitioners (i.e., NP and supervising physician) billing for the same patient service. If all states allowed NPs to practice autonomously, the estimated annual cost savings would be \$810 million.³⁰

Mandatory CPAs effectively place one class of health care professional under the control of another class. In some states, for example, nurse practitioners must be supervised by physicians and may have to pay the doctor for such services. Such agreements consume time and financial resources for practitioners involved.³¹ Brendan Martin and Maryann Alexander wrote, “Required CPA fees, whether offset by a facility or not, emerged as particularly strong barriers to independent practice and, thereby, possible impediments to access in this analysis. In line with market research on provider compensation, out-of-pocket expenses to establish and maintain CPAs often exceeded \$6,000 annually, with numerous respondents reporting fees more than \$10,000 and up to a maximum of \$50,000 per year.”³²

One company advises that “NPs can expect to pay a physician anywhere from \$5 to \$20 per chart reviewed. . . . As a flat, annual fee, [one legal advisor] most commonly sees MDs paid anywhere from five to fifteen thousand dollars per year.”³³ A number of states suspended mandatory CPAs during the COVID emergency.³⁴

PROPOSAL

There are many proposals to address the limits that government places on health care professionals—to allow them to provide services for which they are fully trained and qualified, in order to best meet patient need. Interstate licensure reforms include having states join the Interstate Medical Licensure Compact (IMLC)³⁵ or Arizona’s 2019 action that enables licensed professionals from other states to begin practicing as soon as they relocate to Arizona.³⁶ Many of these ideas have been embedded in state laws and regulations for years.³⁷ Policy options include allowing APRNs to practice “at the top of their license”³⁸ and without CPAs.³⁹ (Some have suggested using the term “top of education” or “top of skill set,” since actual licenses may forbid providers from performing certain services for which they are trained and qualified. With that caveat in mind, we will retain the term “top of license” here in the interest of familiarity.)

Relaxing the strictures of licensure, scope of practice, and CPAs can be cost-effective by, for example, enabling a patient to seek care from a less-expensive NP or PA rather than from a doctor. It can help expand access in communities where care is in short supply—especially in rural areas, inner cities, and among linguistic minorities. In essence, these reforms would expand the supply of health care without necessarily increasing the number of providers.

States should eliminate arbitrary restrictions on where providers may practice, which services they may provide, and how much autonomy the professionals may possess. States should consider the following policies:

1. Allow a provider with a valid license in another state to practice immediately upon relocating. In 2019, Arizona became the first state to pass such sweeping legislation (for all licensed professionals other than attorneys).⁴⁰
2. Join the IMLC.⁴¹ States that belong to this grouping agree to recognize medical licenses issued by all other members of the compact. Hence, a physician licensed (and in good standing) in one of these states may practice in any of the other member states. As of July 2021, 30 states, the District of Columbia, and Guam belonged to the IMLC, and others were in the process of joining.
3. Allow licensed physicians (and perhaps PAs and APRNs) to practice telehealth across state lines. During the COVID-19 pandemic,

licensed physicians nationwide have been allowed to treat patients via telemedicine in any state. As the pandemic recedes, a number of states have taken action or begun to make this interstate provision of telehealth permanent.⁴² (See chapter 6 on telehealth.)

4. Simplify the process of offering licenses to IMGs—those who received their training outside the United States or Canada.⁴³
5. Allow all providers—physicians, PAs, APRNs, and other non-MD health professionals (e.g., pharmacists, therapists, psychologists, optometrists, nurse midwives) to practice at the top of their respective licenses. That is, a health care professional could be allowed to provide any service that is a standard component of his or her profession's formal training.
6. Allow APRNs, PAs, and others to practice without CPAs that require them to be supervised or reviewed by a physician. Of course, APRNs or PAs are free to enter voluntarily into such agreements if they wish.

RATIONALE

The inability to access our health care system in a timely fashion is a recognized problem in the United States, exacerbated by a worsening shortage in the health care workforce. As the U.S. population ages and consumes more medical care, providers are aging as well. According to the Association of American Medical Colleges, in 2017, 44 percent of U.S. doctors were over the age of 55.⁴⁴ In a 2017 survey, the National Council of State Boards of Nursing noted that 50 percent of the nursing workforce was 50 years old or older.⁴⁵ The World Health Organization (WHO) projects a shortage of 18 million health care workers worldwide by 2030—limiting America's capacity to rely on immigrant providers.⁴⁶

In 2017, the U.S. Census Bureau estimated that the number of Americans over age 65 would increase from 56 million in 2020 to 73 million in 2030 and 81 million in 2040.⁴⁷ A 2009 Institute of Medicine paper also suggested that the number of doctor visits per person would increase.⁴⁸ We simply cannot train enough providers soon enough to meet the projected gap. Current bottlenecks include restrictive health care training (e.g., limited residency slots for physicians⁴⁹), a shortage of community training sites in rural areas,⁵⁰ and a shortage of nursing school faculty.⁵¹ Under current conditions, delayed access

to health care will only worsen in the United States as the existing health care workforce retires and health care needs grow.

The importance of health care access became more apparent during the COVID-19 pandemic. In a June 2020 KFF Health Tracking Poll, 27 percent of respondents who reported skipping or postponing care during the pandemic also reported worsening medical conditions.⁵² States with high numbers of COVID-19 deaths also reported more deaths from non-COVID-related causes, such as diabetes and heart disease.⁵³ Older data, such as a VA study showing increased mortality among those waiting more than 31 days for an outpatient doctor's visit, also confirms the importance of access.⁵⁴

The canary in the coal mine is the collapse of health care access in rural America, foreboding a disturbing national picture if we do not make aggressive policy changes soon. The recommendations for overturning scope-of-practice regulations, liberating medical licensure, welcoming foreign graduates, and expanding telemedicine (see chapter 6) have been echoed by the National Rural Health Association, inspired by the direct trauma of hemorrhaging resources.⁵⁵ To expand health care access and improve health, we must utilize our health care professionals to the full extent of their training, allow them free movement to areas of high demand across state borders, and liberate them from needless supervision that prevents patients from benefiting from their full skills and knowledge. According to the American Association of Nurse Practitioners, 23 states, the District of Columbia, and two U.S. territories have the best policy for NPs, allowing them "full practice authority."⁵⁶ This means that they can "evaluate patients; diagnose, order and interpret diagnostic tests; and initiate and manage treatments, including prescribing medications and controlled substances, under the exclusive licensure authority of the state board of nursing."⁵⁷

OVERCOMING OPPOSITION

Some physicians and other providers will oppose relaxation of these restrictions, many because they sincerely believe the restrictions improve patients' safety,⁵⁸ but states that exert a lighter touch on scope of practice, licensure, and CPAs ought to provide a beacon to other states. COVID-19 provoked a great loosening of restrictions. It is still too early for conclusive evidence, but there are indications that these actions were beneficial.^{59,60} A 2020 paper found that telemedicine improved obstetric and gynecological care.⁶¹

Unleashing health care providers is not an easy or overnight task. After all, well over a century's effort went into restricting providers' ability to practice to the full extent of their capabilities. The advocates of such restrictions often have hidden motives—to protect the turfs and financial interests of established providers. Nobel Prize-winning economist Milton Friedman described the American Medical Association (AMA) as “the strongest trade union in the United States.” He argued that the AMA effectively had the means to limit the supply of physicians, thereby increasing doctors' incomes.

