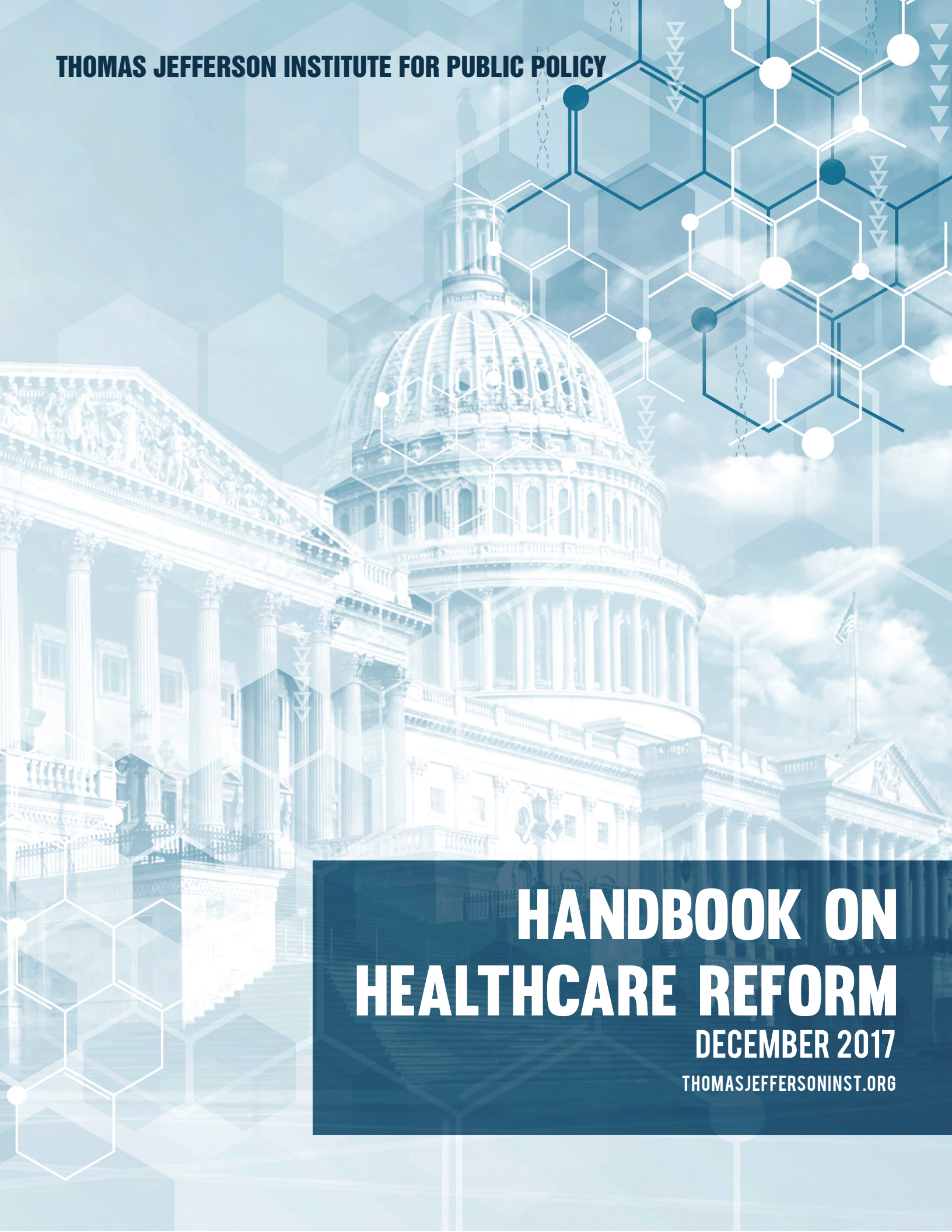

THOMAS JEFFERSON INSTITUTE FOR PUBLIC POLICY

HANDBOOK ON HEALTHCARE REFORM

DECEMBER 2017

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Thomas Jefferson Institute for Public Policy

The Thomas Jefferson Institute for Public Policy is a non-partisan research and education organization devoted to improving the lives of the people in Virginia. The Institute was organized in 1996, and was the only state and local government focused public policy foundation in Virginia based on a philosophy of limited government, free enterprise and individual responsibility. It is a "solutions tank" seeking better ways to accomplish the policies and programs currently being undertaken by state and local government – always based on the Institute's underlying philosophy. The first study was published in February 1997.

The work of the Thomas Jefferson Institute for Public Policy is geared toward educating our political, business and community leadership about the issues facing our society here in Virginia. The Institute offers creative solutions to these problems in a non-partisan manner.

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FOREWORD

One of the most contentious issues facing our citizens deals with healthcare, its costs and its availability. This is an issue that has been "front and center" in American politics for years and it is one that the state legislators here in Virginia will be facing again and again.

Healthcare is a highly regulated and complicated system with government involved at the federal and state levels.

This Handbook on Healthcare Reform is an effort by the Thomas Jefferson Institute for Public Policy to bring ideas to the table for discussion and legislative debate in order to highlight areas where Virginia and other states can take action to reduce costs, increase availability and thus broaden the number of people who can better afford, thanks to the reforms outlined in this Handbook, to see a doctor.

We hope that this Handbook will provide ideas to our state legislators, healthcare providers, government leaders, and policy leaders throughout the state reasonable ideas where healthcare can be improved through innovative policy reforms.

The Thomas Jefferson Institute worked closely with Dr. Hal Scherz of Atlanta to create this special Handbook on Healthcare Reform. We wanted to bring together the ideas of doctors and other experts in the field of Healthcare on how healthcare can be reasonably reformed so that a better system is the result.

Dr. Scherz reached out to colleagues around the country to write essays on specific areas of healthcare that they felt should be reformed in order to better serve their patients. These doctors work within the current web of regulations and they provide innovative ideas on creating a less bureaucratic system that can improve the overall healthcare delivery system. And we found a few essays from academic healthcare experts to add ideas to this Handbook.

As the founder of "Docs 4 Patient Care," Dr. Hal Scherz has a deep interest in how healthcare can be improved for all of us and he spent a good deal of time in helping us put this Handbook together. He is well respected urologist and is deeply interested in improving the healthcare system in this country. We deeply appreciate his time and effort in this project.

This Handbook on Healthcare Reform brings ideas to the table for public debate and discussion. It is not an effort to support specific legislation, although it is hoped that the ideas presented herein will become public policy as is the case with Direct Primary Care (DPC) that became state policy earlier this year when Governor Terry McAuliffe signed legislation into law. This DPC law will allow those in underserved areas to gain better healthcare access if it works as it has in other states. We are proud to have had a small role in putting some of the early pieces together which ultimately resulted in this new law here in Virginia.

The ideas brought forward in this Handbook are from a number of authors. We have listed the authors at the beginning of this Handbook in the order that their essays appear in this publication. Those who have more than one article are listed in the order of their first article.

We hope that this Handbook on Healthcare Reform will initiate a much needed conversation on specific actions that can be taken to improve healthcare in our state and in the country. Oftentimes, those who opposed additional government involvement in the healthcare industry do a good job in saying "No." However, rarely does this conversation turn to specific actions that can be taken to improve healthcare while government involvement is avoided or reduced.

We hope that this Handbook provides a positive roadmap that can become an important part of the healthcare reform debate that will continue here in Virginia and throughout the country for a long time to come.

Michael W. Thompson
Chairman and President
Thomas Jefferson Institute for Public Policy
December 2017

INTRODUCTION

By: Hal Scherz, M.D.

There is almost universal agreement that healthcare in the US has problems. Regardless of your political affiliation and positions, there can be no denying that healthcare costs too much. There are many other problems such as access to care, the quality of care and the lack of perceived value for the money spent on healthcare and health insurance.

At the extremes there exists two competing philosophies about healthcare: the role of government, and the financing of it. Some believe that healthcare should be provided by the government and that there should be the single payer for this care. At the other extreme is the philosophy that the government has no business at all being involved in healthcare. With Medicare, Medicaid, and other government programs well entrenched, the solutions will lie somewhere in between.

The federal government has its "fingerprints" all over healthcare. The Affordable Care Act (Obamacare) was the latest attempt to move healthcare further toward the first extreme. The bureaucratic regulatory state has done more to contribute to the problems in healthcare than it has solved. Special interests such as insurance companies, large hospital corporations, and big Pharma have contributed to the problems in healthcare by making it more expensive than it needs to be. They have disproportionately taken more from the system than they have contributed.

It is impractical and unrealistic to wait and hope for solutions for healthcare to come from Washington D.C. Swift and meaningful changes can and should originate with the states. Every state is different and the needs of its citizens are best served when decisions are made locally and not passed down from Washington, in a one size fits all manner. Lawmakers at the state level are more attuned to the needs of their constituents and can be held more accountable for their actions or inactions.

This Healthcare Reform Handbook touches on a few of the important issues in healthcare that can be positively impacted at the state level. It is far from an exhaustive list but constitutes some big and not so big ideas that can lower healthcare cost, improve the delivery and quality of healthcare, and return some measure of medical decision making back to patients.

Medical tort reform, Direct Primary Care, Medicaid reform, Certificate of Need repeal, and relaxing or ending regulations on healthcare innovators who seek to improve care, access

and cost are just some of the ways that lawmakers in Virginia and in states across the country can honor the obligation to their constituents to improve healthcare. It is time for them to take a hard look at the issues and do the right thing, by putting patients' needs ahead of special interests.

The essays in this Healthcare Reform Handbook outline the problems in various areas of healthcare, how they adversely affect patients, and why and how to fix these problems.

If lawmakers focused on what is outlined in this Handbook, healthcare for their constituents would be dramatically improved and costs would come crashing down. Their states will rise in rank on the list of Healthcare Access across the country, and become a place where doctors wish to practice, patients flock to for their healthcare, and where businesses choose to relocate.

Everyone wins when we put the needs of the patients ahead of all other needs. Remember that eventually, we will all be a patient.

BIOGRAPHIES OF AUTHORS IN THIS HANDBOOK FOR HEALTHCARE REFORM

(These names are in the order of their articles in this publication.)

Dr. Hal Scherz, MD

Dr. Hal C. Scherz is the Founder and Secretary of Docs 4 Patient Care. He is a renowned Pediatric Urologist practicing in Atlanta Georgia. His training has taken him from New York to Texas to California at some of the most well regarded institutions in American Medicine. He is a full time practicing urologist at Children's Healthcare of Atlanta, and is an Asst. Professor at Emory University. He has one of the few fellowship training programs in Pediatric Urology in the US and serves as a principal investigator on numerous studies in his field of expertise and a reviewer for several peer reviewed journals in Urology.

Dr. Scherz has significant medical executive experience currently serving as the managing partner of Georgia Pediatric Urology. He is a former president of the American Association of Pediatric Urologists. He is currently on the executive boards of the Children's Healthcare of Atlanta Ambulatory Surgery Center, the Children's Healthcare Network of Atlanta, and the Children's Subspecialty IPA.

He is a highly sought after speaker on healthcare issues having appeared on numerous national TV news programs and nationally syndicated radio shows. In his specialty, Dr. Scherz has published over 70 articles and 6 book chapters. He has been named by Atlanta Magazine as one of the leading doctors in Atlanta each year since 2005. In the area of the national health care debate he has published editorials in some of the leading publications of the nation.

Dr. Mike Koriwchak, MD

Dr. Michael J. Koriwchak received his medical degree from Duke University School of Medicine in 1988. He completed both his Internship in General Surgery and Residency in Otolaryngology-Head and Neck Surgery at Vanderbilt University Medical Center. Dr. Koriwchak continued at Vanderbilt for a fellowship in Laryngology and Care of the Professional Voice. He is board certified by the American Board of Otolaryngology-Head and Neck Surgery.

After training Dr. Koriwchak moved to Atlanta in 1995 to become one of the original physicians in Ear, Nose and Throat of Georgia. He has built a thriving practice in Laryngology,

Care of the Professional Voice, Thyroid/Parathyroid Surgery, Endoscopic Sinus Surgery and General Otolaryngology. A singer himself, many of his patients depend on their voice for their careers. Some are well-known entertainers.

Dr. Koriwchak has performed thousands of thyroid, parathyroid and head and neck cancer operations. He was also one of the first to offer balloon sinuplasty for the treatment of chronic sinusitis.

Dr. Koriwchak has also been working with information technology since 1977. While an undergraduate at Bucknell University he taught a computer-programming course. In medical school he wrote his own software for his laboratory research. In the 1990's he adapted generic forms software to create one the first electronic prescription applications. Soon afterward he wrote his own chart note templates using Visual BASIC script. In 2003 he became the physician champion for ENT of Georgia's EMR implementation project. This included not only design and implementation strategy but also writing code. In 2008 the EMR implementation earned the e-Technology award from the Medical Association of Georgia.

Dr. Koriwchak serves as Vice President, Docs4PatientCare Foundation.

Dr. Jeffrey English, MD

Dr. English is the medical director of clinical research at the MS Center of Atlanta and is board certified by the American Board of Psychiatry and Neurology. He has been lecturing for over a decade on the economics of health care and its effects on the point of delivery. He authored a book on the fact of healthcare entitled, Now, It's Personal. The Truth about Health Care, Doctors, and Patients. In 2013, he was invited to testify at the House Oversight Committee Hearing, and he frequently gives lectures and interviews on healthcare reform.

Dr. Meg Edison, MD

Dr. Meg Edison is a pediatrician in private practice in Grand Rapids, Michigan and is actively involved in state level health care policy via organized medicine and grassroots physician efforts.

Dr. Edison graduated from Hillsdale College in 1996 with degrees in Biology and Chemistry and received her M.D. from the University of Michigan Medical School. She completed pediatric residency training at the Barbara Bush Children's Hospital in Portland, Maine in 2003 before returning home to Michigan.

Dr. Edison runs the popular blog Rebel.MD, Which garnered more than 100,000 readers in December 2015 when she posted an open letter to the American Board of Pediatrics stating her decision to opt out of the board's maintenance of certification process (commonly "MOC"), which she deems a fear-based money-making scheme that diverts doctors' resources of time and money away from providing top-flight patient care.

Dr. Edison serves on the Board of Directors for the Kent County Medical Society, has served as a delegate and reference committee chair to the Michigan State Medical Society House of Delegates, and has testified in the state legislature on many occasions on behalf of the state medical society and sometimes testifies in opposition to the state medical society.

Dr. Brian Hill, MD

Dr. Hill is a partner and practicing physician with Urology Specialists of Atlanta, is on the board of the Medical Association of Atlanta and is a delegate to the Medical Association of Georgia annual House of Delegates. He has been selected to the League of Leaders with the Institute of Healthcare Consumerism and service on the IHC editorial advisory board. Dr. Hill is the author of Stop the Noise: A Physician's Quest to Silence the Politics of Health Care Reform as well as numerous articles on healthcare reform.

Dr. Robert Graboyes, PhD

Dr. Robert Graboyes is a Senior Research Fellow and Health Care Scholar at the Mercatus Center at George Mason University. Author of "Fortress and Frontier in American Health Care," his work asks, "How can we make health care as innovative in the next 25 years as information technology was in the past 25?"

Previously, he was health care advisor for the National Federation of Independent Business, economics professor at the University of Richmond, regional economist/director of education at the Federal Reserve Bank of Richmond, and Sub-Saharan Africa economist for Chase Manhattan Bank. His work has taken him to Europe, Africa, and Central Asia. An award-winning teacher, he holds faculty appointments at Virginia Commonwealth University and the University of Virginia. Previously he taught at George Mason University and the George Washington University.

His degrees include a PhD in Economics from Columbia University; master's from Columbia University, Virginia Commonwealth University, and the College of William and Mary; and a bachelor's from the University of Virginia. He has chaired the National Economists Club, Richmond Association for Business Economics, and National Association for Business

Economics Healthcare Round-table.

Andrew Poole, FACHE

Mr. Poole began his career in healthcare as a Physical Therapist in 1998. After several years of clinical practice, he transitioned into leadership roles, becoming the Director of Therapies for Augusta Medical Center. In 2009, he received his Masters of Healthcare Administration from Virginia Commonwealth University, and later that year joined the University of Virginia Health System. He is a Fellow of the American College of Healthcare Executives.

In 2016, Andy became CEO of Monticello Community Surgery Center (or MCSC) in Charlottesville, VA. MCSC is a multi-specialty independent center with four operating rooms and a procedure room which began operations in 2003. At the core of the MCSC mission is to bring greater value to healthcare which it believes is enhanced by transparency in pricing, as well as outcomes. MCSC has shared transparent, bundled pricing on its website for the past 3 years and has helped many individuals and now self-funded companies saving money for their care.

Bill Finerfrock

Bill Finerfrock is Co-Founder and Executive Director National Association of Rural Health Clinics and President of Capitol Associates, Inc. in Alexandria, Virginia.

Dr. Steven Lee, OD

In addition to his formal training in eye care, Dr. Steven Lee has a background in engineering and optics. Before starting Opternative, an online vision test company, he was in clinical practice from 2007-2013. During that time, he focused on the areas of difficult contact lens fittings, ocular disease treatment, and dry eye management. In addition to seeing patients in the past, Steven has also taught ophthalmology students the basics of clinical refraction and the systematic approach to contact lens fittings. He has managed numerous surgical cases and was previously a reviewer for the Council on Optometric Practitioner Education, as well as a researcher and clinical investigator for the Global Revitalens Experience and Acceptance Trial. In addition to many of the public speaking engagements he has had, Dr. Lee has given a TEDx talk outlining his journey to make vision care accessible to the entire world, titled “Mission for Vision”. Dr. Lee has a focus on improving eye care accessibility around the world, and Opternative was his first endeavor to distribute eye care in a universal fashion.

Dr. Lee Gross, MD

Lee S. Gross, M.D. is Co-founder and Senior Vice President of Epiphany Health. He received his Bachelor degree from The Ohio State University in Columbus, Ohio, and earned his medical degree from Case Western Reserve University. After graduating from medical school he completed his residency in Family Medicine at University Hospitals of Cleveland, where he was chief resident. He is Board Certified in Family Medicine.

Dr. Gross has also been awarded Best Doctor in 2008 and 2010 by the North Port Sun-Herald newspaper.

Dr. Gross remains civically active and is currently serving on the Board of Trustees of Fawcett Memorial Hospital. He is a founding member and former chairman of the North Port Community Health Action Team. He serves on the Board of Governors of the Charlotte County Medical Society and serves as a delegate to the Florida Medical Society.

Beyond his new position as President of the non-profit Docs4PatientCare Foundation, Dr. Gross is the President of the Florida Chapter of Docs4PatientCare, a non-partisan national physician organization dedicated to implementing meaningful reforms that protect and reinforce the sanctity of the doctor-patient relationship.

Dr. Charles Blahous, PhD

Charles Blahous is the J. Fish and Lillian F. Smith Chair and Senior Research Strategist at the Mercatus Center at George Mason University. Blahous specializes in domestic economic policy and retirement security (with an emphasis on Social Security), as well as federal fiscal policy, entitlements, and health care programs.

Blahous served as a public trustee for Social Security and Medicare from 2010 through 2015. He was formerly the deputy director of President Bush's National Economic Council, special assistant to the president for economic policy, and executive director of the bipartisan President's Commission to Strengthen Social Security. He recently served on the Bipartisan Policy Center's Commission on Retirement Security and Personal Savings.

Blahous received his PhD in computational quantum chemistry from the University of California at Berkeley and his BA from Princeton University.

Dr. Matthew D. Mitchell, PhD

Matthew D. Mitchell is a Senior Research Fellow and Director of the Project for the Study

of American Capitalism at the Mercatus Center at George Mason University. He is also an adjunct professor of economics at Mason. In his writing and research, he specializes in public choice economics and the economics of government favoritism toward particular businesses, industries, and occupations. Mitchell 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.

Christopher Koopman

Christopher Koopman is a Senior Research Fellow and Director of the Technology Policy Program at the Mercatus Center at George Mason University. He specializes in regulation, competition, and innovation. His research and commentary has appeared in the Wall Street Journal, New York Times, Washington Post, USA Today, Bloomberg, and NPR. He is also a contributor at The Hill, and was named to Forbes' 30 Under 30 2016 for law and policy.

Koopman earned his J.D. from Ave Maria University and his LL.M. in law and economics at George Mason University where he now teaches in both the economics department and the George Mason University School of Law.

Anne Philpot

Anne Philpot is a Research Assistant for the Study of American Capitalism at the Mercatus Center at George Mason University. Her research on government-granted privilege supports the work of the team's scholars. Her writing has appeared in a variety of outlets including the Washington Post, Newsday, and US News & World Report. Prior to joining Mercatus, she interned at the Washington Policy Center in Seattle. Anne is a J.D. candidate at George Mason University Scalia Law School and holds a B.A. in political science from Seattle Pacific University.

Josh Archambault

Prior to joining the Foundation for Government Accountability (FGA), Josh served as the director of the Center for Healthcare Solutions and as program manager for the Middle Cities Initiative at Pioneer Institute, a Boston-based think tank. While at Pioneer he co-authored the nationally acclaimed book The Great Experiment: The States, The Feds, and Your Healthcare (2012).

Josh was previously selected as a health policy fellow at the Heritage Foundation in Washington, D.C., where his research concentrated on the impact of Obamacare on small businesses and the lessons that could be learned from Massachusetts. He served as a legislative director for Massachusetts State Senator Scott Brown and as senior legislative aide for Governor Mitt Romney in his Office of Legislative Affairs.

Josh holds a master's in public policy from Harvard University's Kennedy School of Government and a B.A. in political studies and economics from Gordon College.

Nicholas Horton

Nicholas Horton is the research director for the Foundation for Government Accountability. Nic's portfolio of research has focused on Medicaid expansion and welfare reform, including two groundbreaking reports that analyzed the impact of work requirements on welfare enrollees, finding massive increases in incomes. He is also the co-author of two first-of-their-kind studies on Medicaid expansion enrollment that garnered attention from numerous national media outlets.

Nic has provided policy analysis, legislative testimony, and policy briefings on Medicaid expansion and welfare reform in 19 states and D.C., ranging from Maine to Montana. His work regularly appears in Forbes, The Hill, and National Review Online, and he is a frequent guest on talk radio across the country.

Prior to joining FGA, Nic worked as a reporter and policy analyst for a free-market think tank in Little Rock, Arkansas, focusing on health care policy, tax policy, and government transparency. He holds a Bachelor of Science in Public Administration and a Master of Business Administration from Harding University.

WHY IS HEALTH CARE SO EXPENSIVE & WHAT CAN STATES DO TO LEAD THE WAY?

By: Hal Scherz, MD

If you ask the average person why healthcare is so expensive, they can't explain it. That's because they don't understand it nor how it operates. It is not really a system at all, but a nebulous economy that makes up between 1/5 to 1/6 of the Gross Domestic Product or GDP. It is a $3.4 trillion annual economy with many components.

Breaking things down into its simplest terms, there is healthcare and there is healthcare insurance. Many people consider the two to be indistinguishable. In a sense, they would be right. Healthcare insurance has become a type of a pre-paid health care arrangement. It has not always been this way, but over the past 50 years, since the creation of the government entitlement programs Medicare and then Medicaid, the third party payer system has replaced the transactional nature of medical service and the payment of these services to doctors. Private insurers also took over the responsibility of paying for services and leaving the patient out of the transaction altogether.

Over time, patients expected that their insurance would pay for most, if not all of the care that they received; from the simplest of services like removal of a wart, to open heart surgery. The problem is that they did not care how much something cost, nor did they ever ask. Neither did the doctor. Patients wanted something done, and doctors, not wanting to upset their patients by telling them "no," would order tests, do procedures, and give medications that might not have been warranted, but that made the patient happy. And since they "were not paying for it," all was good.

No one understood that there is never a "free lunch." They were in fact paying for everything in the form of increasing healthcare insurance premiums, which have been and continue to be spiraling up out of control. There has always been a "disconnect" with patients, regarding how much medical services cost, ever since they stopped directly paying for them. There has not been price transparency in medicine for over half a century.

The largest expense in the healthcare economy is hospital care. Hospitals are the new power brokers in healthcare. Federal and state regulations have been written in such a way which favors the hospitals at the expense of all others in the healthcare delivery system. Whether this was calculated or not is difficult to determine. However, there is no denying the fact that hospitals control healthcare in most places around the country.

They are paid at a higher rate for services than doctors who deliver the identical service outside of the hospital. The hospital gets additional funds from state and federal sources. They have stifled competition thanks to Certificate of Need laws which make it impossible for competitors to open up in the hospital's geographic area. Hospitals were unable to purchase physician practices in the past, but these regulations seemed to simply go away, enabling them to unfairly compete with doctors in the community and put them out of business. Large hospital systems can absorb smaller hospitals, further reducing competition in the marketplace. The list goes on and on.

The result of giving hospitals enormous power over healthcare, they have been granted "carte blanche" with regard to how much they will charge for medical services. No one is really certain how much things cost in the hospital, because two patients can have identical services and be charged vastly different amounts of money. It is perhaps the most arbitrary business in America. No one can tell you how much anything will cost, but you can be fairly certain that it has been marked up 5-10 times the actual cost.

The insurance companies previously paid the majority of healthcare bills. Most people were covered by plans that paid a portion of the hospital and physician charges, while the balance was "written off" because of the terms of the contracts with the insurers. Patients had small to no co-pays or deductibles. People were insulated from the shockingly higher and higher medical charges because of this third party arrangement. No one seemed to care much because it did not directly affect them. Now that more of the out of pocket costs are being transferred to patients in the forms of higher co-pays and deductibles, without any reduction in the cost of insurance premiums, they appear to be paying more attention.

There are several other big ticket items contributing to the high cost of care. The first is insurance mandates. Most Americans know about the Essential Health Benefits required to be offered by insurance companies participating in the Obamacare healthcare exchanges. This means that insurance costs are higher because more services are covered.

Insurance mandates predated Obamacare though, and have been controlled by state insurance commissioners for decades. They vary by state, but on average, there are 24 essential services that must be offered by an insurer who writes healthcare policies in a particular state. What those benefits are and how many must be included will depend on the lobby for a particular group of health care providers and how much influence they have over state lawmakers and regulators. For example, if the chiropractic lobby is very strong in a particular state and spends a lot of money influencing lawmakers, suddenly, chiropractic care is an essential benefit that must be offered by every insurer operating in that state. This is another reason why healthcare insurance costs are so high.

Another reason for the high cost of care is called Defensive Medicine. This is when doctors order tests that check for unusual problems that likely do not affect the patient, but if they did and the doctor missed it, would result in a possible large lawsuit against him or her. So, doctors order these tests to "cover their tail." This practice has been estimated to cost the system as much as $650 billion annually. And because patients are now picking up the tab on more items that insurance will not pay for and current deductibles are so high under Obamacare, this makes direct costs to patients even higher.

Any discussion about the high cost of healthcare would be incomplete if drug costs were not included. Drug prices in the US are the highest in the world. Some of the reasons can be explained while others are a mystery. The drug industry would say that the process of FDA approval is lengthy and expensive. It costs over $1 billion to develop a drug and bring it to the market, and on average, only 1 out of 20 drugs being developed makes it to the market. The pharmaceutical industry would contend that the patent process for drugs is unfair because it is difficult for them to recoup their investment in the 7-14 years of the life of an exclusive patent. The drug companies are businesses with a fiduciary responsibility to shareholders and should be expected to recoup losses and deliver a profit. Finally, the mass tort phenomenon that allows predatory lawyers to find "victims" who have taken certain medications and developed certain problems will have the result of dis-incentivizing companies from developing potentially life-saving treatments that may carry with them some risk of side effects.

These reasons for drug company behavior by no means are any excuse for predatory business practices on sick patients and price gouging. Even some drugs which are generic and have been around for years are suddenly, and without explanation, costing 50-1000 times of what they once cost. The only solution to this problem is for less regulation and allowing the international market to drive costs down, because these astronomical costs are only being charged in America, where these companies can get away with it.

The solution to all of these problems which are driving costs of healthcare up, is more competition, not more regulation -- a freer market where choices will result in costs coming down. Deregulation, both at the state and federal level, will open up markets. Price transparency should be required so that patients can once again be consumers. Insurance commissioners must allow insurance companies to write "basic " policies, and they need to embrace healthcare delivery models like Direct Primary Care, which cuts out third party payers and re-establishes a financial connection between patients, their doctors, and the cost of the care that patients receive from their doctors. Allowing patients to get care in facilities outside of the hospital will require eliminating laws that favor hospitals over doctors, such as the outdated Certificate of Need laws. Governors

should apply for Medicaid State Innovation Waivers (known as 1332 waivers), which will give them more flexibility to control healthcare spending for an out-of- control Medicaid program. These are some, but hardly not all, of the ways that states can begin to put some sanity back into an out of control healthcare system. It has to begin somewhere and the states are the best place to make these changes happen. It needs to be done tomorrow.

SCOPE OF PRACTICE: BE CAREFUL OF WHAT YOU WISH FOR

By: Mike Koriwchak, MD

(Editor's note: Many states have statutes making it difficult for non- physicians to deliver care without the direct supervision of a physician. Virginia would be such an example. Other states have relaxed regulations, making it possible for healthcare delivery by professionals who are not physicians. There are many reasons given by these professionals to open up the healthcare market to them. This piece, written by an ENT surgeon, is a cautionary opinion regarding pitfalls in taking a purely "Libertarian" view regarding this matter of opening up the market to "any willing provider.")

Not everything that is wrong about healthcare can be blamed on Obamacare. Lurking in the background is another potentially harmful threat to the practice of medicine: the politically driven expansion of the scope of practice of non-physician healthcare providers. This class of caregivers includes many professionals including optometrists, audiologists, certified registered nurse anesthetists, nurse practitioners and physician assistants. The vast majority of these professionals make invaluable contributions to patient care. However, the politically aggressive leadership of these organizations seeks to expand the scope of their practices to include treatments and procedures, many of which might be hazardous to patients when performed by individuals other than physicians. By altering the labeling of their training, conferring on them "doctorate" degrees, misrepresenting medical research regarding their professions and leveraging these with very aggressive and talented politics, they have made significant inroads towards gaining license to practice parts of medicine which, for the safety of patients, should be restricted to formally trained medical doctors with four years undergraduate training, four years of medical school and at least three (usually more) years of residency and fellowship training.

Before going any further it is appropriate again to recognize that the vast majority of each of these groups consists of talented, dedicated and worthy medical professionals who make tremendous contributions to patient care. But they do not hesitate to acknowledge the limits of their practice based on training. They are important members of a multidisciplinary health care team, led by physicians who rely on these highly trained professionals to complement them in the delivery of care. Unfortunately, the professional/political leadership of these groups is committed to fight for the ability of their constituencies to try to take on responsibilities that they might not be well suited to do, often with disregard for the safety of patients.

The most flagrant and unethical step that they have taken is to relabel their education and training processes, enabling them to confer on themselves doctoral degrees. They defend this step as a necessary one to reflect the increasing knowledge and complexity of the practice of medicine as the fund of medical knowledge is advanced. The argument is specious; the fund of knowledge is increasing for all medical professionals including physicians. But the relative differences in training between physicians and the other "mid-level" medical professionals remain. Their true objective is obvious – by conferring doctoral degrees, they refer to themselves the title of "Doctor" in an effort to mislead patients regarding their level of training and role in patient care. This self-proclaimed title is also very convenient politically since it implies to legislators and regulators that their training is indistinguishable from that of a medical school educated and residency trained physician.

Significant research has been done to compare the care given by primary care physicians with the care given by "mid-levels" such as nurse practitioners. Although many of these studies claim to measure overall patient outcomes, they actually tend to focus on small, easily measurable parameters such as blood pressure, cholesterol level and patient satisfaction. It comes as no surprise that for parameters such as these, the "quality of care" given by mid-level providers is comparable to that provided by physicians and, in some cases, even better. The reason for this is because these metrics actually measure what these caregivers are best at- the hands-on, compassionate, personal care required to successfully care for very challenging chronic diseases. Nurse practitioners are ideally suited to spend the extra time required to successfully manage patients whose diagnosis is already established and in whom a complete medical evaluation by a physician has already been performed. Most of the studies that compare nurse practitioner/physician assistants to primary care physicians have been performed under these conditions.

There is, however, evidence that mid-levels can cause significant harm to patients when they are given the ability to practice medicine beyond their training. A study published in JAMA Ophthalmology in 2016 reviewing over 1000 procedures documented that laser trabeculoplasty performed by optometrists generated over twice the complication/reoperation rate as those performed by ophthalmological surgeons (35.9% vs 15.1%).

The "cost/access" argument is another common narrative among those who support the expansion of mid-levels' scope of practice. They use the argument that there is a physician shortage, therefore mid-level practitioners are badly needed to help close the "provider gap." In an effort to appear sensitive to this need, insurers, hospitals and healthcare networks are eager to jump on the bandwagon as well. Unfortunately, there is absolutely no evidence that any cost savings in the form of lower provider fees (for example paying nurse practitioners less than physicians for similar care) will ever be passed on to the

patients themselves. In the current third-party payer system, insurance companies and hospitals will pay mid-level providers less, charge patients the same and pocket the difference. Consequently, it should come as no surprise that hospitals and insurance are on board with this concept.

The political action groups and leadership organizations representing mid-level providers are extremely motivated and well-funded. In Kentucky, legislation was successfully passed allowing optometrists to perform laser eye procedures in the office, inject medications into the eyes, and perform other minor surgical procedures around the eyes. Kentucky optometrists and their political action committees had given money to 137 of the 138 members of the state legislature and to the Governor, contributing over $400,000 in total. In the state of Georgia, where similar legislation was just passed, some extremely clever politics regarding legislative rules and procedures were employed between the House and the Senate, as well as some legislative sleight-of-hand involving hearing aid legislation, to allow bill SB 153 to pass just before the end of the legislative session in 2017.

The great physician Sir William Osler said, “It is astonishing with how little reading a doctor can practice medicine, but it is not astonishing how badly he may do it.” Similarly, it takes only minimal training (and no small amount of clever politics) for mid-level practitioners to feign competence regarding complex medical procedures.

Through politics and manipulation of language, physicians are now called “providers” and mid-level providers are now called “doctors”. Those who aspire to control the narrative have attempted to create a “universal equivalence” among all classes of medical professionals. This is inappropriate and hazardous for patients and deliberately misleading to legislators. Although mid-level providers make excellent physician extenders they are not capable of safely functioning as physician replacements. In the new world of medicine, all “doctors” are no longer created equal. Patients and lawmakers should take heed of the age old maxim “caveat emptor- let the buyer beware.”

TECHNOLOGY, TELEMEDICINE, AND APP BASED SOLUTIONS FOR HEALTHCARE

By: Jeffrey English MD

Science and technology are constantly improving our lives. Not only have we cut down on the time needed to accomplish great tasks, we have also improved the ability to perform them. The same is true in healthcare. In the case of healthcare, we have all heard stories about major scientific breakthroughs in therapeutics, diagnostic techniques, and surgeries from remote locations. We are at the point now where technology will drastically improve the way we interact and enhance our interaction with our healthcare providers.

The idea of traveling to a physician's office or healthcare facility will soon be as ancient as the idea of traveling across country on a horse or in a buggy. If you could sit in your home, stay at your office, connect from anywhere in the world and receive the same care from your physician, why would you choose any other method? I have patients that travel across a busy, traffic filled city, across my state, and from surrounding states to see me with travel time anywhere from 20 minutes to 6 hours. We will limit that waste and improve care.

Information is the key to maximize patient outcomes. Physicians need test results, imaging studies for review, and they need to evaluate the response from a new or altered medication. In the past, this information took weeks to obtain. Through digital results and patient driven wearable devices, this information will be available in minutes or in real time. In many cases now and most certainly a lot more in the future, this will limit the need to even go back to the physician's office. A recent article in the Wall Street Journal by Dr. Eric Topol outlines these advances as does this short paper. You can find that article here:https://www.wsj.com/article_email/the-smart-medicine-solution-to-the-health-care-crisis-1499443449-lMyQjAxMTE3MzAzODkwNjg1Wj/

Health Information

In medical school, I was taught that when I simply spoke to a patient, obtained a medical history and asked the questions necessary to get the full idea of the symptoms, I should be able to make an accurate diagnosis approximately 80% of the time. The physical exam and testing were needed for the other 20%. This information has relied on a patient's memory and patient data copied and mailed or faxed to our offices. I can now obtain an accurate history, see the results of testing, and often perform an equally proficient examination without having the patient in my office, the emergency room, or the hospital.

The most important information for physicians is a patient's past medical problems, family history, current medications and prior allergic reactions, along with prior testing, both laboratory and diagnostic. In electronic health record (EHR) systems now, this information is owned by dueling corporations designing systems that do not communicate with each other. A patient's history is still scattered all over various institutions in electronic charts, just as it used to be in paper charts of the past. It is not easily accessible.

There will be a time soon when, from anywhere in the world, a patient and his/her provider can access this information. Each patient should have their own personal "virtual medical file cabinet." The EHR from any doctor's office or hospital will send its data almost immediately to the virtual file cabinet. Pharmacies will send new or changed prescriptions. The data will be placed in the correct file in a more sensible order, easily accessible by any provider. We need a paradigm shift from medical facilities housing and owning patient medical information to the patient's being the owners and possessors themselves.

Accurate medical information updated almost immediately will improve patient care. It will save enormous amounts of money avoiding unnecessary testing and reducing medical errors. When a physician does not have your past information and prior tests, they often need to be repeated. When your physician has the results of prior testing at their fingertips, they will more accurately make a diagnosis and limit unnecessary work ups. Complications resulting from medication errors will be reduced.

Apps, Patient Involvement

The world of healthcare "Apps" will help revolutionize patient care. Smartphones and wearable devices are now able to track information needed to help your physician fine tune your care. They can now track your responses to medications for effectiveness and side effects. They can track cardiac information such as heart rate, rhythm, and blood pressure. Instead of setting up a follow-up visit at your doctor's office 6 to 12 weeks later for a snapshot of how you are feeling that day, technology will allow the relatively constant flow of pertinent information to your provider in real time. No more wasted hours or days playing "phone-tag" with your doctor's office trying to update and get an answer. Your doctor will monitor how you are doing and make contact digitally or by phone when changes need to be made.

Information obtained from Apps will need to be seamlessly incorporated into your medical file cabinet. I believe that the most important data physicians need easiest to access is a list of current medications, allergies, list of medical problems and most recent labs. However,

each patient may choose other medical information they feel is most important to their specific disease. The flow of information between Apps, the comprehensive medical file, and the physician is critical.

Telemedicine

The world of healthcare "Apps" will help revolutionize patient care. Smartphones and wearable devices are now able to track information needed to help your physician fine tune your care. They can now track your responses to medications for effectiveness and side effects.

Not only will your healthcare information be transported digitally to your doctor with great speed, so will you. "Formally defined, telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status. Telemedicine includes a growing variety of applications and services using two-way video, email, smart phones, wireless tools and other forms of telecommunications technology." (American Telemedicine Association)

Telemedicine has been around for years and now will begin to take over healthcare. Three things had to occur for this to happen. The first was technology. Technology had to be good enough to replicate what providers could do in person. We are at that point. Telemedicine system video capability is now fast enough and clear enough to simulate a live, in person, history and examination in a large number of cases. Test results, both written reports and diagnostic images themselves, can be seen simultaneously. Some telemedicine devices now have the same equipment doctors need when they examine patients in person, such as a stethoscope. Ophthalmologists can look in a patient's eyes and dermatologists can see a patient's skin with equal or better precision.

The second was demand. Demand first occurred in situations where live physicians were not available. Patients could be seen by providers thousands of miles away. No longer was it acceptable for a patient not to access a medical emergency service just because a hospital didn't have a specific type of physician. Patients and society now demand fast access to quality information and services. Current and future generations will not stand for delay in care, needing to take hours out of their day with travel, sitting in waiting rooms, when they can access similar care in minutes without leaving their location.

The third was legislation and, as usual, this has lagged behind the other two. Technology moves fast, legislation the opposite. However, technology and demand, coupled with telemedicine's ability to lower costs and increase care will undoubtedly drive legislation forward where it needs to be.

Neurology provides a great example of how technology, demand, and legislation came together to move telemedicine to the forefront of care. In neurology, it was in the case of acute strokes. Neurologist are in short in supply. Most hospitals do not have them.

New life saving therapies for acute stroke required action in a short time window of a few hours. Stroke therapies were supported by legislators and Medicare since stroke is the 3 highest cause of death in the United States and the highest cause of disability. Hospitals were being told that they needed to provide acute stroke care without the ability to do so. The problem was solved with telemedicine. Within minutes, hospitals could access the expertise of a neurologist when a patient arrived at the emergency room.

Video telemedicine can occur between 2 people through any 2 devices that have a camera. Apps and EHR's already exist that facilitate video interactions between providers and patients through secure platforms. These platforms will replace many of the office visits between primary care doctors and their patients. They will also allow a patient in their primary care doctor's office to connect with a specialist when consultation is needed. Specialty care can occur in minutes, the same day, instead of the 3 to 6 weeks it customarily takes to see a specialist in their office.

Legislation — the time to catch up with technology and demand is now

Legislators must allow healthcare to embrace technology wherever possible. Any advancement that makes it easier for doctors and patients to exchange information, enhance patient care through meaningful digital interactions, should be embraced as long as it meets privacy and security standards.

Legislators must remove barriers to healthcare innovation. When it comes to technology that improves care, makes access readily available, reduces costs, and improve efficiency, the lobbying efforts of groups that benefit from the old system must not be allowed to stand in the way.

Federal and state legislators must allow patients to access the healthcare system through digital and remote platforms if they choose to do so. Currently, each state legislates how a healthcare encounter can occur. In many cases, it is illegal for a patient to access a physician who is not licensed in their state via telemedicine, even if there are no physicians capable of handling the patient's problem in the state. While the states should retain their own jurisdiction of licensing rules, the rules governing patient accessing physicians out of state need to be more seamless.

One of the barriers that prevent the adoption of new technologies is the difficulty that doctors have getting paid for services associated with non-traditional healthcare encounters. State legislators need to ensure that physicians that offer innovative services receive compensation for them from third party payers if they are to be widely adopted.

Conclusion

Healthcare reform is supposed to improve patient care while reducing costs. It is supposed to increase access to needed care while reducing waste and unnecessary care. Technology, entrepreneurs, patient demand for telemedicine, and easy access to data will lead the way. Legislation at the state and federal level must embrace digital health and remove unnecessary obstacles standing in the way.

RIGHT TO CARE LEGISLATION PROTECTS PATIENTS & THEIR DOCTORS

By: Meg Edison, MD

Physician burnout, early retirement, and subsequent physician shortages are all current trends in medicine today and these problems are escalating. While many factors contribute to these problems, which are approaching crisis levels, a common thread is the seemingly endless, time-consuming, and expensive bureaucratic demands that takes away time from doctors and strips away the joy from patient care.

A good deal of this red tape comes from the federal government, with little to no relief in sight. Faced with federal dysfunction, the challenge for states is to find innovative ways to protect patients and their physicians with state based solutions.

One of the biggest contributors to physician burnout and early retirement—Maintenance of Certification (MOC)-has an easy, tested, and elegant state-level solution. The degree to which MOC is negatively affecting patients and their physicians cannot be overstated, yet very few outside medicine have heard of it or are aware that it is one of the key drivers in physician stress and early retirement.

One reason many have not heard of "MOC" may be because it has nothing to do with medical education, training, or licensure. "MOC" is an invention of the American Board of Medical Specialties (ABMS) that has changed board certification from a voluntary one time test, as originally intended, into a highly invasive, expensive, and mandated program that is resulting in good doctors leaving medicine.

In order to become a licensed physician, doctors must graduate from an accredited medical school and pass a series of examinations (USMLE Steps 1, 2, 2CS and 3). Following completion of a three to seven year residency program, doctors may apply for a state medical license to practice medicine. Each state has different "continuing medical education" (CME) requirements to demonstrate ongoing education necessary to maintain a medical license. This may be as many as 50 hours per year.

After completion of residency or specialty fellowship training, physicians may also take a "specialty board examination" administered by one of the 24 boards that comprise the American Board of Medical Specialties. The ABMS is a 501-c-6 non-profit organization, but that does not mean that they are not interested in developing products which will

bring revenue to their respective organizations. The board certifying exam is purported to be voluntary, inasmuch as it is not required for medical licensure in any state. The majority of physicians completing their residency take this exam because it conveys a level of expertise in their field. After passing the test, doctors are able to call themselves "board certified" in their specialty (surgery, pediatrics, internal medicine, etc.). The ABMS has branded the term "board certified."

Initially, this was a one-time examination, never to be repeated. In some respects it can be compared to the bar exam for lawyers or CPA exam for accountants, except that in the case of doctors, board certification is not required for state licensure. The problem is that over the past few years, these specialty boards changed the rules without any input from their diplomats (this term needs to be defined – who are these people and what do they do?), While at the same time working to make this program mandatory to practice medicine.

In an attempt to further increase revenues, the ABMS has moved from a one-time exam at a modest fee, to a program called "Maintenance of Certification" (MOC). This has mushroomed into a billion dollar industry involving multiple secure examinations, ongoing online testing, research on patients and exorbitant fees. The most recent analysis published in the Annals of Internal Medicine, estimates the cost of "maintaining certification" at $5.7 billion over 10 years with 32.7 million physician hours spent on this process instead of seeing patients. This analysis only looked at internists certified through the American Board of Internal Medicine. There are 23 other specialty boards doing the same thing.

These unilateral changes to board certification would not be quite so onerous if MOC was truly a voluntary program, as the specialty boards claim it is, and if physicians could simply opt out. Although not required for a medical license, ABMS has advertised their MOC product to hospitals and insurers as a "quality measure," despite any evidence to support this claim. Two recent studies in JAMA show MOC is not linked to better patient outcomes.

Hospitals and insurers want to advertise their doctors as "board certified" for marketing purposes, so MOC is often required for a physician to work in a hospital or to be included on an insurance panel. Physicians are in a very precarious position, where these outside, unaccountable board certification companies have ultimate authority over the ability for a doctor to practice medicine. As a result, doctors are forced to do anything, and pay any amount to the specialty boards, in order to work. Refusal by doctors to pay the thousands of dollars required to maintain their certification at any point, even after decades of

compliance, will result in the board stripping a doctor of its certification. There are no exceptions for extenuating circumstances such as a personal or family health crisis.

These tests are highly irrelevant and often outdated, and many are designed with a 20-30% failure rate to ensure re-examination with additional fees associated with it. If a physician fails the MOC exam a certain number of times, the only pathway to regain board certification is to complete an additional year of residency training. This can be demeaning to a physician who has provided excellent care to his patients for years, and disruptive or devastating to a medical practice and to patients. There are no waivers; there are no alternative pathways.