Some physician groups will argue against the relaxation of scope-of-practice laws, licensure procedures, and mandatory CPAs. Those who favor the unleashing of providers will need to have their counterarguments in order, including that:

1. Maintaining current restrictions is simply not feasible given that certain health care professionals are in short supply and that this situation is likely to worsen over the next few decades.
2. Many of the existing restrictions cannot be defended on the basis of patient well-being.
3. The restrictions are particularly damaging in rural areas, inner cities, and among certain minority groups, including linguistic minorities.
4. A substantial number of states have already loosened these strictures, with no apparent untoward effects on patients' well-being.
5. COVID-19 prompted a “great unleashing.” Scope-of-practice laws were temporarily eased, as were mandatory CPAs. Barriers to interstate practice of medicine were suspended—both for telemedicine and, to a lesser extent, for in-person services. The easing of these restrictions proved to be a great boon to the fight against COVID, again with few, if any, deleterious effects. If removing these restrictions made sense in the fight against COVID, then it follows that removing them makes sense generally.

CONCLUSION

America's principal debate over health care has revolved around coverage—how many Americans have insurance coverage and how that coverage is paid for. But insurance cards do not assure that care will be available. Many

localities are short on providers or appointments to see those providers. Some states have now reduced the strictures imposed by scope of practice, professional licensure, and CPAs.

The COVID-19 pandemic vastly accelerated this trend. A leading health policy issue in the coming years will be whether this opening up will be permanent or ephemeral. Americans' access to care will greatly depend on the answer.

ABOUT THE AUTHORS

Darcy Nikol Bryan, MD, is a senior affiliated scholar with the Mercatus Center at George Mason University and has an active practice in obstetrics and gynecology at Women's Care Florida. She earned an MD from Yale University School of Medicine and a master's in public administration from the University of Texas at Arlington. Her research is in technological and organizational innovation in health care, with a particular focus on public policy and women's health. She has authored a chapter in *The Economics of Medicaid: Assessing the Costs and Consequences* (Mercatus Center at George Mason University, 2014), and coauthored the medical humanities book *Women Warriors: A History of Courage in the Battle against Cancer* (AuthorHouse, 2002).

Robert F. Graboyes, PhD, is a senior research fellow at the Mercatus Center at George Mason University, where he focuses on technological innovation in health care. His work asks, "How can we make health care as innovative in the next 30 years as information technology was in the past 30 years?" He authored the monograph "Fortress and Frontier in American Health Care" and won the 2014 Bastiat Prize for Journalism. Previously, he worked for the National Federation of Independent Business, the University of Richmond, the Federal Reserve Bank of Richmond, and Chase Manhattan Bank. He has been an adjunct professor of health economics at Virginia Commonwealth University, the University of Virginia, George Mason University, and George Washington University. His work has taken him to Europe, sub-Saharan Africa, and central Asia. He earned his PhD in economics from Columbia University and also holds degrees from Virginia Commonwealth University, the College of William and Mary, and the University of Virginia.

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Unleash Technology

Maximize Telehealth's Potential

Naomi Lopez

KEY TAKEAWAYS

- Health care delivery often is not patient focused, leading to patients missing needed care, needless complications and inconveniences, and higher costs.
- Telehealth has received widespread public attention during the COVID-19 pandemic as a method for delivering some health care services to improve patient care and convenience, but most states have barriers that limit telehealth's potential.
- COVID-19-related telehealth flexibilities have started to expire, so policymakers need to act to update, improve, and expand their telehealth laws to remove barriers that prevent patient-centered care while evaluating and incorporating best practices to maximize telehealth's utility and limit potential abuse. Arizona's 2021 patient-centric telehealth reform provides a strong model for reform across the nation.

PROBLEM

When we think about telehealth, we probably imagine hailing a doctor from a smartphone or laptop to tell them what is ailing us. However, telehealth is not novel or new.

Telehealth has existed in some form since ancient times, when smoke signals and light reflection were used to communicate medical information, plagues, and other health events. A *Lancet* article published in 1879 discussed how telephones could reduce unnecessary office visits.¹ Nearly 150 years later, most Americans today have had some direct experience with telemedicine if they have ever used a phone—landline or mobile—to obtain medical advice.

Unfortunately, a myriad of restrictions have not only stunted the potential growth and adoption of widespread telehealth use to harness the full potential of modern technology, but these restrictions are also obstacles to meeting patients' health care needs when and where they need it. Fortunately, that has changed during the COVID-19 pandemic. Policymakers in Washington and governors across the country realized early in the crisis that there was an urgent need both to reduce face-to-face medical interactions to limit potential virus exposure and to preserve medical personnel resources. As a result, the federal government and states across the country took steps to make telehealth more available and accessible.²

COVID-19 Provided Temporary Relief from Some Telehealth Barriers

Under the federal health emergency declared beginning in January 2020, federal flexibilities allowed temporary reimbursement for a wide array of services under federal health care programs. This allowed many patients, particularly seniors on Medicare, to comply with stay-at-home rules and guidance while obtaining needed medical care and monitoring. Many private insurers followed suit, waiving copays for telemedicine visits for any reason. Other insurers waived cost sharing for all video visits through services such as CVS's MinuteClinic app and Teledoc.

The states also relaxed many of their rules that limited the availability of telehealth. These modified requirements included allowing out-of-state providers to provide telehealth services, eliminating the requirement for preexisting provider-patient relationships, suspending the requirement that a patient be in a medical facility in order to obtain an evaluation via telehealth, and allowing for both audio and video telehealth options.

Removing these obstacles has been a good policy during the pandemic and will remain so once it is over. The alternative was unattractive, as the avoidance or delay of care associated with the pandemic contributed to untold patient deterioration and, in some cases, death. According to the Centers for

Disease Control and Prevention (CDC), 4 in 10 adults reported delaying or avoiding care. Twelve percent reported avoiding urgent and emergency care.³ As federal and state telehealth flexibilities granted under COVID-19 start to expire, state lawmakers can play an outsized role in unleashing the full potential of telehealth as an integral part of the nation's health care delivery system.

PROPOSAL

Despite all the suffering brought on by the COVID-19 pandemic, policymakers now have an important opportunity to learn from the successes of the temporary telemedicine flexibilities and make these policies permanent, improving health care access. Too frequently, lawmakers in many states have imposed one-size-fits-all rules that prevent medical innovation and restrict the availability of health care services to patients in need. But reform can be a rejection of an outdated and less flexible approach to health care delivery, allowing patients greater access to the care they need when they need it and at a lower price point.

These policy changes did just that for an Arizona mother, Claudia, and her daughter. Before COVID, Claudia's frequent, all-day drives to get needed medical treatment for her disabled daughter were simply a fact of life. Twice a week, Claudia drove three hours each way, plus frequent stops, to take her daughter from their Yuma, Arizona, home to Phoenix to get the regular medical visits she needed, but now, thanks initially to an executive order issued by Governor Doug Ducey in March 2020⁴ and then later to a May 2021 law that was passed with strong bipartisan support,⁵ Claudia's daughter is now able to see her doctor on a computer or a smartphone for most appointments. Now, the mother and daughter only need to make the trip to Phoenix about once a month.