Unbelievably, the board members who invented MOC exempted themselves and their contemporaries, creating a "grandfathered" class that has no MOC requirements. This sets up a highly discriminatory credential that harms younger physicians, but exempts older physicians.

The MOC process and the desire to do away with it should not be interpreted as an attempt to avoid "keeping current." Physicians are licensed by the state and part of this process includes documentation that a physician has completed a minimum amount of Continuing Medical Education (CME) hours, set by each state Medical Board. It has never been up to the medical specialty boards to get involved with this, and the only reason that they do so is to participate in the financial benefits associated with testing doctors. Furthermore, it should be up to an individual doctor what the most beneficial continuing education would be for them, and not the decision of a specialty board.

Faced with this trap of endless testing, research, and fees, many physicians choose to retire rather than endure another cycle of MOC. For physicians who are willing to put up with this program because they wish to work in a hospital or see patients with insurance, there is still the negative impact upon patients. Compliance with this process takes away valuable time from doctors which could be better spent caring for patients. In addition, physicians are unable to choose the type of continuing medical education specific to them and the problems that they see in the patients that they serve. They are only allowed to learn what the boards think is necessary.

Most insidious is the "practice improvement" component of MOC, where physicians have to perform research projects on their patients, often without patient consent, and send that data to the specialty boards. Some of these research projects are seemingly benign but are completely useless, such as having patients rate the doctor's hand washing technique. Some are more concerning such as the requirement of doctors to enlist patients

into untested protocols for research purposes. Even more devastating is the impact on long-term medical progress: novel research is put on a back burner, as doctors are busy complying with the MOC research.

In as much as there is no oversight of these specialty boards, they can change requirements and fees capriciously. The efforts of the specialty boards to convince health insurers and hospitals to require physicians to purchase and participate in this product have been very successful. Physicians must choose between compliance, giving up their patients, or retirement. Options such as class-action lawsuits and federal anti-trust lawsuits are being pursued but are years away from being settled.

The best strategy at this time to deal with this MOC trap is via state legislation that protects the voluntary nature of MOC, preventing its requirement for hospital privileges, insurance participation or state licensure (being discussed in some states). In 2016, Oklahoma unanimously passed the first "Right to Care" legislation (SB 1148). In 2017, there are 13 states with Right to Care legislation pending. There currently is no one "model language" being used, although the American Legislative Exchange Council (ALEC) approved very broad model language in 2014 in the "Patient Access Expansion Act." Later this year, the AMA will also produce model state legislation on MOC.

"Right to Care" legislation protects patients and their physicians from undue influence by these outside unaccountable board certification companies. It places the state board of medicine back in control of continuing education and discipline within a state. It opens up a free market for continuing medical education conferences and programs by ensuring that one company no longer has a monopoly on this process.

This legislation improves patient access by attempting to address the problem of physician shortages, caused by the MOC process. Physicians will no longer feel pressured to consider early retirement rather than dealing with the onerous, expensive, and irrelevant cycle of MOC. It protects the physician-patient relationship, as insurance companies and hospitals can no longer cut off a patient's access to their doctor, should the doctor choose to stop participating in MOC. This legislation also encourages ethical novel medical research, as physicians are not compelled into performing research for outside entities and can instead work on their own novel research using proper informed consent.

Improved health care access, medical education, and medical research are tangible benefits associated with Right to Care legislation. The intangible benefits—the positive effect upon physician morale and autonomy—are not to be over-looked. Removing red tape and unnecessary bureaucracy allows physicians to return to what they love --

caring for patients. Right to Care legislation is Right to Work legislation. Right to Care is a healthcare prescription that every state should follow.

i. Sandhu AT, Dudley RA, Kazi DS. A Cost Analysis of the American Board of Internal Medicine's Maintenance-of-Certification Program. Ann Intern Med. 2015;163:401-408. doi: 10.7326/M15-1011

ii. Gray BM, Vandergrift JL, Johnston MM, Reschovsky JD, Lynn LA, Holmboe ES, McCullough JS, Lipner RS. Association Between Imposition of a Maintenance of Certification Requirement and Ambulatory Care–Sensitive Hospitalizations and Health Care Costs. JAMA. 2014;312(22):2348-2357. doi:10.1001/jama.2014.12716

iii. Hayes J, Jackson JL, McNutt GM, Hertz BJ, Ryan JJ, Pawlikowski SA. Association Between Physician Time-Unlimited vs Time-Limited Internal Medicine Board Certification and Ambulatory Patient Care Quality. JAMA. 2014;312(22):2358-2363. doi:10.1001/jama.2014.13992

iv. Edison, Megan. Part 4 MOC: Research on Children Without Consent. Rebel.MD 17 Sept. 2014. http://rebel.md/part-4-moc-research-on-children-without-consent/

v. Karmasek, Jessica. Doctors File Class Action Lawsuit Over Osteopathic Association's Membership Fees. Legal NewsLine. 8 Aug. 2016. http://legalnewsline.com/stories/510988243-doctors-file-class-action-lawsuit-over-osteopathic-association-s-membership-fees

vi. Lowes, Robert. First State Goes MOC-Free, Others May Follow. Medscape. 22 April 2016. http://www.medscape.com/viewarticle/862331

vii. 2017 State MOC Legislation. Rebel.MD. http://rebel.md/2017-state-moc-legislation . Accessed 8 April 2017.

viii. Patient Access Expansion Act. ALEC. 1 July 2014 https://www.alec.org/model-policy/patient-access-expansion-act/

HOW THE CURRENT MEDICAL LIABILITY SYSTEM FAILS PATIENTS

By: Hal Scherz, MD and Brian Hill, MD

The problems with health care in America are numerous and often interconnected. As the cost of care continues to move in the wrong direction, policy makers and politicians focus predominantly on healthcare insurance, believing that the solution lies there. Although tackling the healthcare problem needs to start somewhere, it is clear that ignoring other factors of equal importance might be a mistake and make a meaningful and long term solution less likely.

One such factor is the dysfunction that exists between the legal system and medicine. The current system pertaining to the adjudication of medical "mal-events", through the current tort system, negatively impacts medical decision making by doctors, forcing them to always consider possible liability. This practice is called "defensive medicine" and significantly increases the cost of healthcare and often decreases the accessibility and quality of care. Moreover, the current tort system fails to help the people who are actually harmed by medical errors because they only receive a fraction of the compensation to which they are entitled, while other participants in this system (lawyers, insurance companies) are disproportionately enriched.

An optimal medical liability system should ensure that the facts of each claim are properly evaluated, to assure all parties involved that the claim is legitimate and compensated fairly, while at the same time eliminating from consideration frivolous claims. There needs to be open communication and transparency when a medical error occurs and the patients need to have access to this information so that the validity, extent, and financial impact of the event can be fairly and accurately determined. A claim by a patient who has experienced an untoward medical event needs to be assessed in a fair and impartial manner by experts, to determine the legitimacy of a claim. Meritorious cases should be dealt with through a predictable, equitable, expeditious and fiscally sustainable process. Finally, errors need to be analyzed to improve patient safety and to prevent recurrent similar bad outcomes. The question of "why" and not "who" is important in addressing this problem, which is impossible to determine in a system designed to hide errors, because of fear of legal retribution. If this concern could be eliminated, then root causes for errors could be determined by the analysis of more accurate data, which would be easier to ascertain in a system that did not punish disclosure of such information.

Additionally, an ideal system would minimize collateral damage that we so often see in our current system of dealing with medical liability. It would end the practice of defensive medicine which occurs when doctors order tests, prescribe medications or even recommend procedures that may not always be necessary, but which they believe makes them less susceptible to patient dissatisfaction or bad outcomes from rare, but known medical conditions. Decreased utilization of unnecessary medical services reduces patient costs, the risks of bad events resulting from these tests or procedures, and decreases total costs to the system. It also frees up resources, making them more available to patients who actually need, and would benefit, from them.

The current system has forced doctors to leave the profession or change specialties, resulting in critical doctor shortages in many areas of the country. It has also eroded the doctor-patient relationship, when doctors have to consider each patient entering their practice as a potential lawsuit.

When viewing the current medical malpractice system through the lens of what is ideal, it is evident how damaging to the healthcare system the current tort system actually is. The current system is counterintuitive to the goals already presented.

Medical error adjudication is based upon an adversarial process focused on the finding of negligence. Such an approach promotes concealment of injurious events rather than creating an environment conducive to an open and honest dialogue. This lack of personal engagement, and the ensuing antagonism, induces bitterness between the patient and physician, disrupting the patient-physician relationship. This leads to a level of distrust on the part of the patient and creates anxiety amongst doctors.

Upon initiation of legal proceedings, fault is directed at the physician who last interacted with the patient, but often lawyers tend to “load the boat” and bring everyone associated with the patient, into the case. The goal of both the trial and defense attorneys involved in the dispute is to “win the case;” not determining truth. Although truth, at times, may be uncovered, it is not the primary focus of the process, so its discovery becomes incidental. One defense attorney stated that, “a tort case is not about finding facts, but it’s about creating a story; creating villains, and creating a scenario that can persuade the jury to award compensation. The focus is on winning, not truth.” (1) In fact, the best predictor for the size of a medical malpractice award is the severity of the disability or extent of injury, not the presence of negligence. Because of this, doctors attempt to hide errors because of fear of financial loss and damage to their reputation. Consequently, the number of medical errors has not significantly decreased, despite attempts to control for variables that lead to them. Truth is obscured, and the opportunity to capture data regarding

negative medical events is lost. The learning potential is squandered and the ability to develop best practices remains unfulfilled.

Defensive medicine is the biggest waste in the healthcare system and the sad part is that all the money spent toward this could finance an entire medical system for those who cannot pay for healthcare. PriceWaterhouseCoopers reported that $210 billion annually can be attributed to defensive medicine (2). A Gallup Physician survey puts this figure at $650 billion (3). A survey of physicians done by Jackson Healthcare found that 75% of physicians admit to practicing defensive medicine, principally to avoid having to go to court because they may have missed something; even rare and uncommon events (4).

Patient compensation for medical errors is far from ideal. It begins with access to the system. Most patients will be unable to seek compensation for an adverse medical event, because malpractice lawyers will not talk to a patient whose award is deemed trivial or insignificant to them. The threshold to get a lawyer to take on a malpractice case has been reported to be about $500,000 (5). If someone is fortunate to get representation, the average time it takes to conclude medical claim proceedings is 3-5 years (6). Ultimately, the patient receives less than 20% of the award (7).

The solution to this problem requires bold steps, not Band-Aids. It cannot be repaired but needs to be deconstructed and put back together in a different way. Unless that is accomplished, the incentives to solving the problem of medical errors cannot be aligned for the stakeholders -- the patients and the doctors. All of the other parties in this process, such as lawyers and insurance companies, are disproportionately rewarded and determined to retain the status quo.

Many of the attempts to repair this broken system have fallen short of the goal. The system must be fundamentally changed in order to create a meaningful solution. Caps on non-economic damages decrease premiums for physicians but do not change the dynamic of the current tort system. Arbitration fails to avert the threat of legal proceedings. The fear of litigation remains a barrier to the disclosure and open discussion of medical error. Loser pays laws may decrease the number of court cases but the potential for litigation still remains. It also punishes patients with injuries that are associated with minimal economic compensation and individuals who cannot afford taking the chance that even a meritorious claim might be ruled against them (ie: indigent and elderly). The current system makes it unlikely that these individuals would ever receive compensation for real medical errors.

It is time to look for innovative ways to solve the shortcomings of the current system. Continuing to place doctors in an adversarial role with patients in a system built around a blame and shame approach will not allow for change. True reform will come when the system is altered to align the interests of medical caregivers and their patients.
A possible alternative exists outside of tort law.

Administrative systems would make more sense in the evaluation of injurious events. This approach utilizes panels of medical experts to evaluate cases on merit rather than emotion. In doing so, conclusions can be reached quicker and more fairly. Injured patients would receive compensation faster than they do presently, and since the system functions with less attorney interaction, more of the awards would go to those who have suffered injury from medical errors. Centralization of information in an administrative system designed to evaluate medical errors would allow analysis of those errors, with the goal being that of decreasing future events. If funded through current malpractice premiums, then the concerns of doctors regarding personal financial loss are removed, which would result in less defensive medicine. Outliers could be identified and state medical boards would be empowered to take proper disciplinary action.

In order to truly reform healthcare, medical liability must be addressed. It is time to embrace real change because nothing short of this will have any real impact on a badly broken medical liability system.

References:

1. Personal Communication with Keynote Speaker (Defense attorney) at Medical Association of Georgia House of Delegates Meeting

2. "The Factors Fueling Rising Healthcare Costs 2006", PricewaterhouseCoopers

3. Gallup Jackson Survey 2/2010 Quantifying the Costs of Defensive Medicine -- 73% of physicians practice defensive medicine https://www.patientsforfaircompensation.org/media/59308/4gallup-poll-quantifies-us-physician-opinionsdm.pdf

4. Physician Survey: Quantifying the Costs of Defensive Medicine -- $650-850 billion in costs https://www.jacksonhealthcare.com/media-room/surveys/defensive-medicine-study-2010.aspx

5. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2147915

6. "The average length of time between the occurrence of the injury and the closure of the claim was five years." http://www.nejm.org/doi/full/10.1056/NEJMsa054479#t=article

7. $.22 of every dollar that goes through the tort system is returned to consumers for compensation for economic damages. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=781424

This has also been looked at from various viewpoints. When compensation is paid, "The combination of defense costs and standard contingency fees charged by plaintiffs' attorneys (35 percent of the indemnity payment) brought the total costs of litigating the claims in our sample to 54 percent of the compensation paid to plaintiffs."

Without compensation/frivolous cases: "Eliminating the claims that did not involve errors would have decreased the direct system costs by no more than 13 percent (excluding close calls) to 16 percent (including close calls)."

Both of these are taken from article quoted in 6 above.

Expense ratio for mutual v stock owned med mal companies: typically in the 4-5 percent range versus 10-20 percent https://www.irmi.com/articles/expert-commentary/medical-malpractice-the-high-cost-of-meritless-claims

TRANSPARENT HEALTH CARE PRICING

KEITH SMITH AND THE SURGERY CENTER OF OKLAHOMA

By: Robert F. Graboyes

It's neither exaggeration nor ideology to argue that the pricing of health care services in America resembles the pricing of everything in the old Soviet Union. That's why Keith Smith's Surgery Center of Oklahoma (SCO) stuns U.S. healthcare professionals, who are unaccustomed to meaningful, transparent prices.

In competitive sectors of market economies, prices reflect costs to producers and value to consumers. The price of a car is the sum of underlying costs: materials, labor, marketing, distribution, capital. The price also reflects the sum of characteristics that consumers value: speed, reliability, comfort, aesthetics.

In contrast, Soviet prices were accounting fictions, detached from real economic factors. Opaque and decreed by distant bureaus, they reflected bureaucratic divinations — not producer costs or consumer values. Prices provided little information about what to make or buy. And those same pathologies infect American healthcare.

Ask how much a surgery will cost. Your doctor will likely shrug or offer a meaningless number plucked from the firmament. After surgery, you'll probably experience a months-long stream of indecipherable documents.

Keith Smith and his partners decided to be the exception. The SCO website features outlines of the human body. Click on the knee, and down falls a menu of surgical procedures. Click on "Total Knee Replacement," and up pops a price: $15,550. Click again to schedule surgery. Once you have your new knee, you pay $15,550 — period.

Each semester, I show SCO's website to my graduate students, all of whom are mid-career health professionals — doctors, nurses, professors, hospital administrators.

"Where do the anesthesia charges show up?" One asks. "They're already included in that price," I answer.

The students then cock their heads the way my dogs do when I play a harmonica. Unlike typical hospitals' charges (or Soviet prices for tractors or tomatoes), the $15,550 reflects actual underlying costs.

Keith tells of a patient in Georgia who needed a particular surgery and happened onto SCO's website. The procedure cost around $3,600 at SCO. The patient's hospital in Georgia was going to charge $40,000. The patient told his doctor that, given these prices, he would go to SCO.

Confronted with this challenge, the Georgia hospital dropped its cost by 90 percent to $4,000 — so the patient opted to have the procedure there. Afterward, he called SCO, a bit apologetically, to tell Keith he had saved him $36,000 without even doing the surgery. Keith says the story itself was more valuable than the $3,600 he would have charged.

Keith says physicians were initially skeptical about transparent pricing but are coming around to the idea. A modest number have begun moving to similar pricing models. Many have banded together as the Free Market Medical Association, which connects cost-conscious patients and providers. Still, there are impediments. Large hospitals and insurers have strongly resisted this movement. Most insurers refuse to allow employers with whom they contract to engage in direct contact with such facilities.

Perhaps the biggest impediment to transparent pricing is the federal government's outsize role in providing health insurance. Programs like Medicare rely on price controls and rationing (formal and informal) to balance supply and demand and maintain budgets. Private insurers design their plans to mimic Medicare — in part because it is easier to do so than to maintain two radically different pricing models.

Still, Keith is optimistic, noting that individuals and self-funded employers are rejecting hospitals' opaque and inflexible pricing and shifting their contracts to facilities like SCO: "The state of Oklahoma's self-funded health plan is now waiving all out-of-pocket expenses for beneficiaries who elect to secure their healthcare services at transparently priced facilities like mine. A $200 million savings is predicted for the first year this is fully operational, after a limited roll out this past April."

Interestingly, SCO and other facilities with transparent pricing regularly attract patients from Canada and other foreign countries. In part, this is because in those countries, as in America, incoherent healthcare pricing fails to reflect costs to producers and value to consumers. Our problems are visible in patients' indecipherable hospital bills. In Canada and Europe, public financing of healthcare may render the problems less visible, though no less real.

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INDEPENDENT SURGERY UNITS CAN SAVE PATIENTS MONEY

By: Andrew Poole, FACHE

Independent surgery centers in Virginia and around the country are modern, specialized facilities providing patients surgical services and trained physicians that offer surgeries at dramatically lower prices than do neighboring hospital centers, the traditional venue for patients to turn to when faced with an operation.

Here is one example in Virginia:
The Monticello Community Surgery Center (MCSC) is a physician-owned multi-specialty Ambulatory Surgery Center (ASC) located in a modern, facility in Charlottesville, Virginia. It is fully accredited by the Accreditation Association for Ambulatory Health Care, which recognizes organizations that meet or exceeds nationally recognized standards of care for quality and safety.

This surgery center began operations in 2003 as a joint venture between the physicians and a local community hospital. When the hospital was acquired by a larger health care system in 2012, our physicians determined that to remain independent and provide optimal care to their patients they needed to exit the joint venture. After the exit, we changed our name from the Martha Jefferson Outpatient Surgery Center, becoming Monticello Community Surgery Center (MCSC), and ultimately were forced to move to a new physical site in 2014, where we have continuously operated since.

We performed over 5500 medical procedures in 2016, and are continuing to add new services. Specialties offered at MCSC include General Surgery, Ophthalmology, Orthopedic Surgery, Otolaryngology, Neurosurgery, Podiatry, Pain Management and Urology. As an Ambulatory Surgery Center, all procedures are done on an outpatient basis. Candidates for care at an ASC are screened carefully by their surgeon and anesthesiologist to make sure they can have their procedure done safely. Individuals who require an overnight stay, or those with significant health issues which may complicate care, are not good candidates for care at an ASC.

In 2012, the decision to remain independent in a largely consolidated health care market was a difficult one, and remains rife with challenges. This decision was based on the belief that physician owned practices can deliver the right care for its patients in a more effective and efficient manner. Independent Ambulatory Surgery Centers have been

recognized, as delivering higher patient satisfaction scores, with lower complications and at a lower cost than when patients receive care in a hospital or hospital based center. Satisfaction in an ASC was found to be rated as 92% positive vs. 70% for hospital based in a hospital setting in data collected by the Surgery Center Network. With the health care consumer clamoring for a better level of care, provided safely and at a lower cost, one would expect to see more physician's and health systems working to perform a greater number of procedures in centers similar to MCSC.

However, ASC's are typically reimbursed at a much lower rate than Hospital Outpatient Departments (HOPDs). Thus, cases done at an ASC serve as a direct threat to current revenue streams of the hospital systems. Hospital systems work vehemently to fight any new ASC construction through the Certificate of Public Need process (see other articles in this Handbook about Certificate of Public Need), and attempt to prevent physicians in their area from performing surgeries at an ASC. To simply relocate our existing practice within the same town was a year-long process involving legal fees amounting to millions of dollars.

Advantages of Ambulatory Surgery Centers

Performing surgeries in a hospital or in an HOPD is a greater personal health care expense to consumers. Health Care Blue Book sponsored a review of commercial claims completed in 2016 and demonstrated an annual savings of $38 billion dollars attributable to the use of ASC's over Hospital Outpatient Departments. $33 billion of these savings was by the insurance provider, which increasingly is the employer, and $5 billion on the part of the patients. They also identified an additional $55 billion of savings based on additional procedures that could be performed in an ASC, but instead were done at the more-costly HOPD. Add to this an additional $2.3 billion saved annually to Medicare because of procedures performed in an ASC that researchers at University of California-Berkley reported in 2014.

While hospital systems seek to employ the remaining independent physicians, or create relationships to drive referrals to their more expensive centers, patients remain largely unaware of the financial impact on them depending on where the surgery will occur. As identified by the word COMMUNITY in our name, we feel a responsibility to our local, regional, and even national community to inform individuals about this impact and to offer high-quality care at a lower cost directly to the patient. The physicians at MCSC believe that if individuals are given the information about the available care with regard to both outcomes and price, then they will be able to make the best decision about their care which will ultimately help to lower the health care costs for everyone.

The problem is that most patients do not think to ask about where the surgery will be performed or how that impacts their out-of-pocket expenses. The common belief is, if I have insurance, and in their network, then I am covered. In reality, a surgery done by the same physician can have significantly different costs based on the facility's fees. In the review by Health Care Blue Book, it was found that facility prices can vary by over 600% within the same community for the same procedure.

Even when patients attempt to seek the information about costs, it can be confusing and complex. Hospitals are reluctant or incapable of providing this information. Generally, the patient will receive three bills: one from the surgeon; one from the anesthesiologist; and one from the facility itself. The physician typically receives a similar reimbursement wherever the operation is performed. Anesthesia rates can vary, but the largest factor in surgery cost variation lies with the facility fees.

While we do not seek out other local surgical provider's facilities fees, we frequently receive calls to inquire about price and are met with disbelief. It is not uncommon for the facility fees of our ASC to be thousands of dollars less than those at the local hospitals. A patient requiring a sinus procedure by an ENT surgeon was quoted a facility fee that was 10 times higher than what we would have charged ($3,000 vs. $30,000). If this patient had a 20% coinsurance for that procedure, his out of pocket cost would be $5400 more for the same doctor to do the operation in the hospital rather than the ASC.

Bundled Surgical Pricing

While the lower rates of an ASC such as ours helps those with more traditional insurance, it is amplified for those who are uninsured or have a large out of pocket expense, such as with a high deductible plan. For those individuals, a bundled price offered outside of traditional insurance can result in thousands of dollars of savings. Since opening our doors, we have posted and honored a fair, bundled price for any individual who does not have insurance or decides not to use it. With a bundled price, all of the 3 charges, plus standard post-operative care are included. Bundled pricing is achievable because by eliminating insurance, administrative costs and total overhead is greatly reduced. This practice has resulted in hundreds of patients traveling to MCSC for their care from as far away as Seattle, Washington and the Virgin Islands.

Recently, we have provided care for a patient requiring ACL replacement and meniscal repair. The patient was quoted a facility fee by a hospital of over $15,000. We provided care at a bundled rate, or just $9,040. This patient saved approximately $10,000 by coming

to see us. There occasionally will be charges not covered in the bundled price such as surgical implants. These charges are passed along directly to the patients at our cost and with no mark-op. A hospital will typically mark-up implants 2-3 times or more. Some savvy health care consumers in high deductible plans utilize our bundled price rather than their insurance. A person with a $10,000 deductible plan may have to pay that entire amount for a surgery rather than pay the bundled rate. In 2015 the average cost of an ACL reconstruction nationwide was $9,276. If an individual, instead, opts for a bundled rate at our surgery center, they would pay $6990. That is a savings of over $2000 for an individual who opts not to use insurance.

When MCSC was being developed, we consulted with Dr. Keith Smith- the founder of the Surgery Center of Oklahoma and the Free Market Medical Association. The Surgery Center of Oklahoma has been a trailblazer in the Free Market movement in health care. Its model of offering a single bundled price directly to the health care consumer or to the business funding the patient's health care, resonated with our leaders. Their model of bundled prices and price, transparency inspired us at MCSC. They have contracted with the State of Oklahoma, providing care for some state employees and already have demonstrated millions of dollars in savings over a short time period. Along with a local Third Party Administrator, Jay Kempton, the Surgery Center of Oklahoma has developed a model for delivering a low cost bundled payment to self-funded entities, including municipalities.

Oklahoma has used this bundled price model successfully, first on the county level and now at the state level to provide a "No-Cost" surgery option to their employees. Individuals who go outside of this option may do so but would pay the traditional coinsurance and deductible. At the 2016 Free Market Medical Association, Dr. Smith reported plan members are utilizing the "no-cost" option over 70% of the time. In the first two years, Oklahoma County has saved $1.7 million in health care costs. County employees have saved $250,000 in out-of-pocket expenses; about $2000 per person per procedure. Being able to replicate this model in Virginia could provide similar savings. We have met with local employers and municipalities that self-fund their health care coverage, and they are very excited about the concept.

These plans have advanced as the employer, whether it be private industry, or a city or state plan, has entered into direct contracting with lower cost providers who offer a single, transparent price. This work goes beyond surgery centers and includes services such as imaging and direct primary care. Private industry has begun the practice of direct contracting on a smaller scale, including some serviced by MCSC. One such group BevCap touts a $1.5 million dollar savings through the travel surgery program, including procedures done here in Virginia.

There are willing providers and purchasers in the health care market, but large insurance companies stand in the way. Removing the obstacles that stand in the way of companies (especially those that self-fund their own health care) from reducing their healthcare costs while maintaining high quality care needs to be a focus for Virginia. One barrier is the restriction which prevents patients from utilizing cash pay options and then allowing them to apply those expenses to deductibles or seek reimbursement from the insurance company with which whom they are insured. This small change would incentivize patients to seek seeking out more affordable cash pay options.

Virginians can experience a reduction in their health care expenses by demanding to know the price of care. This extends beyond surgery to services such as lab work, imaging studies and consultations. The push for price transparency, both in cost and outcomes, should be driven by consumers and supported by legislation. In 2015 Virginia passed legislation supporting price transparency in Health Care. As we have seen with the work done in Oklahoma, Virginia has the opportunity to use the data on price and quality to significantly lower the cost of care for its citizens. With healthcare benefits escalating for Commonwealth employees, there is a huge amount of potential savings for the State and its taxpayers. Following in the footsteps of Oklahoma, developing a network of providers across the state willing to provide care at a fair, bundled rate could put money back in the hands of our state employees and help with the state and local budgets.

Additionally, the state should look to examine and remove the current barriers that prevents in the expansion of ASCs and should also encourage bundled surgical price utilization. Specifically, this would include expanding access to high quality, lower cost settings by eliminating the Certificate of Public Need process.

Sources:

ACL cost: https://amino.com/blog/acl-surgery-cost/

Free Surgery for Oklahoma Teachers, State Workers http://kfor.com/2016/09/20/free-surgery-for-oklahoma-teachers-state-workers/

ASC Savings- https://healthcarebluebook.com/files/ascsavings.pdf
Department of Health and Human Services, Office of Inspector General. (2014, April). Medicare and Beneficiaries Could Save Billions If CMS Reduces Hospital Outpatient Department Payment Rates For Ambulatory Surgical Center Approved Procedures to Ambulatory Surgical Center Payment Rates.

Munnich, E. L., & Parente, S. T. (2014). Procedures Take Less Time At Ambulatory Surgery Centers, Keeping Costs Down And Ability To Meet Demand Up. Health Affairs, 33(5), 764-769.
Surgery Center Network- https://www.surgerycenternetwork.com/hospitals-vs-ascs
ASCA Cost Reduction http://www.ascassociation.org/asca/aboutus/pressroom/2016/ascs-reduce-outpatient-surgery-costs-for-commercially-insured-patients-by-38-billion-annually.

IMPROVING HEALTH CARE IN RURAL AMERICA: A GUIDE TO POLICY MAKERS

By: Bill Finerfrock

There's an old saying in the rural community: "Once you've seen one rural community, you've seen one rural community." These words are critically important to understanding the best approach to reforming our nation's healthcare delivery system and, more importantly, the best approach to address the unique healthcare challenges and needs of rural communities.

Rural America is not monolithic

At the outset it bears stating the obvious: How you effectively deliver healthcare in rural Montana, is different than how you will effectively deliver healthcare in rural Virginia. The people of rural Maine are different from rural Mississippi. And, because of this fundamental reality, flexibility in addressing the unique healthcare delivery needs of rural communities is essential.

Giving states flexibility, as has been proposed by some federal policy makers, is not just a "state's rights" philosophical battle cry, it is a necessity born of the fact that the geographic, demographic, economic, and population density differences demand different approaches to paying for and delivering quality healthcare. It is simply not possible to design a program in Washington, DC that meets all of the unique needs of all Americans.

This does not mean there is no role for federal policy makers – Congress and the agencies. Indeed, to the extent federal dollars are at stake (particularly federal matching dollars for Medicaid) the federal government must maintain some control over how those dollars are spent. If Medicaid is truly a federal state partnership, then each of the partners must play a role in determining how the money is spent and evaluating the success at achieving the goals of the program.

Rural Providers are heavily reliant on Medicare and Medicaid revenues

Healthcare providers receive the money they obtain for delivering healthcare from four main sources:

- Medicare
- Medicaid
- Commercial Insurers
- Individuals (self-pay)

The "mix" of revenue sources varies considerably depending on whether the provider is located in an urban/suburban area or a rural area. Most rural providers are disproportionately dependent on government payers (Medicare and Medicaid) for the majority of revenues. Commercial payer revenues, which are typically higher on a per claim basis, constitute a relatively small percentage of a rural provider's revenues. It is not uncommon for Medicare and Medicaid revenues to exceed 60% of a rural providers total revenues and in some rural pediatric practices, Medicaid could represent 90% of the practice revenues.

For years, the Medicaid (and to a lesser degree Medicare) programs relied on the generosity of health care providers to receive less than market-value for services provided to Medicaid beneficiaries. The general philosophy seemed to be that "profits" from commercially insured patients could offset "losses" for care provided to Medicaid or Medicare patients.

In rural communities, this trade-off simply didn't work because there was insufficient revenue from commercial payers to offset these losses. And as commercial insurance payments became tighter and tighter, the profit margins for the so-called "no paying" patients evaporated.

Because of their reliance on Medicare and Medicaid relative to commercially insured individuals, it is critical to the survival of rural hospitals and rural clinics that the revenue generated by federal programs at least cover the costs associated with providing care to these patient populations. Cost shifting just isn't an option.

Unique Payment Models

Over the years, the federal government and commercial payers have tested and adopted a variety of different payment models to determine how best to compensate providers for the care they deliver. In the mid-1980s, we transitioned from a hospital payment system that was based on "reasonable costs" to a Prospective Payment System (PPS) that paid hospitals based on the average cost of care for a typical patient with the principle diagnosis at time of admission.

It wasn't long after this "average cost" method of payment began that it caused problems for rural hospitals. Throughout the late 80s and into the early 90s, we saw massive closures of rural hospitals due to financial insolvency. In the late 90s, Congress approved a return to cost-based payments for these small rural hospitals (15 or fewer beds) when it created the Critical Access Hospital (CAH) program that pays 101% of costs of care for Medicare patients. The cost-based CAH program has been essential to the survival of the more than 1,000 CAHs located throughout the United States (eight in Virginia).

The Rural Health Clinics (RHC) program, which provides cost-based payment for primary care clinics located in under-served rural areas, has also been critically important to ensuring continued access to primary care in rural states and communities. There are over 4,000 federally certified RHCs nationally and 30 in the Commonwealth of Virginia.

Although not perfect, the importance of the RHC and CAH payment models is that they are based upon the individual costs of the hospital or clinic. This allows for variability within a state and among the states to reflect the unique cost of delivering healthcare in each community.

Size Matters

In an effort to address the rising cost of healthcare, many third party payers, including the federal government (Medicare) and state governments (Medicaid) are attempting to shift the liability for clinical decision making from the third party payer to the individual clinician. In other words, insurance companies, which were created to spread risk over large numbers of people in order to minimize the potential for financial ruin from health care costs, now want to redesign payment models for rural providers so that the providers themselves bear the financial risk for clinical decision making, not the insurance company.

This cost-shifting philosophy is not unique to commercial insurance companies and can also be seen in new Medicare and Medicaid payment policies that seek to cap provider payments based upon either capitation or so-called “bundled payments” or “episode of care” payments.

Actuarial scientists (those really smart kids in high school who were good in math) will tell you that if the number of people is large enough, they can reasonably predict what percentage of people in the group will develop certain diseases and require hospitalization over time. But there is a limit to what actuarial science can reasonably predict. It can tell us that out of 1,000 people, 100 are going to be hospitalized; it just can’t tell us which 100. It can tell us that out of 100,000, X% will get cancer, it just can’t tell us which of those 100,000 people it will be.

Rural health providers suffer from the opposite problem. For them healthcare is small numbers. 20 patient visits per day, 100 per week. Given the fixed costs of operating a medical practice, maintaining a viable medical practice on such low volume is extremely difficult.

When you hear politicians and insurance company executives at all levels talk about moving away from the "inherently inflationary" fee-for-service system to alternative payment models, rural America should be afraid … very afraid. What this means is that the doctor is about to assume financial risk for clinical decisions.

Current provider payment models cannot adequately adjust for risk. So unlike health plans that will receive additional monies to shield against "adverse selection," no similar payment adjustments are made for clinicians who have a run of "bad luck" when it comes to high cost patients.

Workforce

Finally, we cannot talk about improving healthcare in rural America without recognizing the challenges these communities face in attracting and retaining qualified health professionals. For many years, we operated on a "physician-only" workforce approach and over the last two decades we have come to realize that there are many well-qualified health professionals who can deliver a range of services to rural communities much more cost-effectively. We must recognize that meeting the challenge of rural healthcare will require a very diverse health workforce. Physicians, PAs, NPs, Nurse Midwives, Psychologists, Social Workers and others working collaboratively to the full extent of their educational preparation.

State legislatures and regulatory boards must re-examine the various practice laws and regulations to determine whether there are artificial barriers to full use of all appropriately trained health professionals.

Improving access to quality care must be the guiding principle.

Conclusion

Retaining payment models that ensure that patient costs are covered by government programs and giving states some flexibility to adjust to the unique healthcare delivery challenges found in the different states are critical to designing an effective rural health delivery system.

Change, for the sake of change, is not healthy or effective. Policy makers must look at what works in rural America and build on those documented successes and not try new, untested payment models on communities that already have difficulty attracting and retaining qualified health professionals.

THE BENEFITS OF TELEMEDICINE IN EYE CARE

By: Dr. Steven Lee, OD

Telemedicine has transformed the delivery of care to the patient in a number of profound ways. Not only are patients able to receive care in a convenient manner at the time of their choosing, but they are also able to receive care that they may not have been able to access in the past due to geographic challenges. Furthermore, telemedicine may be a more financially viable option, especially for those with limited or no healthcare coverage.

As noted by the Ocular Telehealth SIG[1], the eye is a window into the health status of the body. In the United States alone[2], there are approximately 14 million individuals over the age of 12 that have self-reported vision impairments due to an acuity level (eyesight) worse than 20/50. Amongst the 14 million individuals, 11 million of them could have their vision improved to the bare minimum level of acuity to drive a car, which is 20/40, through the use of refraction and vision correction. There are also 1.6 million individuals in the United States over the age of 50 who have macular degeneration, a disease process that affects the central portion of vision. There are also 5 million individuals in the United States that are 40 years of age or older who have cataracts, a condition that clouds the overall vision in a patient. And 2.7 million individuals in the United States also have glaucoma, a condition causing the gradual loss of vision due to increased pressure within the eyeball. Nearly 7.7 million Americans have diabetic retinopathy. 8.1 million Americans do not even know they have diabetes.

Each of these vision or eye health issues can be solved or monitored via telemedicine.

Convenience

Vision and eye health care has made significant strides since the phoropter eye exam instrument of old. Today, online vision tests can alert patients of potential deficiencies in their vision and advise them to visit an eye care professional for further evaluation as well as treatments that can be delivered via an online format. Virtual Amsler grids can track the progression of macular degeneration in individuals with central vision deficiencies. Diabetes can be caught early in those 8.1 million unwary Americans, increasing the potency of their treatment process. Each of these testing methods can be completed at any time of day or night, from the comfort of home without the hassle of making appointments and navigating complex family schedules.

S.M. Thomas and others concluded that teleglaucoma is beneficial for early detection of glaucoma, reduced wait times and travel times, cost savings, and increased specialist

referral rates[3]. Telemonitoring is a game changer for patients with age-related macular degeneration and can improve vision outcomes, according to E.Y. Chew and others in a 2016[4]. Telemedicine can even be used for monitoring the worsening of diseases over a long period of time, notes S. I. Mansberger in a study analysis from 2015[5].

Access

Telemedicine for the screening of diabetic retinopathy has found success in Italy[6], where 5.5% of its population suffers from diabetes, as well as in Zimbabwe[7]. B. K.Host and others conclude in a 2017 study that teleopthalmology is a promising way to bypass the hurdles of providing eye care services to rural and remote populations[8]. And in Hungary, D. J.Eszes discusses the reliability and satisfaction garnered from the use of a digital retinal screening device, and notes that telemedicine is a strong tool that can allow for faster and more comfortable diabetic retinopathy screening[9]. In "Supply and Perceived Demand for Teleophthalmology in Triage and Consultations in California Emergency Departments" (2016), I. Wedekind and his colleagues suggest that teleophthalmology could help mitigate coverage gaps in emergency ophthalmic care[10]. In their article "Improved access and cycle time with an 'in-house' patient-centered teleglaucoma program versus traditional in-person assessment" (2014), S.Arora and others state that teleglaucoma improves access to care and is a better way to manage glaucoma, as compared to in-person assessment[11].

Cost Savings

According to the World Health Organization[12], approximately 90% of the world's visually impaired live in low-income settings and developing countries. J. S. Wittenborn and others found that the home telemonitoring of patients with age-related macular degeneration who are at risk for choroidal neovascularization (new blood vessels growing in the eye) was cost-effective compared with solely scheduled examinations[13]. And in 2015, S. Thomas found that teleglaucoma had a 20% increase in ophthalmologist-referral rates, reduced patient travel times by 61 hours, and reduced physician wait times by 30% as compared to in-person examination. Additionally, Thomas found that teleglaucoma costs $872 per patient screened, which was 80% less than in-person examination. Other noted benefits of teleglaucoma were its increased sensitivity and greater incremental effectiveness than in-person examination. With many facets of eye care, it is a viable solution to break apart the individual components and allow patients to receive a la carte tests depending on the requirements of their visual function. This can pertain to splitting apart refraction (the determination of glasses and contact lens prescriptions) from eye health checks (which include a dilation to look at the back of the eye). Both are important, but individually

can be highly beneficial as well. In rural areas, telemedicine eye care and teleglaucoma improved the efficiency of healthcare service, and increased access to ophthalmic care[14].

Summary

The revolution of healthcare in America demands a strong symbiotic relationship between traditional in-person care and modern telemedicine. As noted in a study out of Canada, [15], the common goal is providing excellent, high quality, timely, cost-effective health care. Acknowledging that it is appropriate to separate the individual components of a comprehensive eye exam in order to best care for the patient and also improve the economics of the health care system should be appreciated. The best approach is a collaborative approach that combines the knowledge and skills of all stakeholders, while reducing inefficiencies.

Telemedicine in eye care should be encouraged and any existing legislative roadblocks should be reconsidered based on the current studies cited in this essay and the cost benefits and health consequences for the patients.

References

1. Ocular Telehealth SIG. (n.d.). Retrieved July 14, 2017, from http://www.americantelemed. org/main/membership/ata-members/ata-sigs/ocular-telehealth-sig
2. Eye Health Statistics. (n.d.). Retrieved July 14, 2017, from https://www.aao.org/newsroom/eye-health-statistics
3. Thomas, S. M., Jeyaraman, M. M., Hodge, W. G., Hutnik, C., Costella, J., & Malvankar-Mehta, M. S. (2014, December 05). The effectiveness of teleglaucoma versus in-patient examination for glaucoma screening: a systematic review and meta-analysis. Retrieved July 20, 2017, from https://www.ncbi.nlm.nih.gov/pubmed/25479593
4. Chew, E. Y., Clemons, T. E., Harrington, M., Bressler, S. B., Elman, M. J., Kim, J. E., . . . AREDS2-HOME, G. R. (2016, August). EFFECTIVENESS OF DIFFERENT MONITORING MODALITIES IN THE DETECTION OF NEOVASCULAR AGE-RELATED MACULAR DEGENERATION: The Home Study, Report Number 3. Retrieved July 20, 2017, from https://www.ncbi.nlm.nih.gov/pubmed/27243927
5. Mansberger, S. L., Sheppler, C., Barker, G., Gardiner, S. K., Demirel, S., Wooten, K., & Becker, T. M. (2015, May). Long-term Comparative Effectiveness of Telemedicine in Providing Diabetic Retinopathy Screening Examinations: A Randomized Clinical Trial. Retrieved July 20, 2017, from https://www.ncbi.nlm.nih.gov/pubmed/25741666
6. Vujosevic, S., & Midena, E. (n.d.). Diabetic Retinopathy in Italy: Epidemiology Data

and Telemedicine Screening Programs. Retrieved July 20, 2017, from https://www.ncbi.nlm.nih.gov/pubmed/27990441

7. Matimba, A., Woodward, R., Tambo, E., Ramsay, M., Gwanzura, L., & Guramatunhu, S. (2016, July). Tele-ophthalmology: Opportunities for improving diabetes eye care in resource- and specialist-limited Sub-Saharan African countries. Retrieved July 20, 2017, from https://www.ncbi.nlm.nih.gov/pubmed/26407990
8. Host, B. K., Turner, A. W., & Muir, J. (n.d.). Real-time teleophthalmology video consultation: an analysis of patient satisfaction in rural Western Australia. Retrieved July 20, 2017, from https://www.ncbi.nlm.nih.gov/pubmed/28436157
9. Esces, DJ, et al. (n.d.) Diabetic Retinopathy Screening Using Telemedicine Tools: Pilot Study in Hungary. Retrieved July 20, 2017, from https://www.ncbi.nlm.nih.gov/pubmed/28078306
10. Wedekind, L., Sainani, K., & Pershing, S. (n.d.). Supply and Perceived Demand for Teleophthalmology in Triage and Consultations in California Emergency Departments. Retrieved July 20, 2017, from https://www.ncbi.nlm.nih.gov/pubmed/27010537
11. Arora, S., Rudnisky, C. J., & Damji, K. F. (2014, May). Improved access and cycle time with an "in-house" patient-centered teleglaucoma program versus traditional in-person assessment. Retrieved July 20, 2017, from https://www.ncbi.nlm.nih.gov/pubmed/24568152
12. Visual impairment and blindness. (n.d.). Retrieved July 14, 2017, from http://www.who.int/mediacentre/factsheets/fs282/en/
13. Wittenborn, J. S., Clemons, T., Regillo, C., Rayess, N., Liffmann, D., & Rein, D. (2017, May 01). Economic Evaluation of a Home-Based Age-Related Macular Degeneration Monitoring System. Retrieved July 20, 2017, from https://www.ncbi.nlm.nih.gov/pubmed/28358948
14. Thomas, S., Hodge, W., & Malvankar-Mehta, M. (2015, September 18). The Cost-Effectiveness Analysis of Teleglaucoma Screening Device. Retrieved July 20, 2017, from https://www.ncbi.nlm.nih.gov/pubmed/26382956
15. Collaborative care and teleglaucoma: a novel approach to deliveringglaucoma services in Northern Alberta, Canada. (n.d.). Retrieved July 20, 2017, from http://onlinelibrary.wiley.com/doi/10.1111/cxo.12065/epdf

DIRECT PRIMARY CARE: THE SOLUTION FOR THE BROKEN HEALTHCARE SYSTEM BEGINS HERE

By: Lee Gross, MD

It isn't often we can see positive, common-sense free-market ideas grab headlines when it comes to health care. But that is what is happening in Primary Care across the nation. Direct primary care (DPC) is an innovative primary care medical practice model that eliminates third party payers from the primary care provider-patient relationship. This innovation is now allowed in Virginia thanks to concerned legislators who understood that it can reduce health care costs. Governor McAuliffe, after vetoing similar legislation last year, signed this into law earlier this year. Through a contractual agreement, a patient pays a monthly fee, usually between $50 and $100 per individual, to the primary care provider for defined primary care services. These primary care services may include: office visits; annual physical examinations; routine laboratory tests; vaccinations; wound care; splinting or casting of fractured or broken bones; routine testing (e.g. basic colon cancer screening); or other medically necessary primary care procedures.

After paying the fee, a patient can access all services under the agreement at no extra charge, including chronic care management such as diabetes, high blood pressure, and high cholesterol. Some DPC practices also include routine preventative services, like laboratory tests, mammograms, Pap screenings, vaccinations, and home visits. A primary care provider DPC model can be designed to address the large majority of health care issues, including women's health services, pediatric care, urgent care, wellness education, and chronic disease management. A few notable rural DPC practices also provide inpatient hospital care and obstetrics care.

In the DPC practice model, price transparency is the rule. The primary care provider eliminates practice overhead costs associated with filing claims, coding, refiling claims, write-offs, appealing denials, and employing billing staff. The cost and time savings can be reinvested in the practice, allowing more time with patients to address their primary care needs. In many instances, these DPC practices also arrange wholesale purchasing of labs, imaging, and physical therapy services. These savings are then passed directly along to the patient, often at discounts of up to 95% off of standard billed charges. Examples might include a CT scan for $175, MRI for $225. Many of these practices will also incorporate an in-house medication dispensary, where necessary medications are sold to patients at wholesale prices. In the latest development, DPC practices are now forging relationships

for price transparency among supportive specialist services, including inpatient and outpatient surgical care.

Differentiating from Concierge Medical Practices

Direct Primary Care is often referred to as "blue collar concierge care" or "concierge care for the little guy." While the roots of DPC are in the concierge care model, the concierge relationship often targets a more affluent patient population and most concierge practices continue to bill third parties for services on a fee-for-service basis, in addition to the monthly fee. The monthly fee in concierge is usually defined as being for "non-covered services" such as after-hours phone support, extended office visits and same-day appointments. These are all standard procedures for the DPC practice, while still not billing for office based care. Many practices that would qualify for the definition will often refer to themselves as "Concierge" in their marketing, which does blur the definition.