These policies also improved the health care experience for others who were able to obtain care when they needed it and in a manner that met their family's needs and preferences. The ease of telehealth spurred its heavy usage, as evidenced by numerous studies documenting its increased use during COVID-19.^{6,7}

Case Study: Arizona House Bill 2454

Arizona's HB 2454 is based on the idea that the patient should have greater options for medically appropriate care. This bill makes the patient the "nexus"

of care by creating an almost universal registration approach (as opposed to licensing) for out-of-state health care providers. Most state reforms narrowly apply to specific health care professionals. This reform takes a patient-centered approach, allowing almost any procedure or service that can be reasonably performed through telehealth technologies. The law also allows up to 10 telehealth encounters without provider registration under certain circumstances. In order to meet the needs of those patients who are in rural areas or do not have access to high-speed internet services (which would allow video consultations), telephone visits are allowed for some services.

Telehealth can be conducted in real time, where the provider and patient are interacting in real time. Telehealth can also be asynchronous, where, for example, a patient's x-ray is sent to a surgeon for evaluation. This "store and forward" modality allows patient evaluation that is not conducted in real time. Patients can also be monitored remotely, where, for example, a patient's heart monitor data is being sent to a provider, who is alerted when an anomaly occurs. All three telehealth modalities are allowed under the Arizona law.

The Arizona law 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 telehealth platform. For services done outside an insurer platform, there is a requirement to provide reimbursement equal to that for an in-person visit but does not establish a minimum reimbursement.

Critics have expressed concern that a parity requirement will drive up spending and misuse and prevent lower-priced and more efficient telehealth providers from gaining market share. Supporters have argued that the economics of delivering care via telehealth often require significant investment on the part of providers.⁸ Because of a lack of economies of scale, these costs can be more burdensome on smaller practices and could potentially discourage these practices from offering telehealth. In order to ensure that in-state, smaller providers would be more likely to participate (and not be undercut by out-of-state providers), Arizona's law includes a parity-lite approach that recognizes the challenges of telehealth investment while also encouraging the use of insurer platforms that avoid the parity requirement—alleviating the upfront telehealth investment costs for those providers least able to bear them.

While many have focused on how this law will add convenience for patients, the importance of this law is found in the ways that it will transform the health care delivery landscape, allowing the reimagining of how care is delivered. This reform makes the ground fertile for harnessing the

power of technology and medical expertise in ways that have not yet been fully realized or, in some cases, yet imagined.

Meeting Patients' Needs and Preferences

For some patients, the convenience of not having to schedule an appointment, wait days or weeks for a visit, take time off work, and be exposed to viruses or bacteria in waiting rooms and facilities with other sick patients is attractive for certain types of health care services.

Increasing Rural Care Access

Most states have many care options in larger urban areas, with some drawing patients from around the world. But these same states almost always face shortages of providers in rural areas (and specialists in all geographic areas), making it difficult for their residents to access needed care without travel and its associated expenses. Too often, patients with limited access either delay care or forgo it altogether, which may cause further deterioration in their health. Telehealth reform will make it easier for those patients—like Claudia's daughter—to get needed care more often and in a timely, convenient manner.

Flexibility for Hospital Redesign

Most hospitals lack the ability to hire a multitude of specialists, but telehealth reform provides an important pathway for medical facilities to provide needed expertise and assistance without needing to have it in-house. For example, should a patient in a rural area suffer a serious stroke, a community hospital may, in real time, be able to have the patient's vital statistics shared and monitored with a leading specialist at another facility across the country, obtaining medical guidance that previously had been unavailable. In this way, hospitals can retool their services and offerings in a way that better allows financial flexibility and can better meet the needs of patients.

Innovation in Insurer Policies

While telehealth reimbursement policies have been dramatically expanded during COVID-19, many government and private policies that limited

coverage of these services are on track to revert to the pre-COVID status quo, absent federal and state policy action. Referred to as the “telehealth cliff,” many anticipate (at the time of this writing in late summer 2021) that patients will lose access to needed health care services that have been more widely available via telehealth. Once the public health emergency ends, this could occur both for patients in government programs and for those privately insured in states that have temporarily allowed telehealth expansion. For example, Florida, which prior to the COVID-19 health emergency had a strong telehealth law that allows a wide range of out-of-state health care providers in good standing to register with the appropriate state board to provide telehealth services to patients inside the state, is now facing this telehealth cliff for any additional flexibility that was not already in state law.

In June 2021, Governor Ron DeSantis allowed the expiration of Florida’s public health emergency. As a result, the temporary flexibilities that allowed the telephonic delivery of care (to non-Medicare patients), for example, have now expired. A crucial question is whether the private insurers that reimbursed for telehealth services for primary care and specialist office visits during the public health emergency will continue to do so now that the emergency has officially expired in the state. This could serve as a bellwether to determine whether and how private insurers continue to provide coverage—and at what level—and whether medical practices continue to provide telehealth.

In the past, the policies that govern the federal health care programs have often been followed by private insurance policies.⁹ Depending on whether and how Congress and states respond, telehealth reform may offer an opportunity to untether these coverage and payment decisions, encouraging new payment models that work better for families like Claudia’s and encouraging long-overdue reform of payment models.

Allowing Seniors More Long-Term-Care Choice for Aging at Home

Given America’s aging population and the looming impact that long-term-care costs will have on state budgets,¹⁰ telehealth may help support older Americans who choose to age in place—at a lower cost to families and taxpayers. Take, for example, a telehealth pilot project at West Virginia University’s Office of Health Affairs that targets older adults who have suffered a traumatic brain injury and wish to transition from an institution back into their communities.¹¹ Patients were able to avoid additional hospitalization

and reinstatement, which, according to the researchers, also contributed to patients' overall health and satisfaction.

Customization of Health Care Services

Prior to COVID, many consumers experienced telehealth through virtual office visits, but rather than a one-off experience, there is the potential to see telehealth layered on top of other health care services¹² and become part of one's usual health care experience.¹³

Telehealth holds enormous potential for health care access, and while there are no magic bullets to reform health care, reforms such as HB 2454 in Arizona and other previous reforms in Florida and Minnesota¹⁴ can help the nation realize the potential of innovative, patient-centric medical care using already available technology and communication platforms.

OVERCOMING OBJECTIONS

For state lawmakers, the biggest challenge in achieving meaningful reform will involve a strong stakeholder engagement process. There will be disagreements over the impact telehealth reform has on patient safety; fraud and abuse; increased utilization, which can increase spending; coverage and payment parity mandates; patient consent; compliance with privacy laws; resolving disputes; and investments in broadband and other technology to facilitate telehealth.¹⁵

The resulting "proof of concept" from the states across the country that took steps to make telemedicine more readily available during the COVID pandemic demonstrates that many of the concerns around patient safety were largely unfounded. What remains unknown, however, is whether and how the new Arizona law contains sufficient safeguards to prevent fraud and abuse. This is an area that will require monitoring and evaluation.

Physician Practice Investment and Adoption

While telemedicine is not new, the cost of investing in and using an online platform, as well as a lack of insurance coverage for many telemedicine services, has deterred many medical practices from offering telehealth services. But as a direct result of the federal flexibilities around telemedicine, online platforms began to offer free trials of their services—and many practices

now have the revenue stream to continue using them, since these services are being reimbursed during the public health emergency resulting from the COVID pandemic.