The generally accepted definition of DPC that is used in many state legislatures is that the practice must:

1) Charge a periodic fee

2) Not bill any third parties on a fee for service basis

3) Any per visit charge must be less than the monthly equivalent of the periodic fee.

Cost Savings with Government and DPC

Early adopters of DPC, Qliance in Seattle, Washington, using a DPC model for Medicaid Managed Care and a shared savings agreement showed millions of dollars in savings. At the same time, patients reported improved health and patient satisfaction. They also showed dramatic decreases in hospitalizations. In Union County, North Carolina, Direct Primary Care was offered as a benefit for public employees. Early data show a first year projected savings of $1.3 million to the county, while participating employees reported markedly improved general health and patient satisfaction. Many of these patients had one or more chronic medical conditions.

A key lesson also needs to be learned from the Qliance experience. The Medicaid experience was so successful at cost savings that it invoked a "claw back provision" in the State of Washington that took back the money that was promised in the shared savings agreement between Qliance and the Medicaid managed care plan. This began a series of

catastrophic turns that ultimately resulted in the demise of Qliance. Michigan is currently designing a DPC pilot program, and lawmakers have used the Qliance experience as a guide to avoid future calamities.

Obstacles to Adoption

It has been argued that a DPC practice charging a flat monthly fee for "unlimited" medical care, that is not fee-for-service, could be viewed as a risk bearing entity by a state insurance commissioner, subject to the same laws as an insurance company.

As of August 2017, twenty-three states have approved legislation which defines DPC agreements or services as outside the scope of state insurance regulation: Alabama, Arizona, Arkansas, Colorado, Idaho, Indiana, Kansas, Kentucky, Louisiana, Maine, Michigan, Mississippi, Missouri, Nebraska, Oklahoma, Tennessee, Texas, Utah, Virginia, Washington, West Virginia and Wyoming . There is a DPC law in Oregon, but it is generally felt to be so restrictive that it is unfavorable to the growth of DPC. Several other states have legislation development in process.

DPC and Health Care Reform

The Patient Protection and Affordable Care Act (PPACA – most often shortened to the Affordable Care Act or Obamacare) addresses the DPC practice model. The individual responsibility provision of PPACA requires individuals to obtain health insurance coverage that meets minimum essential coverage standards in the law. Failure to do so results in tax penalties.

Direct primary care arrangements alone do not constitute minimum essential coverage because they do not cover catastrophic medical events. A qualified health plan under PPACA is permitted to offer coverage through a DPC medical home plan if it provides essential health benefits and meets all other criteria in the law. Patients who are enrolled in a DPC medical home plan may be compliant with the individual mandate if they have coverage for other services, such as a wraparound catastrophic health policy to cover treatment for serious illnesses, like cancer, or severe injuries that require lengthy hospital stays and rehabilitation. The proposed American Health Care Act (AHCA) – recently passed House alternative to Obamacare that failed in the Senate -- used the definition of a Qualified Health Plan with DPC and an associated wraparound policy.

The bipartisan sponsored Primary Care Enhancement Act of 2017 (H.R. 365) clarifies the IRS treatment of DPC arrangements, and defines fees paid to DPC providers as qualified pre-tax health expenses from Health Savings Accounts and Health Reimbursement Accounts.

Next Steps

We are nearing the tipping point where more than half the states in the nation support DPC through legislative protections. As the movement grows, we will quickly see the interest in incorporating DPC into employer sponsored health plans and government employee benefits programs. There will be more interest in Medicaid and Medicare pilot programs. This will put DPC scalability to the ultimate test, as large corporate DPC organizations have stumbled recently, as they try to attain the known DPC benefits of individuality under a much larger umbrella. Individual and small group practices will continue to grow and flourish. There will be a need to incorporate DPC business model education into medical education curriculum. This will require efforts by the professional medical societies and organizations such as the Benjamin Rush Institute.

Physicians seeking to gain more knowledge will find a vast array of seminars and events offered all around the country. One of the more popular programs is the Nuts and Bolts conference series put on by Docs 4 Patient Care Foundation. These events draw hundreds of attendees from around the nation. All of the content is made available for free online at www.D4PCFoundation.org. Lists of upcoming events can be found at www.DPCFrontier.com, an invaluable site hosted by Dr. Phil Eskew, one of the nation's leading legal experts on Direct Primary Care. He provides a host of free legal guidance for those considering entering the practice model. Finally, watch for more information from the Direct Primary Care Coalition, a national organization that supports DPC practices at www.dpcare.org. Model legislation for states can also be found at that site.

One of the most encouraging aspects of the DPC community of physicians is that they are a very close-knit group. Most are willing to provide guidance to new practices for free. While there are consultants that charge for services, most of the needed information is available free of charge. The best thing to do is find a DPC physician and simply ask. There is a map of DPC practices on the DPC Frontier website.

In Summary

Empowering the doctor – patient relationship is the key to advancing health care freedom. DPC practices provide more value to the patient and the system. It allows primary care providers to be higher-performing, more patient-responsive, and less expensive than it is today. The ultimate goal of health and wellbeing over disease-centered care is achievable with Direct Primary Care.

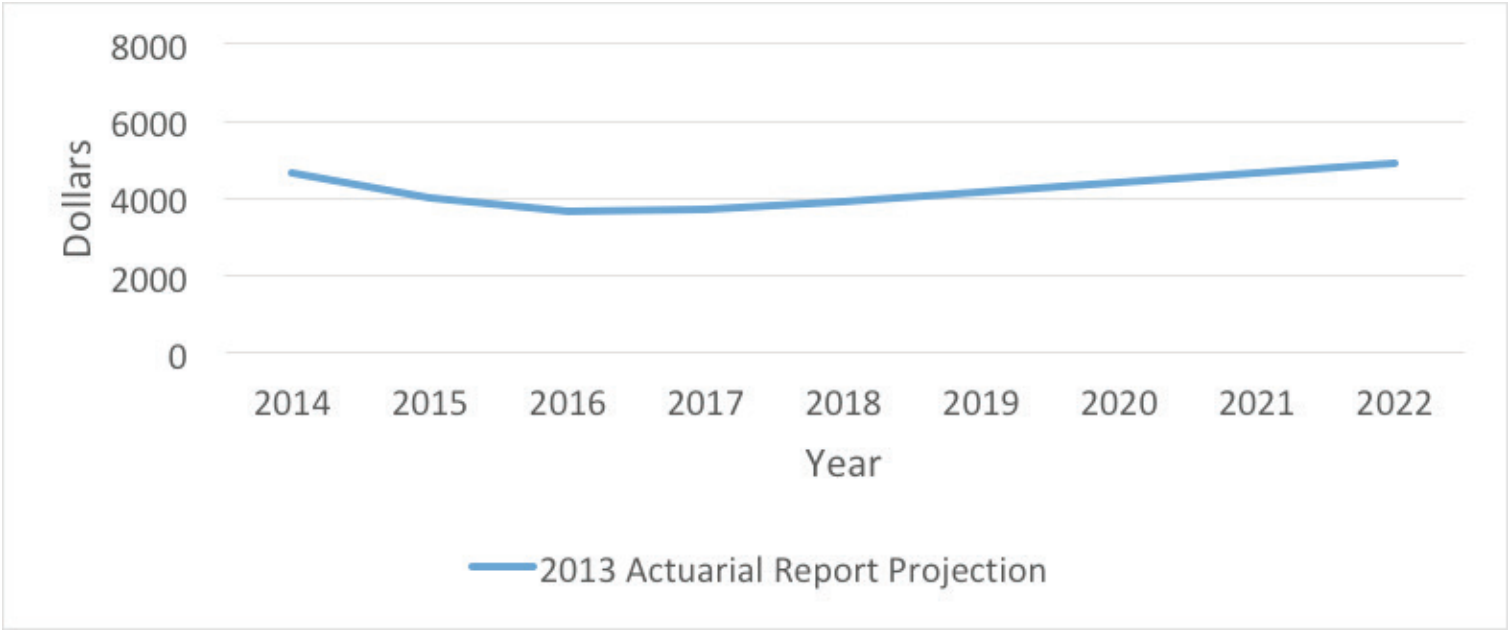
PROJECTED MEDICAID EXPANSION COSTS JUST ROSE AGAIN

By: Charles Blahous

Earlier this month the Centers for Medicare and Medicaid Services (CMS) actuary published a score of the House bill to repeal and replace the Affordable Care Act (ACA). Contained within that score is a concerning update of CMS's projections for the costs of the ACA's Medicaid expansion. Incredibly, the latest projections now indicate that per capita expansion costs will remain more than 50% higher, through 2022, than previously projected.

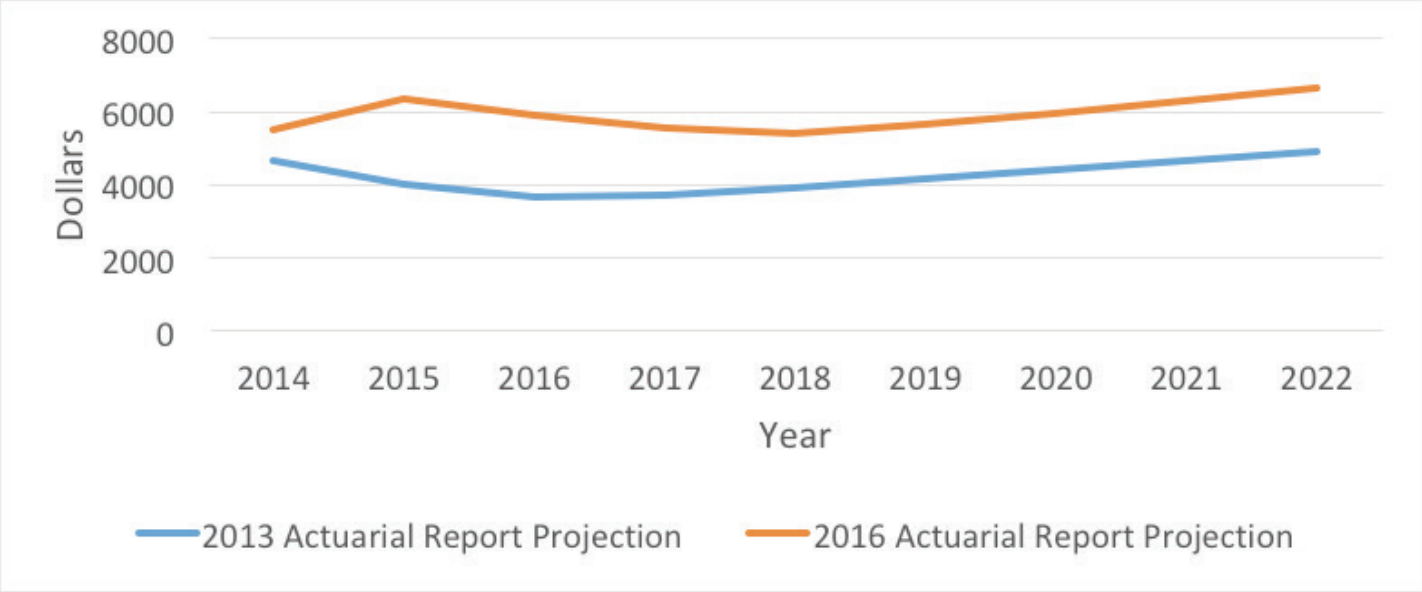
When the ACA first passed it was expected that the per capita cost of covering its Medicaid expansion population (childless adults under the age of 65 up to 138% of the federal poverty line) would be substantially less than for the adults under 65 who were already on Medicaid. This seemed a perfectly sensible prediction. After all, the already-eligible population included individuals (such as pregnant women) with substantial known health care needs. Accordingly, as seen in Figure 1, the 2013 Medicaid actuarial report projected that the cost of covering newly eligible adults would be $3,625 per person in 2016. This was substantially lower than the same report's projection of 2016 per capita costs of $5,002 for covering previously eligible adults.

Figure 1: Projected Cost Per Person, Medicaid Expansion



These early projections, however, failed to anticipate the substantial cost growth that would arise from states under the ACA being able to pass 100% of expansion costs on to the federal government. Figure 2 shows that in both 2015 and 2016 per-capita Medicaid expansion costs came in more than 60% higher than the earlier projections, as reflected in the 2016 actuarial report.

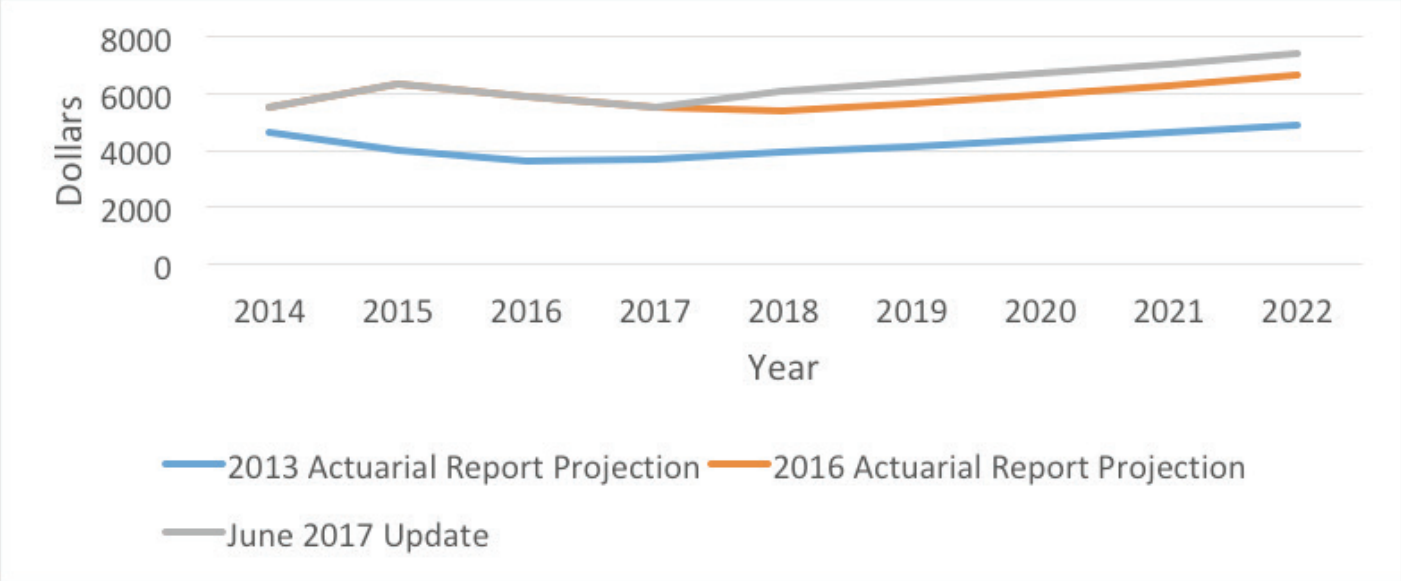
Figure 2: Projected Cost Per Person, Medicaid Expansion



The 2016 Medicaid actuarial report noted that states had attributed the high initial expansion costs to "pent-up demand," as well as to states having anticipated that "the persons who were most likely to enroll in the first year would be those with the greatest health care needs." Accordingly, CMS projected that the unexpected initial cost surge would soon ebb, gradually lowering per-capita costs through 2018. Thereafter per-capita costs would rise only gradually such that through 2021 they would still be below the heights they had climbed to in 2015. In support of this projection, CMS offered the hopeful take that "the effects of pent-up demand and adverse selection are expected to end after the earliest years of the eligibility expansion, and more recent information . . . indicates that the average costs of newly eligible adults were significantly lower than the States anticipated."

But based on its recent score for the House's American Health Care Act (AHCA), CMS appears to have abandoned these last glimmers of optimism about the costs of expansion. Per-capita expansion costs under the ACA are now projected to be more than 10% higher, through 2022, than expected even in the most recent actuarial report. See Figure 3.

Figure 2: Projected Cost Per Person, Medicaid Expansion



What this all means is that CMS now expects that through 2022, Medicaid expansion costs will be $7,436 per person, more than 50% higher than the $4,875 projected in the 2013 report. Thus, rather than just being an initial burst due to pent-up demand, this excess cost is now seen as a permanent feature of the ACA's Medicaid expansion.

The latest CMS projections show other concerning trends as well. From 2018 to 2026, per capita expenditures for covering the expansion population are now projected to grow more rapidly than they are for Medicaid's more vulnerable historically eligible population of pregnant women, poor children, seniors and disabled. This rapid expansion expenditure growth would occur on top of the unexpectedly large costs in evidence to date. In other words, expansion has made Medicaid spending more poorly targeted. We're already spending a far greater share than expected on Medicaid's relatively less needy participants, and this poor targeting is expected to grow worse.

Lawmakers are currently debating whether and how to modify the ACA's substantial expansion of Medicaid. CMS's latest projections show the per capita costs of that expansion rising still further beyond prior expectations.

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MEDICAID CAN BE FIXED AND PATIENTS CAN GET BETTER CARE

By: Hal Scherz MD

For over half a century, Medicaid has presented mounting challenges for every state across the country. It is the promise made by the federal government and transferred over to states, to cover the healthcare costs for the neediest among us, but it is getting more difficult to do so. The program depends upon doctors seeing these patients, which is becoming increasingly more problematic. According to Sandra Decker in the August 2012 issue of Health Affairs, over 30% of US doctors will not take new Medicaid patients, with the problem being worse in some of the more populous states like New Jersey where this number is at 62% and California where it is 46%.

The reasons for this are multi-factorial, but starts with the dismal payments received by doctors, for the care of these patients. This amount varies by state and by specialty, but can be as low as 15% of the physician's charges and as low as 40% of Medicare rates (the average is about 60%). In April 2016, the Kaiser Family Foundation reported that a GAO study found that Medicaid payments to physicians were 31-65% lower than commercial insurance. Contributing to the decision by doctors not to accept new Medicaid patients is the fact that these patients tend to be sicker and more difficult to care for because they often let their healthcare problems escalate to crisis stages before seeking care. They tend to be less compliant, meaning that they do not follow through with recommendations, such as taking medications or coming back for follow up appointments. It has been hypothesized that part of the reason this occurs may be that many of these patients do not place any value on the care that they receive because it is viewed as free. They have no "skin in the game."

Medicaid patients will typically utilize facilities and services inappropriately for routine services, such as Emergency Rooms and urgent care centers. A study published in The New England Journal of Medicine (Finkelstein, et al, Oct 20, 2016) reported that ER visits went up by 65% when Medicaid was expanded. This is the most expensive place in the healthcare delivery system to administer primary care. It is no wonder that Medicaid is often the largest expenditure in the state budgets.

According to a 2014 Pew Foundation report, 21% of Americans are covered by Medicaid, which on average, accounts for 16% of a state's budget. New York comes in highest at 26%. In actual dollars, $430 billion was spent by all the states combined as their share of Medicaid spending in 2012, with New York and California both spending $53 billion each.

Between the years 2000-2012, Medicaid spending increased 63%. Over the past 5 years, this spending has increased further; made worse by the Medicaid expansion. This level of spending is unsustainable and will soon crowd out other needs that the states provide such as funds for education, public safety, infrastructure, and other essential services.

The level of Medicaid spending might be justified if the outcomes achieved for these patients were satisfactory, but they are not. A study from Oregon is one of several showing that when metrics were compared between patients who were covered by Medicaid versus those without any healthcare insurance, the outcomes were no better in the Medicaid group, and in some cases worse. Inasmuch as the average spending across the country on Medicaid is $6250 per person (Kaiser Family Foundation- 2014), we should be able to do much better.

Medicaid expansion is still very much a consideration in the states that have not enacted it. Whether they have done so already or are contemplating it, bringing more individuals into the Medicaid ranks will need to be dealt with in a way that will provide quality care to patients, not inferior care, and not bankrupt the states.

Prior to Obamacare, states could apply for section 1115 waivers (pertaining to the Medicaid code) which would allow states to waive or modify provisions of the Medicaid program, such as eligibility thresholds. These waivers under Obamacare, were expanded under section 1332 of the Affordable Care Act, and were called State Innovation Waivers. States that applied for these waivers and received them were exempted from many elements of the ACA, but needed to provide at least the same level of financial protection to individuals and cover as many people as did the ACA, while at the same time being deficit neutral.

The Secretary of Health & Human Services has the authority under the ACA to grant waivers to the states, and which waivers will be granted is dependent on which political party is in control of the process. During the Obama administration, there were few waivers given to states that wanted to experiment with market driven Medicaid solutions. Former HHS Secretary Tom Price indicated that the section 1332 waivers would be easier to obtain under his leadership, allowing each state to serve as an incubator for innovation. The best ideas will rise to the top for other states to replicate.

Under Obamacare, various states used the waiver program to seek what they hoped to be viable solutions for their Medicaid problems. Many states altered their Medicaid programs and embraced innovations. Some have worked better than others, and two stand out from the field -- Indiana and Washington.

Arkansas used federal funding for Medicaid expansion to enroll patients into private healthcare insurance plans. Montana did the same thing, but turned over the process to Blue Cross/Blue Shield. North Carolina moved its Medicaid program into managed care as did Georgia. Missouri uses "medical homes" for patients to have a doctor that coordinates care and keeps patients out of emergency rooms and prevents unnecessary hospitalizations.

Tennessee is one of 44 states participating in a program called the "Money Follows the Person." This is to safely transition patients from a skilled nursing facility back to their own home or that of a caregiver. Oregon has established Accountable Care Organizations to integrate primary care doctors with other parts of the health care delivery spectrum in order to coordinate care better and to improve efficiencies and reduce wasteful spending. So far, its model seems to be working.

All of the models adopted by the states listed above hoped to restrain costs by limiting the use of resources at the provider end of the patient interaction. By restricting services (i.e. rationing), there is no question that costs can be contained. None of these states rely on the decision making of patients to reduce costs. This is where Indiana is different.

The Healthy Indiana Plan was created under the direction of Seema Verma, who now is the Administrator of the Center for Medicare & Medicaid Services. It encourages Medicaid recipients to adopt healthier behaviors by using financial rewards to incentivize them. Beneficiaries pay premiums, get Health Savings Accounts, make healthcare spending decisions, and can lose benefits if they fail to make their payments. Individuals who make up to 138% of the federal poverty level are eligible for this program. Payments are very affordable; typically not more than $25 monthly. There are copays of $4 for outpatient services, $75 for hospitalization, $4 for preferred drugs and $8 for non-preferred. The copay for an ER visit is $8 for the 1st one and $25 thereafter, in an attempt to discourage inappropriate usage.

Healthy Indiana is a consumer driven healthcare model pairing a HSA with a HDHP (high deductible health plan) and includes a POWER account (Personal Wellness & Responsibility Account). The 1st $2500 in healthcare coverage is paid out of this account, and the state pays most of it. Individuals pay a small portion of initial healthcare costs as previously stated. Any money left in this account rolls over and is retained by the individual. They get to manage the money in their own account. Getting preventative care can reduce by half the future costs that patients are responsible for paying out of pocket. These services include substance abuse treatment programs, smoking cessation programs, chronic disease management programs and even voluntary job referral and training programs.

Patients who transition out of Medicaid get to retain the saved money in their personal HSA.

This successful program is a conservative model that other states like Kentucky and Ohio are ready to embrace and implement. Patients, not government or insurance companies, are controlling health care choices and decisions. Patients have a stake in the process and they value the care that they receive, consequently making better choices. And the state is saving money.

Another successful model that empowers patients is Direct Primary Care (DPC) and it has become an important new delivery system in the state of Washington. This model is "concierge care for the average Joe or Jane." A patient selects a direct primary care doctor to whom they pay a fixed amount for services each month. This typically varies between $50-80 monthly. The patient gets unlimited access and all services that the primary care doctor can provide in the office. Services outside of the office in the direct primary care model are typically negotiated with imaging facilities, laboratories, specialty physicians and even surgery centers for a discounted cash price. With primary care constituting 80% of healthcare delivery, and the cost of a direct primary care doctor being less than $1000 per year, the immediate savings to the state is obvious. The indirect savings are potentially even greater, when patients are kept healthier and steered away from inappropriate and expensive venues for healthcare delivery like emergency rooms.

This model was successfully implemented in Washington state, which contracted through its managed Medicaid company, Centene, to work with the DPC company, Qliance. Millions of dollars were saved using this model.

The promise of fixing Medicaid is right before us and it is up to states to embrace it before the opportunity is gone forever. Whether through the process of Medicaid block grants as promised by the GOP as part of Obamacare repeal, or through 1332 waivers under Obamacare, the only way to get to fiscal sustainability at the state level is to repair a badly broken Medicaid system. A sympathetic Secretary of HHS and an innovative CMS Administrator make this process more achievable than ever before. It is now up to each state to decide what works best for their citizens and to embrace it, learning from the successes and mistakes of other states.

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WHY THE ACA MEDICAID EXPANSION NEEDS TO BE FIXED

By: Charles Blahous

(Editor's note: This was written before the U.S. Senate defeated the House health care reform bill. However, the issues outlined in this article remain important to the discussion of reforming Obamacare.)

Congressional Republicans, having moved their ACA repeal-and-replace bill through committee, are hearing the inevitable criticisms from both sides of the aisle as to what should be done differently. These disparate opinions are only useful insofar as they enable Senate and House leadership to finalize a bill that attracts the votes necessary to pass both houses and get to the president's desk.

One of the issues in contention is what to do with the ACA's Medicaid expansion. Medicaid provides health insurance for the poor and is jointly funded by the federal and state governments. The ACA departed from the historical distribution of government financing obligations, providing inflated federal matching payment rates specifically to cover those brought newly under Medicaid. The federal government covered 100% of these costs from 2014-16, scheduled to phase to 90% from 2020 onward.

The House bill would leave the ACA's match rates in place until 2020, thereafter reverting to Medicaid's historical matching formula through which the federal government provided 57% of funding on average. The expansion population enrolled before 2020 would be grandfathered in; the federal government would permanently fund them at the ACA's elevated (90%) matching rates. After 2020, federal payment growth per Medicaid enrollee would be limited to national health cost inflation.

The issue of how rapidly to reform the ACA's inflated Medicaid payment rates has divided Congressional Republicans. Fiscal conservatives are concerned the bill does not do enough to scale back the ACA's expansion costs. Other Republicans, as well as governors in expansion states, resist even the gradual cost-containment provisions in the House bill. The following explanation is not intended to provide guidance as to what schedule will produce the critical mass of votes necessary to pass legislation. Rather, it is an attempt to explain the substantive problems created by the ACA's inflated match rate. It's important these problems be corrected. While the precise timetable must be determined by the vote-counting, the bill's sponsors are right to be taking this on.

Problem #1: The ACA Medicaid Expansion Payment Rate is Inequitable

The only convincing way the ACA's inflated Medicaid payment rate can be justified is in terms of a political negotiation between the federal government and the states. Otherwise the ACA's match rate makes little policy sense. Consider the following information about current federal Medicaid support payments:

Percentage of Costs Covered by the Federal Government for Pregnant Woman and Children under 6 Below 133% of the Poverty Line, Children Ages 6-18 in Poverty, and Elderly/Disabled on SSI Assistance (Average Among All States)	Percentage of Costs Covered by the Federal Government for Childless Adults From 100–138% of the Poverty Line
57%	100% from 2014–16, phasing to 90% in 2020

It is extremely difficult to explain or even understand this arrangement from a policy standpoint. The federal government has been covering 100% of costs for childless adults above the poverty line, but only 57% for children in poverty. A childless woman above the poverty line receives 100% support; her pregnant sister receives 57% support. An able-bodied adult above the poverty line receives 100% support; a disabled individual in poverty receives 57% support. This defies policy sense.

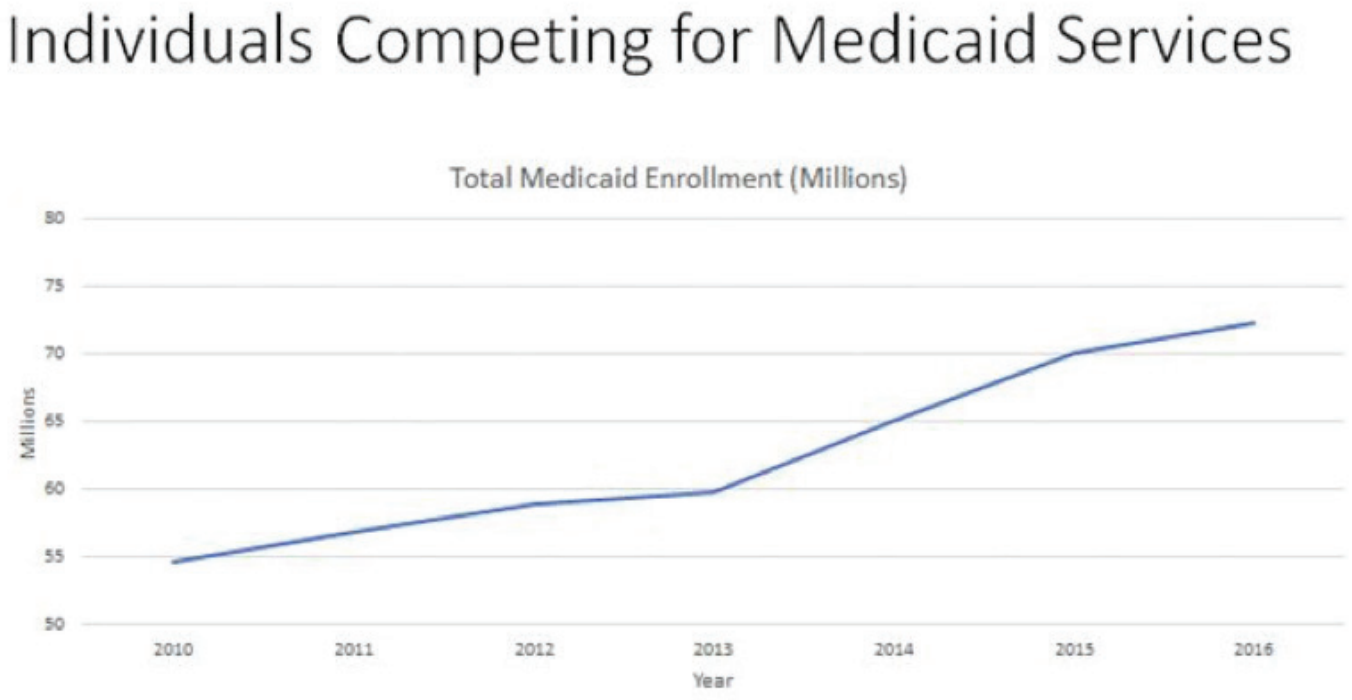
So why has this happened? It happened because the ACA was originally drafted to conscript states to expand Medicaid to cover childless adults up to 138% of the poverty line. The only way to overcome state objections to this was to have the federal government pick up virtually all the costs. After the Supreme Court rendered the ACA's Medicaid expansion optional for states, this elevated match rate thereafter became a lure for states to cover a population they would otherwise decline to spend significant resources to cover.
Had states made a priority of covering childless adults above the poverty line they would have previously sought federal waivers to do so at historical Medicaid match rates--but generally they did not. The ACA's elevated Medicaid match rate for the expansion population, by design, distorted state coverage decisions relative to the results of their own prior policy deliberations.

Problem #2: The ACA's Medicaid Expansion Creates Access Challenges for Vulnerable Populations

There is an understandable tendency to treat the ACA's Medicaid expansion as an unalloyed gain for vulnerable populations. It is assumed that compassion must be unambiguously on the side of Medicaid expansion. This is not necessarily so.

There would be winners and losers from repealing the ACA's inflated Medicaid match rates. The losers would be childless adults with incomes between 100-138% of the poverty line (assuming they do not move into superior coverage), as well as state governments. The winners would be federal taxpayers and, potentially, the most vulnerable populations – poor children, poor pregnant women, and poor aged and disabled.

Recall that the ACA's principal effect on Medicaid was to expand financing support, enrollment, and thus the demand for services. From 2013 to 2016, competition for such services increased from fewer than 60 million individuals to more than 72 million– an enrollment increase of over 20%. As the National Academy of Science's Institute of Medicine has noted, "As a result of the recent Medicaid expansion and the number of patients who are now insured through state exchanges, a shortage has developed in the supply of primary care physicians in some areas of the country relative to the demand."



The ACA attempted to counteract this problem by increasing the supply of physicians willing to take Medicaid, via a fee increase for participating doctors. There is an ongoing argument about whether access to care for Medicaid participants was made better or worse by the ACA on balance. That said, unless the supply of Medicaid services expanded proportionally with higher enrollment, it is virtually certain that part of the cost of expansion was paid by previously enrolled – and more vulnerable -- individuals, in the form of increased competition for limited services.

Repeal of the ACA's inflated Medicaid match rate would not mean childless adults between 100-138% of the poverty line couldn't still be covered. It would simply end the federally-imposed preference for covering this population over concentrating benefits on more vulnerable individuals. Applying the standard federal payment rate equally to the historic population and the expansion population would permit states to more accurately weigh the trade-offs associated with expanded Medicaid coverage.

Problem #3: The ACA Medicaid Expansion Payment Rate is Fueling a Cost Explosion
Medicaid has long struggled with financial stewardship issues due to its hybrid structure in which states do not bear the full costs of their own program management decisions. The ACA worsened that problem by having the federal government pick up 100% of the bill for any cost-increasing decisions the states make. The predictable result has been a cost explosion in covering the newly eligible population.

Table 1 shows the CMS Medicaid actuary's evolving estimates for the per-capita costs of covering newly eligible adults. Note for example that 2015 annual per capita costs, estimated at less than $4000 in the 2013 report, came in at over $6365, a full 60% higher.

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CMS Medicaid Actuary Estimates of Per-Capita Costs of Newly Eligible Adults			
Year	2014	2015	2016
2013 Report	$4636	$3976	$3625
2014 Report	$5517	$4281	$3606
2015 Report	$5488	$6366	$5910
2016 Report	$5511	$6365	$5926

It wasn't supposed to be this way. The Medicaid actuary initially expected that per capita costs for newly eligible adults would be much lower than for previous eligibles, based on the reasonable expectation that the expansion population would have better health and income, while having fewer high-cost health conditions. The warped incentives of the ACA, however, have induced states to set payment rates for the expansion population far higher than for the needier historic Medicaid population.

The specific politics of Medicaid, as well as the general politics of ACA repeal, are inordinately complex. The Medicaid match rate issue, however, is substantively straightforward. While reasonable people can differ on whom Medicaid should cover, there is little sensible policy rationale for the federal government providing greater support for the ACA's Medicaid expansion population than it does for everyone else in the program. Timetable aside, it's a problem warranting correction and the bill's sponsors deserve credit for addressing it.

(This article was published on March 13, 2017 by the Mercatus Center at George Mason University.)

40 YEARS OF CERTIFICATE-OF-NEED LAWS ACROSS AMERICA

By: Matthew D. Mitchell and Christopher Koopman

In the summer of 2016, New Hampshire became the 15th state to repeal its "certificate-of-need" (CON) program. This means that 35 states and the District of Columbia currently prohibit entry or expansion of healthcare facilities through CON programs. These laws, which require government permission before a facility can expand, offer a new service, or purchase certain pieces of equipment, were enacted in the belief that they would achieve several goals.

1. Ensure an adequate supply of health resources
2. Ensure rural community access to care
3. Increase the quality of care
4. Ensure the provision of charity care to those unable to pay and for other under-served communities
5. Encourage the use of hospital substitutes such as ambulatory surgery center (ASCs)
6. Restrain the cost of care

Forty years of peer-reviewed academic research—including the latest studies by researchers at the Mercatus Center at George Mason University—suggests that CON laws have not only failed to achieve their goals but have in many cases led to the opposite of what those who enacted the laws intended.

Consider, for example, the stated aim of CON laws of increasing the supply of healthcare services. GMU professor and Mercatus Center scholar Thomas Stratmann and his coauthor Jake Russ found that CON is associated with a more limited supply of hospital beds and medical imaging equipment. In related research, Stratmann and PhD student Matthew C. Baker found that CON is associated with less utilization of medical imaging equipment among non-hospital providers.

Or consider the goal of increasing rural access to care. Stratmann and Mercatus Center research fellow Christopher Koopman found that CON is associated with fewer, not more, rural hospitals.

Though policymakers didn't originally intend CON as a quality-enhancing regulation, many advocates now contend that it might increase quality by channeling more procedures through fewer hospitals, allowing those hospitals to gain expertise. In research with

Mercatus MA fellow David Wille, however, Professor Stratmann finds that CON regulation is associated with lower, not higher, quality, as measured along multiple dimensions.

The now-repealed federal statute that encouraged states to adopt CON laws explicitly stated that one goal of CONs was to encourage the appropriate use of hospital substitutes such as ambulatory surgery centers (ACSs). Ironically, however, 28 states currently require ASC-specific CONs, effectively limiting the supply of these hospital substitutes. Some CON advocates defend these limits by contending that these lower-cost centers take the highest-paying customers away from hospitals. But Stratmann and Koopman's work found that CON regulations seem to limit the supply of both ASCs and traditional hospitals.

Nor does the evidence suggest that these regulations advance the goal of reducing healthcare costs. On the contrary, the preponderance of evidence suggests that these regulations are associated with higher healthcare prices and higher overall healthcare spending, as is evident in Matthew Mitchell's review of decades of research as well as in the latest research by Professor James Bailey of Creighton University.
As these maps show, the first state to institute a CON program was New York in 1964, followed by Rhode Island, Maryland, California, and 22 other states over the next 10 years. In 1974, Congress passed the National Health Planning and Resources Development Act, requiring states to implement CON requirements in order to receive funding through certain federal programs. Louisiana was the only state not to implement a CON program during this time.

In 1986, the federal government repealed the CON mandate, and many states immediately began retiring their CON programs. By 1990, California, Colorado, Idaho, Kansas, Minnesota, New Mexico, South Dakota, Texas, Utah, Wisconsin, and Wyoming (a total of 11 states) had repealed their CON programs. (Arizona dropped CON regulations for most procedures but continued a regulation that limits air ambulances. Because of its limited scope, most analysts exclude Arizona from their empirical studies. For the purposes of this map, however, we include it as a CON state.) This left 39 states and the District of Columbia with these laws, although Wisconsin reinstated its program in 1993.

By 2000, Indiana, North Dakota, and Pennsylvania had repealed their programs. This brought the number of states with CON programs to 37 (and DC). Since 2000, Wisconsin had been the only state to repeal its CON program until New Hampshire did so in 2016. So now 35 states and the District of Columbia retain these restrictions.

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CERTIFICATE-OF-NEED-LAWS
ARE THEY ACHIEVING THEIR GOALS?

By: Matthew D. Mitchell

More than four decades ago, Congress passed and President Ford signed the National Health Planning and Resources Development Act of 1974 . The act withheld federal funds from states that failed to adopt certificate-of-need (CON) laws regulating healthcare facilities. CON laws require healthcare providers wishing to open or expand a healthcare facility to first prove to a regulatory body that the community needs the planned services. New York had enacted the first CON program in 1964, a full decade before the federal government began encouraging other states to follow suit, and by the early 1980s every state except Louisiana had implemented some version of a CON program. Policymakers hoped these programs would restrain healthcare costs, increase healthcare quality, and improve access to care for poor and under-served communities.

In 1986 — as evidence mounted that CON laws were failing to achieve their stated goals — Congress repealed the federal act, eliminating federal incentives for states to maintain their CON programs. Since then, 15 states have done away with their CON regulations. A majority of states still maintain CON programs, however, and vestiges of the National Health Planning and Resources Development Act can be seen in the justifications that state legislatures offer in support of these regulations. Policymakers claim CON regulation is intended to

√ Ensure an adequate supply of healthcare resources.

√ Ensure access to health care for rural communities.

√ Promote high-quality health care.

√ Ensure charity care for those unable to pay or for otherwise under-served communities.

√ Encourage appropriate levels of hospital substitutes and healthcare alternatives.

√ Restrain the cost of healthcare services.

Research, however, shows that CON laws fail to achieve these laudable goals. In fact, by limiting supply and undermining competition, CON laws may undercut each of these

1) Do CON programs ensure an adequate supply of Healthcare resources

CON programs limit the introduction and expansion of a wide variety of medical services and equipment, such as rehabilitation centers, nursing home beds, and medical imaging technologies. The process for obtaining a CON can take years and tens or even hundreds of thousands of dollars. By definition, CON programs restrict supply, making them unlikely to ensure an adequate supply of healthcare resources. Research on the supply of dialysis clinics and hospice care facilities finds that CON programs do, indeed, restrict the supply of both. George Mason University Professor and Mercatus-affiliated scholar Thomas Stratmann led the most recent comprehensive study of the effect of CON programs on the supply of medical equipment. Stratmann and his coauthor, Jacob Russ, report that there are on average 362 hospital beds per 100,000 people in the United States. Controlling for other factors, however, they find that states with CON programs have about 99 fewer hospital beds per 100,000 people than states without these regulations. Moreover, they find that CON programs that specifically regulate acute hospital beds are associated with an average of about 131 fewer hospital beds per 100,000 people relative to non-CON states. Furthermore, they find that CON regulations reduce the number of hospitals with MRI machines by one to two hospitals per 500,000 people and that states that regulate MRI machines have, on average, 2.5 fewer hospitals providing MRI services than non-CON states. Taking Michigan as an example, this means the state may have between 20 and 40 fewer hospitals offering MRI services than it would if it had no CON program.

In separate research, Stratmann and his coauthor Matthew C. Baker find that patients in states with CON programs are more likely to travel out of their county to obtain healthcare services. (Others find similar results.) They also assess the effect of CON regulations on non-hospital providers such as ambulatory surgical centers (ASCs), finding that—controlling for other factors—there is less market entry and lower market penetration of non-hospital providers in CON states than in non-CON states. They also find that hospitals that opened before the implementation of CON laws face less competition in CON states than in non-CON states. This may explain why hospitals tend to support CON regulation.

2) Do CON programs ensure access to Healthcare for rural communities?

Rural access to health care was a priority of the National Health Planning and Resources Development Act, and many states continue to justify their CON programs by claiming the regulations ensure care will be provided to residents in geographically under-served, economically depressed, or rural communities. Theory, however, suggests that a supply restriction will decrease, not increase, access to care. And, as I have noted, researchers have found that CON regulation is associated with longer travel distance to care. In recent research, Stratmann and his colleague Christopher Koopman explicitly address the

question of rural access to hospitals and hospital substitutes such as ambulatory surgical centers. Examining over 25 years' worth of data and controlling for other factors that might influence the number of hospitals, they find that states with CON programs not only have 30 percent fewer total hospitals per 100,000 residents, but also have 30 percent fewer rural hospitals per 100,000 residents compared with non-CON states. Moreover, their research finds that states with ASC-specific CON restrictions had on average 13 percent fewer rural ASCs per 100,000 residents compared with non-CON states. Their findings are consistent with previous research that found that CON programs correlate with less rural access to hospice care. In short, there is no evidence to indicate that CON programs increase access to care, and they may actually be limiting access for rural residents of CON states.

3) Do CON programs promote high-quality Healthcare?

Unlike other regulatory regimes, such as occupational licensure and scope-of-practice rules, CON regulations do not specifically aim to improve quality. That is, CON regulators typically do not attempt to assess whether providers are qualified to do their jobs, focusing instead on whether there is an economic "need" for their services. Nevertheless, CON advocates sometimes claim that because CON regulations reduce the number of institutions providing care, they will cause more procedures to be performed by the institutions that do obtain permission. Thus, the argument goes, practitioners in CON states will tend to see more patients with the same conditions and therefore might become more specialized and proficient. This theory must be weighed against competing theories that suggest that competition tends to increase quality, especially when regulations prevent price competition.

Much of the literature assessing the effect of CON regulation on quality has tended to focus on individual conditions and procedures, and researchers have had a difficult time disentangling causation from correlation. These studies either suggest that CON regulation has no effect on quality or come to different conclusions about the effect.

In recent research, Stratmann and his coauthor David Wille attempt to overcome the shortcomings of these research designs in two ways. First, they assess the effect of CON regulation using data pertaining to multiple aspects of the patient experience, including readmission rates, mortality rates, and patient experience surveys. Second, they attempt to isolate the causal effect of CON regulation by comparing variation in hospital quality within markets that span CON and non-CON states. This allows them to control for market-specific differences that might otherwise confound estimates. They find that "in states where CON laws regulate provider entry into healthcare markets, incumbents tend to provide lower-quality services." In particular, they find that deaths from treatable complications following surgery and mortality rates from heart failure, pneumonia, and

heart attacks are all significantly higher among hospitals in CON states than in non CON states. They also find that in states with four or more CON restrictions patients are less likely to rate hospitals highly.

4) Do CON programs ensure charity care for those unable to pay or for otherwise under-served communities?

If CON programs limit the overall supply of health care, perhaps they do so by ensuring that supply is more equitably distributed. Some have argued that CON programs were established with the partial intent of creating a quid pro quo: by restricting competition, the regulation increases the profit of some providers who, in return, might use some of this extra profit to subsidize medical services to the poor or under-served. In 11 states, CON statutes explicitly include requirements for the provision of charity care; in others, the quid pro quo is widely assumed.

While this presumed effect is theoretically possible, there is no evidence that hospitals in states with CON programs provide any more charity care or care to under-served communities than hospitals in states without CON programs. In fact, researchers have found that CON regulation seems to increase racial disparities in the provision of certain services. Stratmann and Russ examine the level of uncompensated care across CON and non-CON states and, controlling for other factors, find that CON regulation has had no effect.

What is more, CON programs are a costly and poorly targeted means of ensuring charity care, especially when there are more direct means to achieve the same end. For example, 26 states simply reimburse providers for at least a portion of any uncompensated care they provide.

5) Do CON programs encourage appropriate levels of hospital substitutes and Healthcare alternatives?

CON programs were once intended to promote lower-cost hospital substitutes such as ambulatory surgical centers. In the National Health Planning and Resources Development Act, Congress explicitly declared that “there are presently inadequate incentives for the use of appropriate alternative levels of health care, and for the substitution of ambulatory and intermediate care for inpatient hospital care.”

Ironically, many advocates of CON regulation now believe that ASCs and other hospital substitutes are a threat to the sustainability of hospitals and contend that CON laws are

necessary to preserve community hospitals. Their concern is that ASCs cater to wealthier, less-complicated, and better-insured patients, "cream-skimming" these more profitable patients away from hospitals, diminishing the profitability and long-term sustainability of the affected hospitals. This thinking may explain why CON laws in 26 states and the District of Columbia now explicitly restrict the establishment and expansion of ASCs.

Research suggests that these restrictions significantly reduce access to alternative means of care, contrary to the original intent of CON advocates. Stratmann and Koopman, for example, find that states with ASC-specific CON restrictions have 14 percent fewer total ASCs per 100,000 residents and 13 percent fewer rural ASCs per 100,000 residents than non-CON states. Additionally, Stratmann and Baker find that CON states have significantly fewer non-hospital providers of medical imaging services than non-CON states.