For example, take Dr. Beverly Jordan of Enterprise, Alabama. At one point in the pandemic, she had seen about 30 patients via telemedicine in one week. While telemedicine was already available in the state, the cost of using an online platform, as well as a lack of insurance coverage for telemedicine services, made the expense and effort untenable for her medical practice. But as a direct result of the emergency flexibility of the Centers for Medicare and Medicaid Services (CMS), online platforms began offering free trials of their services. Insurers in Alabama followed the federal government's lead and began covering these visits.¹⁶

Improving Patient Care

No one believes that innovations such as telemedicine should substitute completely for in-person visits with a primary care provider, but they can be an important part of developing a long-term, more functional relationship between patients and their providers. In their initial review of the studies on the effectiveness and safety of telehealth, the Agency for Health Care Research and Quality (AHRQ) found that the evidence for effective patient care is strong, especially for the remote management of chronic health conditions. The report confirms that telehealth improves health outcomes, utilization, and cost of care for a range of chronic diseases and illnesses, including heart failure, diabetes, depression, obesity, asthma, and mental health conditions. In addition, for nonurgent issues, the likelihood of diagnostic error appeared to be roughly comparable to that for face-to-face encounters.¹⁷

States now have their own proofs of concept, as well as those from most states across the country. State lawmakers now face the choice of continuing to operate an antiquated business model or building on the experience brought on by the COVID pandemic. The question for lawmakers is whether they are willing to leapfrog decades of slow adoption of the promises of the twenty-first century.

CONCLUSION

The COVID-19 crisis has demonstrated the benefits of telehealth—and has shown how irrational the past rules limiting telehealth were. The benefits

are real for moms like Claudia, but it should not have taken a pandemic to transform health care for the better for families like Claudia's, and expanded telehealth options should not go away when COVID-19's threat subsides, as telehealth improves everyday care and better prepares our health system for any future pandemics.

Telehealth holds enormous potential for health care access, and while it is not a health system cure-all, state lawmakers across the nation should embrace and build on reforms like Arizona's in order to realize the potential of innovative, patient-centric medical care using already available technology and communication platforms.¹⁸ This is exactly the kind of bold thinking and action that state lawmakers across the country have the authority—and obligation—to embrace and pursue.

ABOUT THE AUTHOR

Naomi Lopez is director of healthcare policy at the Goldwater Institute. Her work focuses on a broad range of health care issues, including the Right to Try, off-label communications, pharmaceutical drug pricing, supply-side health care reforms, the Affordable Care Act, Medicaid, and twenty-first-century health care innovation. Lopez has 25 years of experience in policy and has previously served at organizations including the Illinois Policy Institute, the Pacific Research Institute, the Institute for Socioeconomic Studies, and the Cato Institute. A frequent media guest and public speaker, Naomi has authored hundreds of studies, opinion articles, and commentaries. She holds a BA in economics from Trinity University in Texas and an MA in government from Johns Hopkins University.

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Empower Patients

Let Them Own and Control Their Prescriptions

Jeffrey A. Singer, MD

KEY TAKEAWAYS

- The move to e-prescribing took power away from health care consumers, who previously possessed written prescriptions and shopped around for better prices and service.
- Technology exists to allow patients to possess their e-prescriptions and make shopping even easier.
- Starting in 2022, new federal rules will allow consumers to use this new technology, but state regulations stand in the way.

PROBLEM

Until recently, most patients received their prescriptions in writing, on paper. They carried their prescriptions with them and were able to shop at various pharmacies and decide, based on price and service, where to get them filled. In essence, with that prescription in hand, they were in control. It stayed with them until they gave it to the pharmacy. When health records went digital and e-prescribing became the most common means of prescribing, patients lost control over their prescriptions. Ironically, an unintended consequence of electronic prescribing was to reduce patient autonomy along with the ability to comparison shop.

In March 2020, the U.S. Department of Health and Human Services issued new rules, scheduled to take effect in 2022, that will allow patients to

access their electronic health records using a smartphone app and to share their medical records.¹ This rule change will allow patients to utilize their personal prescription information to shop for prescription drugs. In the same way that consumers can shop for almost every other product, patients will be able to use new tools, such as smartphone apps, to find the best price, convenient delivery time and location, and overall customer service experience for filling their prescriptions.²

These new rules reinforce the idea that patients own their medical records. The ability of patients to access their medical records from a secure electronic database for their own purposes will soon be a reality. For example, an “advocate app” (an app that works for the patient and not a third party such as an insurer) can shop for the prescription and transmit it to the pharmacy offering the best combination of price and convenience. Unfortunately, to make this a reality, states must remove pharmacy and health information transfer regulations that were created decades ago, before the rise and widespread adoption of web-based shopping platforms and information systems.

As health insurance premiums, deductibles, and copays continue to rise, consumers are increasingly seeking ways to diminish the sting of prescription drug prices. Technology entrepreneurs have responded to the problem with online websites and smartphone apps, such as GoodRx and SingleCare, that allow consumers to take advantage of various discounts negotiated with pharmacies by “middlemen” called pharmaceutical benefits managers (PBMs). These websites and apps compare the actual price that consumers will face, accounting for negotiated discounts, for the same drug across pharmacies and then let patients select a pharmacy to dispense their prescription.³ Patients pay out-of-pocket for these prescriptions but often pay less than if they used their health plan.

Pharmaceutical benefits managers contract with health insurance companies to provide prescription drug benefits to health plans, but the discounts that PBMs provide can be misleading. Pharmacies, like other health care providers, artificially inflate the prices they charge third-party payers to start the bargaining process with the PBMs. The negotiated “discount” prices are off the inflated charges and may include hidden PBM fees. These fees are then paid to the PBMs by the pharmacies as a portion of the money patients pay them for prescriptions. Some refer to the payment to the PBMs as a “claw back.” That is why people who do not have insurance often pay less for a drug than people who use their insurance.⁴ They can deal directly with the pharmacies without paying any hidden fees.

Numerous web-based pharmacies, by eschewing third-party payers, already offer patients deeper discounts than can be obtained by PBMs.⁵ They can soon be competing alongside PBMs with price-tracking apps, making shopping easy for consumers. Consumers who forgo their insurance by using these pharmacies are not subject to 30-day or 90-day supply restrictions imposed by health insurance plans and can purchase larger supplies of non-controlled medications, but state-level information regulations and pharmacy regulations need updating for these kinds of innovations to propagate.

Most state pharmacy regulations only permit electronic transfers of original prescription orders between pharmacies owned by the same company that use a common or shared database. For example, in most states, pharmacy law currently permits a patient to have a prescription moved from a Walgreens in one city to a Walgreens in another city by a pharmacy technician or another assistant. While it is not required that the pharmacist perform the e-transfer, this type of prescription updating appears relatively easy for patients.

When two pharmacies are not within the same chain and therefore do not have a shared database, a patient must formally request that a pharmacy transfer the prescription to another pharmacy. In that case, most states only allow a pharmacist or pharmacist intern to transfer the prescription to the new pharmacy, where only a pharmacist or pharmacist intern may receive it.⁶ But under ordinary circumstances, patients using prescription apps who discover they can get a better price for their prescription at a competing pharmacy must make a request to the pharmacist to transfer the prescription to the less-expensive pharmacy.

In most states, pharmacists are not required to oblige such requests and certainly might not prioritize requests to transfer their business to a competitor. Patients can also contact their prescriber to request that a new prescription be issued to the cheaper pharmacy. In some cases, a prescriber will require them to make another office visit just to get the same prescription sent electronically to a different pharmacy. Both options can be inconvenient, time-consuming, and not worth the effort. This presents substantial difficulty for many patients, such as those traveling and needing to transfer a prescription. Furthermore, such inconveniences disincentivize comparison shopping.

State pharmacy regulations have no provisions to address the transfer of prescription orders and prescription history to intermediaries that act on behalf of the patient, including nondispensing pharmacy networks. Nondispensing

pharmacists are often important team members in integrated health care systems.⁷ These are licensed pharmacists who do not dispense drugs. However, they provide advice to patients and prescribers on drug interactions and coordinate and manage dosing and timing of prescribed medications. Nondispensing pharmacy networks are entities that employ pharmacists to provide clinical services aimed at optimizing patients' drug therapy programs to health plans, health care facilities such as nursing homes, and individual patients, but they do not dispense medications.⁸ Such networks are qualified and well positioned to be among the intermediary navigators envisioned here.

State pharmacy and information transfer regulations are insufficient for today's technological advances that can empower patients in the health care marketplace. The federal government updated regulations to comport with technological advances. Now it is time for states to do the same.

PROPOSAL

Putting patients first should be the goal of any health care reform. In many states, regulations do not allow patients to control their prescriptions, and they block patients from the benefits of the revised federal rules expanding patient information access and control. Removing these obstacles would allow a new market in which prescription drug pricing is more transparent to fully blossom.

To improve patients' health and financial well-being and allow them to benefit from technological advances, states should remove regulatory obstacles to the electronic transfer of prescriptions between pharmacies not owned by the same company and not sharing a common database. They must also remove the requirement that such transfers may only be conducted between pharmacists or pharmacy interns.

Furthermore, states should pass legislation that explicitly requires health care providers, including pharmacies not within the same company, to electronically transfer a patient's current medication history to a provider designated by the patient. This would take place upon a patient's request and would be consistent with federal regulations allowing patients access to their medical records. The legislation should stipulate that transferred prescriptions or prescription refill orders would serve as the equivalent of the original electronically transmitted prescription order. It should also require that, upon a patient's request, their current medication history be transferred to a designated third party via a smartphone app. The third party, in turn, will

make prescriptions available for dispensing pharmacies to retrieve and fill as instructed by the patient.

In essence, these reforms would allow patients to own their prescription history and control where to receive their medications. Removing current rules that make it inconvenient for patients to take advantage of price information already available from online and app-based services will stimulate price competition among pharmacies. This competition should lower prices and improve convenience, potentially increasing medication adherence.

Moreover, with these barriers gone, new types of services can emerge, including those that avoid third-party payers and that offer direct-to-consumer pricing. Insurance plans usually limit the dispensed amount of a prescribed noncontrolled medication to either a 30-day or a 90-day supply. Third-party payer restrictions do not apply when patients buy from direct-to-consumer pharmacies without involving their health plans. This allows them to buy a full year's supply of a noncontrolled drug at once, adding cost savings and convenience.⁹ Price-tracking smartphone apps may allow direct-to-consumer pharmacies greater market access.

Customers will be empowered by the easy access to information about drug price differences among a wide array of competing pharmacies. As non-dispensing pharmacies and other intermediaries compete in this new market, expect innovations such as free same-day prescription delivery services, patient education services, and provider rating features. Patients who already seek services from direct primary care and concierge medicine providers should immediately appreciate the advantages this reform offers.

The Goldwater Institute developed model legislation to guide lawmakers who seek to implement such reforms.¹⁰ The model legislation requires that medical practitioners transfer medication history and prescriptions “to a patient’s preferred non-dispensing pharmacy network via smartphone app whereby prescription[s] can be made available for dispensing pharmacies to retrieve and fill prescription[s] as directed by [the] patient.” It requires non-dispensing pharmacy networks to keep records of all inbound and outbound prescription medication activity for seven years. The model bill does not discuss other types of app-based intermediary networks that a patient may wish to contract—it only refers to nondispensing pharmacy networks via smartphone apps. This might be for strategic reasons. The model legislation also provides instructions for circumstances in which connectivity between providers and smartphone app intermediaries is lacking.

OVERCOMING OBSTACLES

Many special-interest groups benefit from the status quo and may oppose these reforms because of their financial interest. For example, existing state regulations making it more difficult to transfer a prescription from a pharmacy to its competitor benefit some pharmacies at the expense of consumers. These pharmacies will likely argue that the regulatory status quo is in the best interest of patient safety.

Pharmacy boards are likely to claim that price-tracking apps managed by nonpharmacists, who may be unaware of drug interactions and contraindications, are a safety risk to patients. However, such apps merely compare prices for prescriptions ordered by licensed health care professionals. The prescriptions ultimately are still dispensed by licensed pharmacists, who can exercise their professional expertise and judgment.

The Goldwater Institute's model legislation only refers to smartphone apps of nondispensing pharmacy networks. It becomes difficult for pharmacies and pharmacy boards to use safety concerns as an argument against this reform if transmissions are occurring between licensed dispensing and non-dispensing pharmacists and other health care professionals.

Electronic health record (EHR) vendors initially balked when the Department of Health and Human Services announced the new rules that allow patients to access their electronic health records using a smartphone app and to share their medical records. They claimed they would incur enormous costs adapting their systems to comply with the interoperability requirement. They also voiced concern about privacy risks.¹¹ By April 2020, the nation's largest EHR vendor, Epic, had announced that it supported the new rules. The American Hospital Association remained opposed, citing compliance costs and privacy concerns.¹² Its president, Rick Pollack, remained concerned that the rules did not adequately "protect consumers from actors such as third-party apps that are not required to meet the same stringent privacy and security requirements as hospitals."

Expect hospital groups and EHR vendors to raise similar concerns at the state level. However, privacy and security requirements for interoperability that satisfy requirements of the Health Insurance Portability and Accountability Act (HIPAA) must be satisfied under the new HHS rule, and under the HHS "Blue Button" project, EHR vendors provide patients a secure way to download their information from a provider's database. The Blue Button

symbol signifies the provider's site has functionality for patients to securely download their records.¹³

Pharmacies may argue it is dangerous for people to use price-tracking apps to distribute prescription orders because prescriptions could be divided among multiple pharmacies, and pharmacists may be unaware of other medications patients are receiving from competitors that might interact with the prescription they are dispensing, but the same is true now. Presently, pharmacists only see the medication history of their patients within the shared company database. It is not unusual for patients to ask their provider to electronically transmit different prescriptions to different pharmacies to save money. The model legislation requires the smartphone app network to maintain records for seven years, from which patients can access a more complete medication history if needed. This feature aligns with federally established Blue Button requirements.

Opponents might raise concerns over how reform would handle prescriptions of controlled substances. The model legislation provides that for the e-transfer of prescriptions covered under the federal Controlled Substances Act, "the medical practitioner and pharmacy shall ensure that the transmission complies with any security or other requirements of federal law."

Unlike GoodRx and SingleCare, which only display PBM-negotiated discounts, emerging apps might display prices offered by direct-to-consumer pharmacies alongside PBM-negotiated prices with different pharmacies. The PBMs might argue that letting patients see the difference between PBM-negotiated prices and direct-to-consumer prices will undermine their efforts to negotiate better prices for the insurance plans they serve, but letting consumers see the difference between the price negotiated by the PBM and the amount of money that is being paid to the pharmacy does not hinder PBM negotiations. Instead, it puts pressure on PBMs to lower their claw-back amounts because of enhanced competition with web-based direct-to-consumer pharmacies.