Furthermore, these restrictions on hospital alternatives do not seem to lead to any more community hospitals, as proponents of the cream-skimming argument contend. In fact, Stratmann and Koopman find that, controlling for other factors, CON laws are associated with 30 percent fewer hospitals per 100,000 residents and with 30 percent fewer rural hospitals per 100,000 residents. Thus, these regulations seem to restrict the supply of both hospitals and hospital substitutes.

5) Do CON programs restrain the cost of Healthcare services?

As they are today, policymakers in 1974 were concerned about healthcare price inflation, and Congress hoped that CON regulations would address the problem. Today, many states explicitly name cost control as a goal of their CON programs. The Virginia Certificate of Public Need Program's website, for example, states that "the program seeks to contain health care costs while ensuring financial viability and access to health care for all Virginia at a reasonable cost."

Cost is a per-unit concept. It refers to the amount of money needed to produce one unit of a product or service. Economic theory predicts that a supply restriction such as CON regulation will increase per unit costs by reducing supply. As economists Jon Ford and David Kaserman put it, "To the extent that CON regulation is effective in reducing net investment in the industry, the economic effect is to shift the supply curve of the affected service back to the left. The effect of such supply shifts is to raise . . . [the] equilibrium price." The empirical evidence on how CON regulation affects cost has been consistent with economic theory, showing that CON regulation tends to increase the cost of healthcare services.

By decreasing the supply of health care, however, CON regulations also reduce the quantity of services consumed. So it is possible that CON regulations might reduce overall spending on healthcare services even if they increase the cost per unit of each service.
In recent research, I review the literature on CON regulations and healthcare spending. Seven studies find that CON regulation increases healthcare spending, two find no statistically significant effect, and two find that CON regulation increases some expenditures while reducing others. To date, only one study finds that CON regulation is associated with less healthcare spending. In this case, however, the connection is tenuous. The author finds that CON regulation is associated with fewer hospital beds, and he finds that fewer hospital beds are associated with slightly slower growth in aggregate healthcare expenditures per capita. Importantly, however, he finds that "certificate-of-need programs did not have a direct effect on healthcare expenditures."

If the goal of CON regulation is to discourage excessive spending caused by the third-party payer problem and other distortions in the healthcare market that divorce consumers from cost considerations, then CON regulations are a poorly targeted method of achieving this end. As many healthcare experts have suggested, the best way to deal with this problem is to reform the policies that divorce consumers from cost. In contrast, CON regulations restrict the ability of everybody—including customers who pay out of pocket—to access healthcare services.

Conclusion:

Table 1. Summary of Research Addressing the Goals of Certificate-of-need (CON) Laws in Health Care

QUESTION	ANSWER	RESEARCH
1. Do CON programs ensure an adequate supply of healthcare resources?	**No.** CON regulation explicitly limits the establishment and expansion of healthcare facilities ans is associated with fewer hospitals, ambulatory surgical centers, dialysis clinics, and hospice care facilities. Its is also associated with fewer hospital beds and deceased access to medical imaging technologies, Residents of CON states are more likely than residents of non-CON states to leave their states in search of medical services.	Ford and Kasherman (1993); Carlson et al (2010); Stratmann and Russ (2014); Stratmann and Baker (forthcoming); and Stratmann and Koopman (2016)
2. Do CON programs ensure access to health care for rural communities?	**No**. CON programs are associated with fewer hospitals overall, but also with fewer rural hospitals, rural hospital substitutes, and rural hospice care. Residents of CON states must drive further to obtain care than residents of non-CON states.	Cutler, Huckman and Kolstad (2010); Carlson et al. (2010); and Stratmann and Koopma (2016)
3. Do CON programs promote high-quality healthcare?	**Most likely not.** While early research was mixed, more recent research suggests that deaths from treatable complications following surgery and mortality rates from heart failure, pneumonia, and heart attacks are significantly higher among hospitals in CON states than hospitals in non-CON states. Also, in states with especially comprehensive CON programs, patients are less likely to rate hospitals highly.	Stratmann and Wille (2016)
4. Do CON programs ensure charity care for those unable to pay for otherwise underserved communities?	**No.** There is no difference in the provision of charity care between states with CON programs and states without them, and CON regulation is associated with greated racial disparities in access to care.	DeLia et al. (2009) and Stratmann and Russ (2014)
5. Do CON programs encourage appropriate levels of hospital substitutes and healthcare alternatives?	**No.** CON regulations have a disproportionate effect on non-hospital providers of medical imaging services and are associated with 14 percent fewer total ambulatory surgical centers.	Stratmann and Baker (forthcoming) and Stratmann and Koopman (2016)

Sources:

James Bailey, “Can Health Spending Be Reined In through Supply Restraints? An Evaluation of Certificate-of-Need Laws” (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2016); Melissa D. A. Carlson et al., “Geographic Access to Hospice in the United States,” Journal of Palliative Medicine 13, no. 11 (2010); David M. Cutler, Robert S. Huckman, and Jonathan T. Kolstad, “Input Constraints and the Efficiency of Entry: Lessons from Cardiac Surgery,” American Economic Journal: Economic Policy 2, no. 1 (2010); Derek DeLia et al., “Effects of Regulation and Competition on Health Care Disparities: The Case of Cardiac Angiography in New Jersey,” Journal of Health Politics, Policy and Law 34, no. 1 (2009); Jon M. Ford and David L. Kaserman, “Certificate-of-Need Regulation and Entry: Evidence from the Dialysis Industry,” Southern Economic Journal 59, no. 4 (1993); Matthew D. Mitchell, “Do Certificate-of-Need Laws Limit Spending?” (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2016); Thomas Stratmann and Matthew C. Baker, “Barriers to Entry in the Healthcare Markets: Winners and Losers from Certificate-of-Need Laws” (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2017); Thomas Stratmann and Christopher Koopman, “Entry Regulation and Rural Health Care: Certificate-of-Need Laws, Ambulatory Surgical Centers, and Community Hospitals” (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2016); Thomas Stratmann and Jacob W. Russ, “Do Certificate-of-Need Laws Increase Indigent Care?” (Working Paper No. 14-20, Mercatus Center at George Mason University, Arlington, VA, 2014); Thomas Stratmann and David Wille, “Certificate-of-Need Laws and Hospital Quality” (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2016). MERCATUS ON POLICY 7 NOTES 1. National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (1975) (codified at 42 U.S.C. §§ 300k–300n-5), repealed by Pub. L. No. 99-660, § 701, 100 Stat. 3799 (1986). 2. Matthew D. Mitchell and Christopher Koopman, “40 Years of Certificate-of-Need Laws across America,” Mercatus Center at George Mason University, September 27, 2016. 3. Patrick John McGinley, “Beyond Health Care Reform: Reconsidering Certificate of Need Laws in a ‘Managed Competition’ System,” Florida State University Law Review 23, no. 1 (1995). 4. New Hampshire is the state that most recently repealed its CON program, in the summer of 2016. Mitchell and Koopman, “40 Years of Certificate-of-Need Laws across America.” 5. Each of these goals was first articulated in the National Health Planning and Resources Development Act of 1974. 6. Christopher Koopman and Anne Philpot, “The State of Certificateof-Need Laws in 2016,” Mercatus Center at George Mason University, September 27, 2016. 7. Kent Hoover, “Doctors Challenge Virginia’s Certificate-of-Need Requirement,” Business Journals, June 5, 2012. 8. As two economists put it, “To the extent that CON regulation is effective in reducing net investment in the industry, the economic effect is to shift the supply curve of the affected service back to the left.” Jon M. Ford and David L. Kaserman, “Certificate-of-Need Regulation and Entry: Evidence from the Dialysis Industry,” Southern Economic Journal 59, no. 4 (1993): 783. 9. Ibid. 10. Melissa D. A. Carlson et al., “Geographic Access to Hospice in the United States,” Journal of Palliative Medicine 13, no. 11 (2010). 11. Thomas Stratmann and Jacob W. Russ, “Do Certificate-of-Need Laws Increase Indigent Care?” (Working Paper No. 14-20, Mercatus Center at George Mason University, Arlington, VA, 2014). 12. An acute hospital bed is one intended for short-term use. 13. Stratmann and Russ, “Do Certificate-of-Need Laws Increase Indigent Care?” 14. Christopher Koopman, Thomas Stratmann, and Mohamad Elbarasse, “Certificate of Need Laws: Implications for Michigan” (Mercatus on Policy, Mercatus Center at George Mason University, Arlington, VA, May 2015). 15. Thomas Stratmann and Matthew C. Baker, “Barriers to Entry in the Healthcare Markets: Winners and Losers from Certificate-of-Need Laws” (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2017). For the previous research documenting this, see David M. Cutler, Robert S. Huckman, and Jonathan T. Kolstad, “Input Constraints and the

Efficiency of Entry: Lessons from Cardiac Surgery," American Economic Journal: Economic Policy 2, no. 1 (2010). 16. Stratmann and Baker, "Barriers to Entry in the Healthcare Markets." 17. Ibid. 18. In early research, national health planning consultants Ken Wing and A. G. Schneider identified this possibility: "A certificate of need program can also be distorted into a tool for the protection of established provider interests." Ken Wing and A. G. Schneider, "National Health Planning and Resources Development Act of 1974: Implications for the Poor," Clearinghouse Review, February 1976, 691. See also the large literature on regulatory capture: George J. Stigler, "The Theory of Economic Regulation," Bell Journal of Economics and Management Science 2, no. 1 (1971); Ernesto Dal Bó, "Regulatory Capture: A Review," Oxford Review of Economic Policy 22, no. 2 (2006); Patrick A. McLaughlin, Matthew D. Mitchell, and Ethan Roberts, "Regulatory Subsidies: How Regulations Can Become Privileges for Firms and Burdens for Consumers" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, forthcoming). 19. See Thomas Stratmann and Christopher Koopman, "Entry Regulation and Rural Health Care: Certificate-of-Need Laws, Ambulatory Surgical Centers, and Community Hospitals" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2016), 8n6. 20. Cutler, Huckman, and Kolstad, "Input Constraints and the Efficiency of Entry"; Stratmann and Baker, "Barriers to Entry in the Healthcare Markets." 21. Stratmann and Koopman, "Entry Regulation and Rural Health Care." 22. Ibid. 23. Carlson et al., "Geographic Access to Hospice in the United States." 24. On whether these other types of regulations achieve their aim, see Morris M. Kleiner and Alan B. Krueger, "Analyzing the Extent and Influence of Occupational Licensing on the Labor Market," Journal of Labor Economics 31, no. S1 (2013); Morris M. Kleiner et al., "Relaxing Occupational Licensing Requirements: Analyzing Wages and Prices for a Medical Service" (NBER Working Paper No. 19906, National Bureau of Economic Research, Cambridge, MA, 2014); Patrick A. McLaughlin, Jerry Ellig, and Dima Yazji Shamoun, "Regulatory Reform in Florida: An Opportunity for Greater Competitiveness and Economic Efficiency," Florida State University Business Review 13, no. 1 (2014); Department of the Treasury Office of Economic Policy, Council of Economic Advisers, and Department of Labor, Occupational Licensing: A Framework for Policymakers, July 2015. 25. John Steen, "Regionalization for Quality: Certificate of Need and Licensure Standards" (American Health Planning Association, March 2004). 26. Martin Gaynor, "What Do We Know About Competition and Quality in Health Care Markets?" (NBER Working Paper No. 12301, National Bureau of Economic Research, Cambridge, MA, 2006). 27. Daniel Polsky et al., "The Effect of Entry Regulation in the Health Care Sector: The Case of Home Health," Journal of Public Economics 110 (February 2014). 28. Evidence about the effect of CON regulation on the quality of coronary artery bypass grafting is especially mixed. Mary S. Vaughan-Sarrazin and her coauthors find that CON regulation reduces mortality rates related to the procedure, David M. Cutler and his coauthors find that CON regulation increases mortality rates after the procedure, and Vivian Ho and her colleagues find that states that drop CON regulation see a temporary reduction in mortality rates related to the procedure relative to states that keep it. Mary S. Vaughan-Sarrazin et al., "Mortality in Medicare Beneficiaries Following Coronary Artery Bypass Graft Surgery in States with and without Certificate of Need Regulation," Journal of the American Medical Association 288, no. 15 (2002); Cutler, MERCATUS ON POLICY 8 Huckman, and Kolstad, "Input Constraints and the Efficiency of Entry"; Vivian Ho, Meei-Hsiang Ku-Goto, and James G. Jollis, "Certificate of Need (CON) for Cardiac Care: Controversy over the Contributions of CON," Health Services Research 44, no. 2p1 (2009). 29. Thomas Stratmann and David Wille, "Certificate-of-Need Laws and Hospital Quality" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2016). 30. Ibid., 3. 31. Dwayne A. Banks, Stephen E. Foreman, and Theodore E. Keeler, "Cross-Subsidization in Hospital Care: Some Lessons from the Law and Economics of Regulation," Health Matrix: Journal of Law-Medicine 9 (1999): 1; Guy David et al., "Do Hospitals Cross-Subsidize?," Journal of Health Economics 37, no. C (2014). 32.

"Free Care Compendium: National Snapshot," Community Catalyst, accessed April 18, 2016, http://www.communitycatalyst.org/initiatives-and-issues/initiatives/hospital-accountability-project/free-care/national-snapshot. 33. Derek DeLia et al., "Effects of Regulation and Competition on Health Care Disparities: The Case of Cardiac Angiography in New Jersey," Journal of Health Politics, Policy and Law 34, no. 1 (2009). 34. "We do not find any evidence of an increase in indigent care. Our coefficients are small in magnitude, not statistically different from zero, and the direction of the effect changes across specifications." Stratmann and Russ, "Do Certificate-of-Need Laws Increase Indigent Care?," 18. 35. See section 6 for a discussion of CON regulation's costliness. 36. "Free Care Compendium: National Snapshot." 37. Pub. L. No. 93-641, 88 Stat. 2226. 38. Ann Tynan et al., "General Hospitals, Specialty Hospitals and Financially Vulnerable Patients" (Research Brief No. 11, Center for Studying Health System Change, Washington, DC, April 2009). 39. Stratmann and Koopman, "Entry Regulation and Rural Health Care." 40. Stratmann and Baker, "Barriers to Entry in the Healthcare Markets." 41. Stratmann and Koopman, "Entry Regulation and Rural Health Care." 42. In the National Health Planning and Resources Development Act, Congress noted that "increases in the cost of health care, particularly of hospital stays, have been uncontrollable and inflationary." Pub. L. No. 93-641, 88 Stat. 2226. 43. "Certificate of Public Need Program," Virginia Department of Health, accessed November 1, 2016. 44. Ford and Kaserman, "Certificate-of-Need Regulation and Entry," 783–84. 45. Monica Noether, "Competition among Hospitals," Journal of Health Economics 7, no. 3 (1988); David C. Grabowski, Robert L. Ohsfeldt, and Michael A. Morrisey, "The Effects of CON Repeal on Medicaid Nursing Home and Long-Term Care Expenditures," Inquiry: A Journal of Medical Care Organization, Provision and Financing 40, no. 2 (2003); Vivian Ho and Meei-Hsiang Ku-Goto, "State Deregulation and Medicare Costs for Acute Cardiac Care," Medical Care Research and Review 70, no. 2 (2013); James Bailey, "Can Health Spending Be Reined In through Supply Restraints? An Evaluation of Certificate-of-Need Laws" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2016). 46. In order for this to be the case, however, the demand for healthcare services would need to be elastic, and the evidence suggests that it is not elastic. Ford and Kaserman, "Certificate-of-Need Regulation and Entry," 783; Bailey, "Can Health Spending Be Reined In through Supply Restraints?" 47. Matthew D. Mitchell, "Do Certificate-of-Need Laws Limit Spending?" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2016). 48. Frank A. Sloan and Bruce Steinwald, "Effects of Regulation on Hospital Costs and Input Use," Journal of Law & Economics 23, no. 1 (1980); Joyce A. Lanning, Michael A. Morrisey, and Robert L. Ohsfeldt, "Endogenous Hospital Regulation and Its Effects on Hospital and Non-hospital Expenditures," Journal of Regulatory Economics 3, no. 2 (1991); John J. Antel, Robert L. Ohsfeldt, and Edmund R. Becker, "State Regulation and Hospital Costs," Review of Economics and Statistics 77, no. 3 (1995); Nancy A. Miller, Charlene Harrington, and Elizabeth Goldstein, "Access to Community-Based Long-Term Care: Medicaid's Role," Journal of Aging and Health 14, no. 1 (2002); Patrick A. Rivers, Myron D. Fottler, and Mustafa Zeedan Younis, "Does Certificate of Need Really Contain Hospital Costs in the United States?," Health Education Journal 66, no. 3 (2007); Patrick A. Rivers, Myron D. Fottler, and Jemima A. Frimpong, "The Effects of Certificate of Need Regulation on Hospital Costs," Journal of Health Care Finance 36, no. 4 (2010); Bailey, "Can Health Spending Be Reined In through Supply Restraints?" 49. Frank A. Sloan, "Regulation and the Rising Cost of Hospital Care," Review of Economics and Statistics 63, no. 4 (1981); Grabowski, Ohsfeldt, and Morrisey, "Effects of CON Repeal on Medicaid Nursing Home and Long-Term Care Expenditures." 50. Christopher J. Conover and Frank A. Sloan, "Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?," Journal of Health Politics, Policy and Law 23, no. 3 (1998); Momotazur Rahman et al., "The Impact of Certificate-of-Need Laws on Nursing Home and Home Health Care Expenditures," Medical Care Research and Review: MCRR 73, no. 1 (2016). 51. Fred J. Hellinger, "The Effect of Certificate-of-Need Laws on Hospital Beds and Healthcare

Expenditures: An Empirical Analysis," American Journal of Managed Care 15, no. 10 (2009). 52. Ibid., 737. 53. John Cochrane, "After the ACA: Freeing the Market for Health Care" (expanded version of remarks at The Future of Health Care Reform in the United States, University of Chicago Law School, June 2014). 54. There are a host of economic and social problems with regulations that favor particular firms. Matthew D. Mitchell, The Pathology of Privilege: The Economic Consequences of Government Favoritism (Arlington, VA: Mercatus Center at George Mason University, 2014). MERCATUS ON POLICY 9

CON programs are a remnant of an era in which it was thought that central regulatory planning could yield better outcomes by restricting the supply of services valued by consumers. Despite the fact that the federal government no longer encourages states to restrict the supply of healthcare services, 35 states and the District of Columbia still maintain CON programs. The justifications for these programs are compelling when they are taken at face value, but a review of the literature finds that CON regulations fail to achieve their worthy goals. This research is summarized in table 1 (above).

For state policymakers eager to modernize their healthcare systems, the first step may be as simple as opening the door to competition. CON programs are effective barriers to entry that give incumbent providers an advantage over new providers. Evidence suggests that CON programs reduce the supply of healthcare resources, limit rural access to health care, diminish the quality of health care provided at hospitals, fail to promote charity care, impede the supply of hospital substitutes, and raise healthcare prices and overall expenditures. Furthermore, CON programs have a disproportionate effect on non-hospital providers, which supports the theory that larger, more established hospitals are benefiting from these restrictions on competition.

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Sources:

1. National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (1975) (codified at 42 U.S.C. §§ 300k–300n-5), repealed by Pub. L. No. 99-660, § 701, 100 Stat. 3799 (1986).
2. Matthew D. Mitchell and Christopher Koopman, "40 Years of Certificate-of-Need Laws across America," Mercatus Center at George Mason University, September 27, 2016.
3. Patrick John McGinley, "Beyond Health Care Reform: Reconsidering Certificate of Need Laws in a 'Managed Competition' System," Florida State University Law Review 23, no. 1 (1995).
4. New Hampshire is the state that most recently repealed its CON program, in the summer of 2016. Mitchell and Koopman, "40 Years of Certificate-of-Need Laws across America."
5 Each of these goals was first articulated in the National Health Planning and Resources Development Act of 1974
6. Christopher Koopman and Anne Philpot, "The State of Certificateof-Need Laws in 2016," Mercatus Center at George Mason University, September 27, 2016.
7. Kent Hoover, "Doctors Challenge Virginia's Certificate-of-Need Requirement," Business Journals, June 5, 2012.
8. As two economists put it, "To the extent that CON regulation is effective in reducing net investment in the industry, the economic effect is to shift the supply curve of the affected service back to the left." Jon M. Ford and David L. Kaserman, "Certificate-of-Need Regulation and Entry: Evidence from the Dialysis Industry," Southern Economic Journal 59, no. 4 (1993): 783.
9. Ibid.
10. Melissa D. A. Carlson et al., "Geographic Access to Hospice in the United States," . Journal of Palliative Medicine 13, no. 11 (2010).
11. Thomas Stratmann and Jacob W. Russ, "Do Certificate-of-Need Laws Increase Indigent Care?" (Working Paper No. 14-20, Mercatus Center at George Mason University, Arlington, VA, 2014).
12. An acute hospital bed is one intended for short-term use.
13. Stratmann and Russ, "Do Certificate-of-Need Laws Increase Indigent Care?"
14. Christopher Koopman, Thomas Stratmann, and Mohamad Elbarasse, "Certificate of Need Laws: Implications for Michigan" (Mercatus on Policy, Mercatus Center at George Mason University, Arlington, VA, May 2015).
15. Thomas Stratmann and Matthew C. Baker, "Barriers to Entry in the Healthcare Markets: Winners and Losers from Certificate-of-Need Laws" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2017). For the previous research documenting this, see David M. Cutler, Robert S. Huckman, and Jonathan T. Kolstad,

"Input Constraints and the Efficiency of Entry: Lessons from Cardiac Surgery," American Economic Journal: Economic Policy 2, no. 1 (2010).

16. Stratmann and Baker, "Barriers to Entry in the Healthcare Markets."
17. Ibid
18. In early research, national health planning consultants Ken Wing and A. G. Schneider identified this possibility: "A certificate of need program can also be distorted into a tool for the protection of established provider interests." Ken Wing and A. G. Schneider, "National Health Planning and Resources Development Act of 1974: Implications for the Poor," Clearinghouse Review, February 1976, 691. See also the large literature on regulatory capture: George J. Stigler, "The Theory of Economic Regulation," Bell Journal of Economics and Management Science 2, no. 1 (1971); Ernesto Dal Bó, "Regulatory Capture: A Review," Oxford Review of Economic Policy 22, no. 2 (2006); Patrick A. McLaughlin, Matthew D. Mitchell, and Ethan Roberts, "Regulatory Subsidies: How Regulations Can Become Privileges for Firms and Burdens for Consumers" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, forthcoming).
19. See Thomas Stratmann and Christopher Koopman, "Entry Regulation and Rural Health Care: Certificate-of-Need Laws, Ambulatory Surgical Centers, and Community Hospitals" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2016), 8n6.
20. Cutler, Huckman, and Kolstad, "Input Constraints and the Efficiency of Entry"; . Stratmann and Baker, "Barriers to Entry in the Healthcare Markets."
21. Stratmann and Koopman, "Entry Regulation and Rural Health Care."
22. Ibid
23. Carlson et al., "Geographic Access to Hospice in the United States."
24. On whether these other types of regulations achieve their aim, see Morris M. Kleiner and Alan B. Krueger, "Analyzing the Extent and Influence of Occupational Licensing on the Labor Market," Journal of Labor Economics 31, no. S1 (2013); Morris M. Kleiner et al., "Relaxing Occupational Licensing Requirements: Analyzing Wages and Prices for a Medical Service" (NBER Working Paper No. 19906, National Bureau of Economic Research, Cambridge, MA, 2014); Patrick A. McLaughlin, Jerry Ellig, and Dima Yazji Shamoun, "Regulatory Reform in Florida: An Opportunity for Greater Competitiveness and Economic Efficiency," Florida State University Business Review 13, no. 1 (2014); Department of the Treasury Office of Economic Policy, Council of Economic Advisers, and Department of Labor, Occupational Licensing: A Framework for Policymakers, July 2015.
25. John Steen, "Regionalization for Quality: Certificate of Need and Licensure Standards" (American Health Planning Association, March 2004).
26. Martin Gaynor, "What Do We Know About Competition and Quality in Health Care Markets?" (NBER Working Paper No. 12301, National Bureau of Economic Research,

Cambridge, MA, 2006).