Health insurance plans may oppose this reform as patients discover they can more effectively cut out-of-pocket drug expenses by using price-tracking and nondispensing pharmacy apps in lieu of their health plans. This helps open the way for disrupters like Amazon and Walmart to offer alternative health plan models to patients and employers, including employers with self-insured health plans.

While some interest groups will oppose this policy reform, permitting patients to fully own their prescriptions should attract support across ideological lines. Reform advocates should cultivate alliances with consumer groups,

faith-based health-sharing ministries, the American Association of Retired Persons, the Association of Mature American Citizens, and other consumer empowerment organizations. This reform is simple. It does not require any revenue expenditure. It imposes no costs on taxpayers or health care providers. It simply updates state regulations that did not anticipate advances in communication technology so patients can make use of an exciting new market that was heretofore suppressed.

ABOUT THE AUTHOR

Jeffrey A. Singer, MD, practices general surgery in Phoenix, Arizona, and is a senior fellow at the Cato Institute and a visiting fellow at the Goldwater Institute. He is a principal and founder of Valley Surgical Clinics, Ltd., the oldest and largest group general surgery practice in Arizona. He received a BA in biology from Brooklyn College (City University of New York) and an MD from New York Medical College. He is a Fellow of the American College of Surgeons.

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Implement Transparency

Release Data to Improve Decision-Making

Heidi Overton, MD

KEY TAKEAWAYS

- There is a significant amount of waste in the U.S. health care system, some of which is driven by inappropriate or unnecessary health care services. Receiving inappropriate or unnecessary services can harm patients and lead to worse health outcomes.
- More than 70 million Americans are enrolled in the Medicaid program, so Medicaid contains a wealth of information about the services received by patients. States should utilize Medicaid data and make it publicly available to help inform patients and providers about the delivery of health care services.
- Providing information about physician practice patterns could improve patient outcomes by reducing provision of unnecessary and inappropriate care and increasing patient selection of clinicians that deliver higher-quality care.
- Appropriateness measures should target areas where there is evidence of significant waste or clinical harm. One potential target area is low-risk Cesarean section. Of U.S. births categorized as “low-risk,” 25.6 percent were delivered by Cesarean section—a surgical delivery typically reserved for high-risk births. Reduction of low-risk Cesarean sections could improve maternal health outcomes and reduce birthing costs.

PROBLEM

Medicaid recipients often receive low-quality care and have worse health outcomes than the general U.S. population.¹⁻³ State Medicaid programs can improve beneficiary health by reducing inappropriate or unnecessary care.

In a 2017 survey, physicians estimated that 21 percent of medical care delivered is unnecessary.⁴ According to some estimates, waste in the U.S. health care system costs between \$760 billion and \$935 billion, nearly one-quarter of total health spending. Overtreatment alone was estimated to account for \$76 billion to \$102 billion of that wasteful spending.⁵ Applied to Medicaid, these estimates suggest that roughly one-quarter of the program's spending, which reached \$613 billion in 2019, is spent on unnecessary care and one-tenth is spent on overtreatment.

Appropriateness of Health Care Services

Appropriateness measures, developed with the input of clinical experts practicing in the area under consideration, can be used to evaluate individual physician practices and drive improvements in care. Unlike traditional quality measures, many of which assess single instances of care (i.e., wrong-side surgery), appropriateness criteria are adaptable and longitudinal, meaning they can quickly change as consensus recommendations evolve and can assess a physician over a long period of time. A 2018 Department of Health and Human Services (HHS) report observed problems with existing quality measures: "In the past, the government has often failed to establish sensible metrics, creating significant reporting burdens for providers and metrics that are not informative for patients or industry and can easily be gamed when reimbursement is tied to them."⁶

Two U.S. Government Accountability Office (GAO) reports, in 2016 and 2019, called for improvements in the government Quality Measurement Enterprise (QME), noting that many metrics promulgated by government programs do not drive hoped-for improvements in health outcomes.^{7, 8} The peer-reviewed literature has echoed the need for improved quality metrics, documenting the shortcomings of many existing metrics: questionable validity, failure to account for the most up-to-date evidence, and implementation costs that can exceed purported benefits.⁹⁻¹¹

Appropriateness measures should be clinically actionable for individual physicians, should prioritize patient outcomes, and should target practice

areas where there is evidence of significant waste or clinical harm.¹² The Improving Wisely project, discussed in detail here, uses physician-specific metrics to advance the delivery of high-value care.¹³ These metrics, developed by provider consensus, aim to reduce clinical waste. Examples of measures include number of biopsies per screening colonoscopy; percentage of elective hysterectomies performed with a laparoscopic approach; number of stages per case in Mohs surgeries; incidence of polypharmacy in the elderly; dosage and duration of opioids prescribed after common medical procedures; and the rate of early peripheral revascularization for claudication.¹⁴⁻¹⁶ The following case study describes how waste can be decreased and care quality improved by applying the Improving Wisely methodology to a clinical practice area known for having suboptimal outcomes for Medicaid recipients.

The Cesarean Section Case Study

Three conditions related to pregnancy and childbirth (liveborn, complications during childbirth, and previous C-section) are extremely common in the Medicaid program.^{17,18} New analysis from the National Vital Statistics Reports (NVSr) found that in 2019 Medicaid paid for 42.1 percent of all births in the United States,¹⁹ including 65.1 percent of deliveries among black women and 29.4 percent of deliveries among white women.²⁰ Cesarean sections (C-sections) were performed in 31.7 percent of *all* U.S. births and were performed in 25.6 percent of U.S. births categorized as “low-risk.”²¹ Low-risk C-sections are surgical deliveries performed for a woman’s first baby, after she has been pregnant for at least 37 weeks, when she is carrying only a single baby, and where the baby would come out headfirst if delivered vaginally.²² C-section rates vary by race, with 35.9 percent of black women delivering by C-section versus 30.7 percent of white women, and with 30.0 percent of black women undergoing low-risk C-sections versus 24.7 percent of white women.²³

Women who undergo C-sections are at higher risk for postnatal infections and blood clots than women who deliver vaginally, although the incidence of these complications is rare overall.²⁴ Nearly 90 percent of subsequent deliveries by women who have undergone a previous C-section will *also* be by C-section.²⁵ Data suggest that by decreasing the number of low-risk C-sections they perform, physicians can reduce birthing costs and significantly improve maternal health outcomes. It has long been a public health goal to

reduce the number of low-risk C-sections performed, both to improve care quality and to reduce racial disparities in maternal health outcomes.

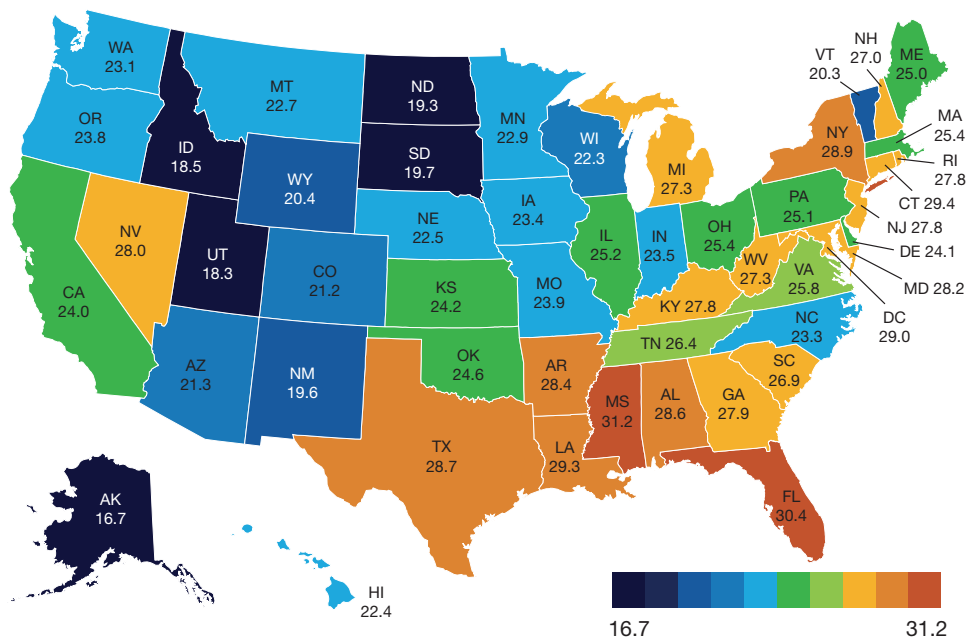
In July 2015, the National Association of Medicaid Directors and the Association of Maternal and Child Health Programs released an issue brief titled “Low-Risk, Primary Cesarean Births in Medicaid.” The brief identified excess use of low-risk, primary C-section as an opportunity for quality improvement and value delivery. The brief further described multiple pathways to reform, including “transparency and reporting on low-risk C-section rates; education efforts for providers and consumers on the risks of non-medically indicated C-sections; and payment mechanisms that target the overuse of C-sections for low-risk, first-time mothers.”²⁶

Despite this initiative from leading organizations, the previously referenced NVSR data showed that overall low-risk C-section rates did not change, accounting for 25.7 percent of births in 2016 and 25.6 percent of births in 2019.²⁷ As demonstrated in Figure 8.1, there is substantial state-level variation in low-risk C-section rates, with the South having the highest rate, followed by the Northeast.²⁸

PROPOSAL

There is bipartisan support for increasing health care transparency, with respect to both prices and quality. This transparency is necessary for Americans to make better health care decisions. Part of this information includes an understanding of physician practice patterns, why practice patterns matter for care quality, and how physicians compare to each other. Since Medicaid pays for health care services for tens of millions of Americans, the program has a wealth of information that can help the decision-making of both physicians and patients. States should first permit Medicaid data to be analyzed for these purposes and make such data publicly available. Second, for certain procedures or services where physician consensus about appropriate practice patterns is clear, states should make the practice pattern information (e.g., physician C-section rates for low-risk pregnancies) available both to physicians and to the public. Note that these clinical appropriateness measures should be viewed as a complement to traditional quality metrics.

In this example, a clinical consensus would determine the maximum percentage of low-risk C-sections that an individual physician should perform. Accessible publication of individual physician low-risk C-section rates would empower women with Medicaid coverage to choose providers with low-risk



Source: Centers for Disease Control and Prevention, National Center for Health Statistics/National Vital Statistics System Birth Date, 2018. https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_13_tables-508.pdf

Figure 8.1 Rate of low-risk Cesarean deliveries per 100 deliveries by state, 2018.

Note: These rates are based on NTSV cesarean deliveries, which occur among women who are pregnant for the first time, are at a minimum 37 weeks of gestational age, giving birth to a single baby (no twins or multiples) that is in the vertex position (positioned in the uterus with the head down). The measure used to generate these rates differs from the measure used to calculate the 31.9 percent overall cesarean estimate, which includes all births.

Source: Graphic adapted from U.S. Department of Health and Human Services, “Healthy Women, Healthy Pregnancies, Healthy Futures: ACTION PLAN TO IMPROVE MATERNAL HEALTH IN AMERICA,” December 2020, https://aspe.hhs.gov/sites/default/files/private/aspe-files/264076/healthy-women-healthy-pregnancies-healthy-future-action-plan_0.pdf, p. 62.

C-section rates in the clinically appropriate range and encourage physicians to evaluate their practice patterns relative to the clinical consensus of their peers.

Learning from an Established Approach to Improve Appropriate Health Care Delivery

In 2015, the Centers for Medicare and Medicaid Services (CMS) made National Physician Identifier (NPI) numbers available to researchers analyzing

CMS claims data.²⁹ The CMS said that its goal was to “benefit health care consumers through a greater understanding of what the data says.”³⁰ Researchers at Johns Hopkins University began to analyze physician-level data and noted some irregular practice patterns.³¹ While some practice variation could be explained by differences in patient populations, the practice patterns of some physicians were clearly outside the range of reasonably appropriate care.

The Improving Wisely project, initially funded by the Robert Wood Johnson Foundation and led by Johns Hopkins University professor and surgeon Dr. Marty Makary, works with clinical experts and specialty societies to develop consensus definitions of “outlier” practice patterns for episodes of clinical care. As part of the consensus-building process, clinical experts in a specialty establish boundaries for acceptable medical practice variation. While variation in medical practice should be embraced, as it allows for learning and innovation, there are limits to what is considered acceptable variation.³² Outside this range, a physician could be considered an outlier, perhaps in need of information and education. Once standard practice thresholds are set via clinical consensus, the Improving Wisely project then reaches out to outlier doctors to let them know of their status compared to their peers, a process called “peer-benchmarking.”

This approach was used by the American College of Mohs Surgeons (ACMS), a society of skin surgeons, which came to a consensus on the acceptable average number of cuts per case a skin surgeon should make to resect a skin cancer. The ACMS identified outlier surgeons—those making too many cuts—and notified them of their outlier status.³³ In a nonrandomized controlled trial of U.S. Mohs surgeons, 83 percent of outlier surgeons who were notified of their status reduced the average number of cuts they made per case.³⁴ Similar interventions to reduce postprocedure opioid prescribing and polypharmacy in the Medicare population are being assessed by the Improving Wisely research team.

Applications for State Medicaid Programs

State Medicaid programs can utilize the Improving Wisely project’s approach to provide patients with information they need in advance of receiving care and to provide physicians with data that could improve their practice. For clinical care areas where significant waste or clinical harm have been identified, such as low-risk C-sections, states should utilize appropriateness measures and

move beyond confidential data sharing with individual physicians to public reporting to help patients make the best possible decisions.

Data Access

The CMS's Transformed Medicaid Statistical Information System (T-MSIS)³⁵ provides data sufficient to allow states to calculate physician practice patterns. Provider identifiers are available in T-MSIS, allowing states to distinguish providers in claims data and to link Medicaid data with other data sources.

Meaningful Metrics

For appropriateness metrics to be meaningful, they should be reliably measured by claims data and supported by the applicable clinical community. Peer-to-peer physician comparison methods, with metrics developed by the physicians with expertise in that area, will have the most support and thus the most impact.

State Medicaid programs can secure actionable appropriateness measures by using established state or federal metrics or contracting with companies that have developed or can develop such measures. One such company, Global Appropriateness Measures, is a consortium of organizations using appropriateness measures in big data to identify global areas of waste and overtreatment.³⁶ Some of the Global Appropriateness Measures participating organizations, such as Accolade (a personal health and benefits solutions company) or Cedar Gate (a value-based care platform), are incorporating appropriateness measures into their business models in order to reduce unnecessary care.^{37,38} Regardless of the development method, metrics chosen by states should be able to delineate the boundaries of standard practice to allow identification of outlier physician practice patterns. Conceptually, the appropriateness measures would be similar across states.

Displaying Data

Many states publish hospital or health plan performance in specific quality metrics. Continuing the case study on low-risk C-sections, the Louisiana Medicaid program offers a strong example of transparency through provision of health-plan-level statistics on Cesarean rates for low-risk, first-birth women (see Figure 8.2).³⁹

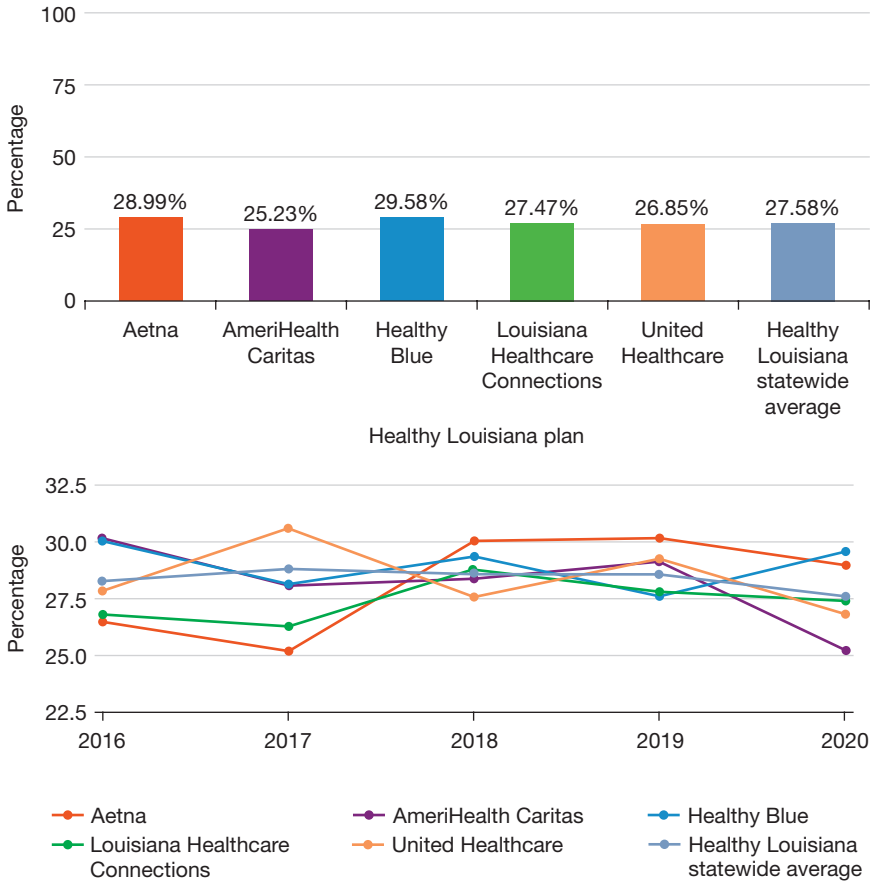


Figure 8.2 Cesarean rates for low-risk, first-birth women, 2016–2020 (top) and 2020 (bottom).

Note: These are inverse (incentive-based) measures.

Source: Louisiana Department of Health, “Medicaid Managed Care Quality Dashboard,” <https://qualitydashboard.ldh.la.gov/>.

While this data may be useful to patients choosing a health plan or hospital, it is not actionable for Medicaid patients seeking to avoid unnecessary C-sections, nor does it allow physicians to benchmark their practice against those of their peers. However, by displaying similar data broken out by individual *physician*, patients can use the data to inform their choice of doctor, and doctors can use the data to benchmark themselves against their peers.

Next Steps

Medicaid claims data can reveal variations in physician practice and can be used to specify, in conjunction with expert consensus, acceptable bounds of practice variation. States should utilize a scaled approach of notification and public reporting. This approach recognizes that most practicing physicians intend to provide high-quality care and will strive to improve their practices when made aware of opportunities to do so. This approach also allows rapid adaptation to changing clinical environments and practice recommendations while still assessing practice patterns over time through the use of retrospective claims data.

On the flip side, the approach can be used to reward clinicians who consistently deliver the standard of care in priority clinical areas. Prior authorization requirements could be relaxed for clinicians who practice appropriate care. While the details of implementation would be negotiated between physicians and managed care organizations, the provision of rewards can be used to promote high-quality care.

The approach should be applied to any high-expenditure Medicaid practice area with identified components of low-value care. For example, there appears to be an overuse of stainless-steel crowns in baby teeth in children enrolled in Medicaid.⁴⁰ The rates and clinical circumstances under which dentists are performing this procedure should be evaluated, and appropriateness measures should be developed and deployed.

OVERCOMING OPPOSITION

A top concern of policymakers is how physicians will respond. This is of special concern for state Medicaid directors, who are loath to offend physicians when there are existing shortages of physicians accepting Medicaid patients. Fortunately, the Improving Wisely approach has received strong support from key clinical leaders. Dr. Jack Resneck, the president-elect of the American Medical Association, coauthored an article supporting the provision of accurate, actionable performance data to Mohs surgeons.^{41,42} In the commentary, Dr. Resneck and his coauthor, Dr. Marta VanBeek, recommended benchmark metrics that target areas of significant waste or harm, saying, “The quality and cost measurement enterprise must be reimagined so that it exclusively targets significant problems that patients and physicians care about while mitigating data collection and reporting burdens that discourage

physicians who are motivated by quality improvement but frustrated by past measures.” This proscription from Drs. Resneck and VanBeek should guide policymakers working to improve quality, particularly those policymakers responsible for managing state Medicaid programs.

The public display of physician outcome data is not new. The Society of Thoracic Surgeons launched a public reporting initiative in 2010 that allowed participating surgeons to voluntarily release their clinical outcomes.⁴³ Other initiatives that deployed behavioral interventions and physician report cards have led to desirable behavior change.^{44,45} Policymakers may have concerns about how appropriateness measures fit into the existing quality measurement framework, and they may have concerns about the costs of data analysis and publication. State Medicaid directors should view appropriateness measures as a complement to current quality metrics. Because they are abstracted from existing claims data, there will be no attendant reporting burden leveled on physicians. The costs of data analysis and display will be contingent on a state’s existing technical resources but should be small compared with the potential savings from reduced waste and increased quality.

Policymakers may also be concerned that this intervention represents government overreach into the practice of medicine. This concern is unfounded, as the government role in this context simply consists of utilizing appropriateness measures and releasing data. The public display of physician practice patterns is aimed at creating a better-informed patient and provider population. By providing transparency into physician practice patterns and utilizing clinically actionable appropriateness measures, Medicaid programs can reduce waste and empower patients and physicians in a way that results in improved quality of care, particularly for the most vulnerable.

ABOUT THE AUTHOR

Heidi Overton, MD, is the director of the Center for a Healthy America at the America First Policy Institute. Overton recently served as a White House fellow in 2019–2020 in both the Office of American Innovation and the Domestic Policy Council. She is currently a PhD candidate in Clinical Investigation at the Johns Hopkins University Bloomberg School of Public Health and is completing her medical training in preventive medicine. Previously, Overton was a general surgery resident at the Johns Hopkins University School of Medicine, and a physician advocate for price and quality transparency in health care through Restoring Medicine. During medical

school, Overton was appointed by Governor Susana Martinez to serve on the University of New Mexico (UNM) Board of Regents, which included fiduciary and full-voting responsibilities for all business and clinical operations of the university and health system. She holds a BA in health, medicine, and human values from the UNM Combined BA/MD Program and received an MD from the UNM School of Medicine.

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