27. Daniel Polsky et al., "The Effect of Entry Regulation in the Health Care Sector: The Case of Home Health," Journal of Public Economics 110 (February 2014).
28. Evidence about the effect of CON regulation on the quality of coronary artery bypass grafting is especially mixed. Mary S. Vaughan-Sarrazin and her coauthors find that CON regulation reduces mortality rates related to the procedure, David M. Cutler and his coauthors find that CON regulation increases mortality rates after the procedure, and Vivian Ho and her colleagues find that states that drop CON regulation see a temporary reduction in mortality rates related to the procedure relative to states that keep it. Mary S. Vaughan-Sarrazin et al., "Mortality in Medicare Beneficiaries Following Coronary Artery Bypass Graft Surgery in States with and without Certificate of Need Regulation," Journal of the American Medical Association 288, no. 15 (2002); Cutler, Huckman, and Kolstad, "Input Constraints and the Efficiency of Entry"; Vivian Ho, Meei-Hsiang Ku-Goto, and James G. Jollis, "Certificate of Need (CON) for Cardiac Care: Controversy over the Contributions of CON," Health Services Research 44, no. 2p1 (2009).
29. Thomas Stratmann and David Wille, "Certificate-of-Need Laws and Hospital Quality" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2016).
30. Ibid 3
31. Dwayne A. Banks, Stephen E. Foreman, and Theodore E. Keeler, "Cross-Subsidization in Hospital Care: Some Lessons from the Law and Economics of Regulation," Health Matrix: Journal of Law-Medicine 9 (1999): 1; Guy David et al., "Do Hospitals Cross-Subsidize?" Journal of Health Economics 37, no. C (2014).
32. "Free Care Compendium: National Snapshot," Community Catalyst, accessed April 18, 2016, http://www.communitycatalyst.org/initiatives-and-issues/initiatives/hospital-accountability-project/free-care/national-snapshot.
33. Derek DeLia et al., "Effects of Regulation and Competition on Health Care Disparities: The Case of Cardiac Angiography in New Jersey," Journal of Health Politics, Policy and Law 34, no. 1 (2009).
34. "We do not find any evidence of an increase in indigent care. Our coefficients are small in magnitude, not statistically different from zero, and the direction of the effect changes across specifications." Stratmann and Russ, "Do Certificate-of-Need Laws Increase Indigent Care?" 18
35. See section 6 for a discussion of CON regulation's costliness.
36. "Free Care Compendium: National Snapshot."
37. Pub. L. No. 93-641, 88 Stat. 2226.
38. Ann Tynan et al., "General Hospitals, Specialty Hospitals and Financially Vulnerable Patients" (Research Brief No. 11, Center for Studying Health System Change, Washington,

DC, April 2009).

39. Stratmann and Koopman, "Entry Regulation and Rural Health Care."
40. Stratmann and Baker, "Barriers to Entry in the Healthcare Markets."
41. Stratmann and Koopman, "Entry Regulation and Rural Health Care."
42. In the National Health Planning and Resources Development Act, Congress noted that "increases in the cost of health care, particularly of hospital stays, have been uncontrollable and inflationary." Pub. L. No. 93-641, 88 Stat. 2226.
43. "Certificate of Public Need Program," Virginia Department of Health, accessed November 1, 2016.
44. Ford and Kaserman, "Certificate-of-Need Regulation and Entry," 783–84.
45 Monica Noether, "Competition among Hospitals," Journal of Health Economics 7, no. 3 (1988); David C. Grabowski, Robert L. Ohsfeldt, and Michael A. Morrisey, "The Effects of CON Repeal on Medicaid Nursing Home and Long-Term Care Expenditures," Inquiry: A Journal of Medical Care Organization, Provision and Financing 40, no. 2 (2003); Vivian Ho and Meei-Hsiang Ku-Goto, "State Deregulation and Medicare Costs for Acute Cardiac Care," Medical Care Research and Review 70, no. 2 (2013); James Bailey, "Can Health Spending Be Reined In through Supply Restraints? An Evaluation of Certificate-of-Need Laws" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2016).
46. In order for this to be the case, however, the demand for healthcare services would need to be elastic, and the evidence suggests that it is not elastic. Ford and Kaserman, "Certificate-of-Need Regulation and Entry," 783; Bailey, "Can Health Spending Be Reined In through Supply Restraints?"
47. Matthew D. Mitchell, "Do Certificate-of-Need Laws Limit Spending?" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2016).
48. Frank A. Sloan and Bruce Steinwald, "Effects of Regulation on Hospital Costs and Input Use," Journal of Law & Economics 23, no. 1 (1980); Joyce A. Lanning, Michael A. Morrisey, and Robert L. Ohsfeldt, "Endogenous Hospital Regulation and Its Effects on Hospital and Non-hospital Expenditures," Journal of Regulatory Economics 3, no. 2 (1991); John J. Antel, Robert L. Ohsfeldt, and Edmund R. Becker, "State Regulation and Hospital Costs," Review of Economics and Statistics 77, no. 3 (1995); Nancy A. Miller, Charlene Harrington, and Elizabeth Goldstein, "Access to Community-Based Long-Term Care: Medicaid's Role," Journal of Aging and Health 14, no. 1 (2002); Patrick A. Rivers, Myron D. Fottler, and Mustafa Zeedan Younis, "Does Certificate of Need Really Contain Hospital Costs in the United States?," Health Education Journal 66, no. 3 (2007); Patrick A. Rivers, Myron D. Fottler, and Jemima A. Frimpong, "The Effects of Certificate of Need Regulation on Hospital Costs," Journal of Health Care Finance 36, no. 4 (2010); Bailey, "Can Health Spending Be Reined In through Supply Restraints?"
49. Frank A. Sloan, "Regulation and the Rising Cost of Hospital Care," Review of Economics

and Statistics 63, no. 4 (1981); Grabowski, Ohsfeldt, and Morrisey, "Effects of CON Repeal on Medicaid Nursing Home and Long-Term Care Expenditures."

50. Christopher J. Conover and Frank A. Sloan, "Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?," Journal of Health Politics, Policy and Law 23, no. 3 (1998); Momotazur Rahman et al., "The Impact of Certificate-of-Need Laws on Nursing Home and Home Health Care Expenditures," Medical Care Research and Review: MCRR 73, no. 1 (2016).
51. Fred J. Hellinger, "The Effect of Certificate-of-Need Laws on Hospital Beds and Healthcare Expenditures: An Empirical Analysis," American Journal of Managed Care 15, no. 10 (2009).
52. Ibid., 737
53. John Cochrane, "After the ACA: Freeing the Market for Health Care" (expanded version of remarks at The Future of Health Care Reform in the United States, University of Chicago Law School, June 2014).
54. There are a host of economic and social problems with regulations that favor particular firms. Matthew D. Mitchell, The Pathology of Privilege: The Economic Consequences of Government Favoritism (Arlington, VA: Mercatus Center at George Mason University, 2014).

THE STATE OF CERTIFICATE-OF-NEED LAWS IN 2016

By: Christopher Koopman and Anne Philpot

Since they were first instituted in 1964, certificate-of-need (CON) laws have experienced a number of changes over the past 52 years—from the mild growth in the 1960s and the federal mandate that every state enact CON laws in the 1970s to the federal reforms and subsequent repeals of the 1980s, along with more recent reform efforts. Recent efforts to compile these laws have been conducted by the American Health Planning Association (AHPA) in 2011 and the National Conference of State Legislatures (NCSL) in 2016. Using the most up-to-date data, we improve upon these efforts by providing a single, comprehensive resource to understand the current status of CON laws in the 50 states and the District of Columbia—and to note how states compare with each other.

Our 2016 data has been compiled from state laws, current regulatory documents, agency forms, and direct communication with regulators in each state.

Comparing our current data with the AHPA's 2011 data sheds some light into how these laws have changed (or not) over the past five years. In 2011, CON laws were enforced in 37 states and the District of Columbia. In 2016, CON laws are enforced in 35 states and the District of Columbia. Both Wisconsin and New Hampshire no longer enforce CON laws. While there are two fewer states with CON laws, the first table ("Regulated Services by State, 2016") shows there has been a net increase in the number of items that require a certificate of need. In 2011, 538 total items required a CON. In 2016, 589 total items require a CON.

As the second table ("Changes in Number of CON Laws Since 2011") shows, the increase in covered items is primarily driven by five states—Massachusetts, New York, Florida, Iowa, Oregon, and New Jersey—which accounted for an increase in 50 covered items combined. Only three states—Maine, Connecticut, and Illinois—have seen a reduction in the number of covered items since 2011. Of the remaining 27 states, 13 states went unchanged and 14 states added four or fewer items.

Two factors seem to be driving these changes. The first is simply changes in the law, which would not be surprising given the amount of attention CON laws have received in a number of states over the past five years. The second is differences in the way the data have been compiled. The AHPA data was collected using surveys of state CON regulators. Our data was primarily sourced using what the laws say in each state. As a result, the current increases (and decreases) could represent the difference between what regulators

believed their program covered and what the law actually stated.
Regardless of the reasons, this finding is disappointing. In particular, while these laws are justified by a number of claims, the evidence demonstrates these laws have failed to achieve their goals and have a number of negative, unintended consequences for competition, innovation, and patient welfare.

Where do the states rank according to this new data? There are now 15 states that no longer regulate health care via a CON program. For those states that continue to regulate via a CON program, some states have seen their ranking change dramatically. As the updated ranking ("State Rankings by Number of CON Laws, 2016") shows, Maine makes the biggest jump: it was ranked 47th in 2011 and is now ranked 25th. New Jersey took the biggest step backward: it was ranked 28th in 2011 and is now ranked 48th. Vermont, Hawaii, and Washington, DC, have held on to their positions as the three most restrictive states, and finished the 2016 ranking ranked 51st, 50th, and 49th, respectively.

While there is some evidence of change in the right direction, the fact remains that nearly two-thirds states continue to restrict entry, expansion, and competition in healthcare through CON laws. Clearly there is more work to be done in explaining to legislators and healthcare policymakers about the potential limiting effects these laws have on achieving high-quality, low-cost healthcare.

Regulated Services by State, 2016

Regulated Services	AL	AK	AR	AZ	CT	DE	FL	GA	HI	IL	IA	KY	LA	ME	MD	MA	MI	MS	MO	MT	NE	NV	NJ	NY	NC	OH	OK	OR	RI	SC	TN	VT	VA	WA	WV	DC	Counts by Service
Acute Hospital Beds	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes*	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	No	No	Yes*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	28
Air Ambulance	No*	No	No	No	No	No	No	No	Yes*	No	No	No	No	No*	No	Yes	Yes	No	No	No	No	Yes*	No	No	No	No	No	No	No	No	No	Yes	No	No	No	No*	5
Ambulance Services, Ground (generally not counted as a CON state)	No	No	No	Yes	No	No	No	No	Yes*	No	No	Yes*	No	No	No	No	No	No	No	No	No	No	No	Yes*	No	No	No	No	No	No	No	No	No	No	No	No	4
Ambulatory Surgical Centers (ASC)	Yes	Yes	No	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes	No	No	Yes	No	Yes*	Yes	Yes	No	No	Yes*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	28
Burn Care	Yes	Yes*	No	No	No	No	Yes*	No	Yes	No	No	No	No	No*	Yes	No	No	No	No	No	No	No	Yes	Yes	Yes	No	No	Yes*	No	No	Yes	Yes	No	Yes	Yes*	Yes	14
Cardiac Catheterization	Yes	Yes	No	No	Yes	Yes	Yes*	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes*	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	27
Computed Tomography (CT) Scanners	No	Yes	No	No	Yes	No	No	Yes*	Yes	No	Yes*	No	No	No*	No	No	Yes	No	Yes	No	No	No	Yes*	Yes	No*	No	No	Yes*	Yes	Yes*	Yes*	Yes	Yes	No	Yes	Yes	17
Gamma Knives	Yes	Yes	No	No	No	No	No	Yes	Yes	No	Yes*	No	No	Yes	No	Yes	Yes	Yes	Yes	No	No	No	Yes*	No	Yes	No	No	No	Yes	Yes	No	Yes	Yes	No	No	Yes	17
Home Health	Yes	No	Yes	No	No	No	Yes*	Yes	Yes	No	No	Yes	No	No	Yes	No	No	Yes	No	Yes	No	No	Yes	Yes	Yes	No	No	No	Yes*	Yes	Yes	Yes	No	Yes	Yes	Yes	19
Hospice	Yes	No	Yes	No	No*	No	Yes	No	Yes	No	Yes*	Yes	No	No	Yes	No	No	No*	No	No	No	No	Yes*	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	18
Hypodermic Syringes and Needles	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	Yes*	No	No	No	No	No	No	No	No	No	No	No	1
Intermediate Care Facilities/Mental Retardation (ICF/MR)	Yes*	No	Yes	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes*	No	Yes	Yes	Yes	Yes*	Yes	Yes	Yes*	Yes	No	Yes	Yes*	Yes*	Yes	Yes	Yes	Yes	No	Yes	Yes*	28
Linear Accelerator Radiology	No	No	No	No	Yes*	No	No	No	No	No	No	No	No	No	No	No	No	No	Yes*	No	No	No	Yes*	No	Yes*	No	No	No	Yes*	No	Yes*	No	No	No	No	No	6
Lithotripsy	No	Yes	No	No	No	Yes	No	Yes	Yes	No	No	No	No	No*	No	Yes	Yes	No	Yes	No	No	No	Yes*	Yes	Yes	No	No	Yes*	No	Yes	Yes	Yes	Yes	No	No	Yes	16
Long-Term Acute Care (LTAC)	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes*	Yes	Yes	Yes	Yes*	Yes*	No	Yes	Yes*	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	30
Nursing Home Beds/Long-Term Care Beds	Yes	Yes	Yes	No	No*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	34
Medical Office Buildings	No	No	No	No	No	No	No	Yes*	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	Yes	No	No	No	Yes	3
Mobile Hi Technology (CT, MRI, PET, etc.)	No	Yes	No	No	Yes	No	No	No	Yes	No	Yes*	Yes	No	No*	No	No	Yes	Yes*	Yes	No	No	No	Yes*	Yes	Yes	No	No	No	Yes	Yes	No	Yes	No	Yes	Yes	Yes	17
Magnetic Resonance Imaging (MRI) Scanners	No	Yes	No	No	Yes	No	No	Yes*	Yes	No	Yes*	Yes	No	No*	No	Yes	Yes	Yes	Yes	No	No	No	Yes*	Yes	Yes	No	No	Yes*	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	21
Magnetic Source Imaging (MSI) Scanners	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	Yes*	No	No	No	1
Neo-Natal Intensive Care	Yes	Yes	No	No	No*	No	Yes	Yes	Yes	Yes	No	Yes	No	No*	Yes	Yes	Yes	No	No	No	No	No	Yes	Yes	Yes	No	No	Yes*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	22
Obstetrics Services	Yes	Yes	No	No	No*	No	No	Yes	Yes	Yes	No	Yes*	No	No*	Yes	No	No	No	Yes*	No	No	No	Yes*	Yes	No	No	No	No	Yes	Yes*	Yes*	Yes	Yes	Yes	Yes	Yes	18
Open-Heart Surgery	Yes	Yes	No	No	No*	No	Yes*	Yes	Yes	Yes	Yes	Yes	No	No*	Yes	Yes	Yes	Yes	No	No	No	No	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	23
Organ Transplants	Yes	Yes	No	No	No*	No	Yes	No	Yes	Yes	Yes	Yes	No	No*	Yes	Yes	Yes	No	No	No	No	No	Yes	Yes	Yes	No	No	No	Yes	No	No	Yes	Yes	Yes	Yes	Yes	19
Positron Emission Tomography (PET) Scanners	No	Yes	No	No	Yes	Yes	No	Yes	Yes	No	Yes*	Yes	No	No*	No	Yes	Yes	Yes	Yes	No	No	No	Yes*	No	Yes	No	No	Yes*	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	21
Psychiatric Services	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes*	No	No	Yes*	Yes	No	Yes	No	Yes	Yes*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	28
Radiation Therapy	Yes	Yes	No	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Yes	No	No	No	No	Yes	Yes	No	No	Yes*	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	23
Rehabilitation	Yes	No	No	No	No	No	Yes	Yes	Yes	Yes	Yes*	Yes	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes*	Yes	Yes	Yes	No	No	Yes*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	27
Renal Failure/Dialysis	Yes	Yes	No	No	No	No	No	No	Yes	Yes	No	No	No	Yes	No	No	No	Yes	No	No	No	No	Yes*	Yes	Yes	No	No	No	No	No	No	Yes	No	Yes	Yes	Yes	13
Assisted Living/Residential Care Facilities	No	No	Yes	No	No	No	Yes*	No	No	No	No	Yes*	Yes	No	Yes*	Yes*	No	No	Yes	No	No	No	Yes*	No	Yes	No	No	No	No	No	No	Yes	No	No	No	No	10
Subacute Services	No	Yes	No	No	No	No	Yes	No	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	No	Yes*	No	Yes	No	Yes	No	Yes	Yes	Yes	Yes	No	Yes	No	Yes	13
Substance/Drug Abuse	Yes	No	No	No	Yes	No	Yes	Yes	Yes	No	No	Yes	No	Yes	Yes	Yes	No	Yes	Yes*	Yes	No	Yes*	Yes*	Yes*	Yes	No	Yes*	Yes*	Yes	Yes	Yes	Yes	No	No	Yes	Yes	24
Swing Beds	Yes	No	No	No	No	No	Yes*	No	Yes	No*	No	No	No	No	No	No	Yes	Yes	No	Yes	No	No	No	No	No	No	No	No	Yes	No	No	Yes	Yes	No	Yes	No	12
Ultra-Sound	No	No	No	No	No	No	No	No	Yes	No	No	No	No	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	Yes	No	No	Yes*	Yes	5
Counts by State	20	20	6	1	12	8	17	20	29	13	17	21	3	12	17	19	18	18	18	8	4	8	26	23	25	1	5	17	23	22	23	30	20	17	23	28	

* Represents a change since 2011.

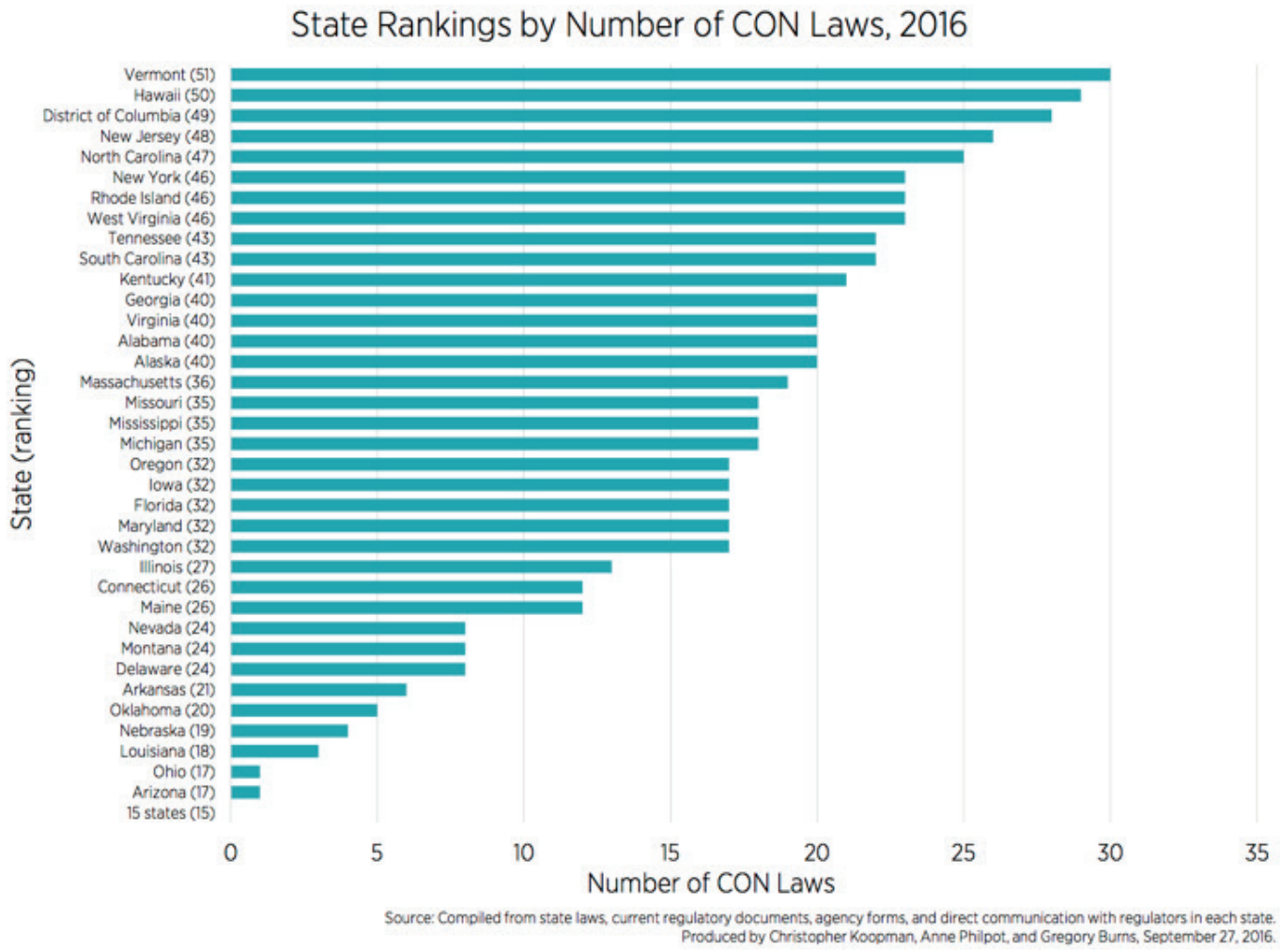
Source: Compiled from state laws, current regulatory documents, agency forms, and direct communication with regulators in each state.

Produced by Christopher Koopman, Anne Philpot, and Gregory Burns, September 27, 2016.

Changes in Number of CON Laws Since 2011

State	CON Laws in 2016	Net Change
Maine	12	-11
Connecticut	12	-5
Illinois	13	-1
Arkansas	6	0
Alabama	20	0
Delaware	8	0
Louisiana	3	0
Michigan	18	0
Mississippi	18	0
North Carolina	25	0
Ohio	1	0
Vermont	30	0
Washington	17	0
District of Columbia	28	0
Arizona	1	0
Maryland	17	1
Montana	8	1
Oklahoma	5	1
Virginia	20	1
Alaska	20	1
Hawaii	29	2
Nebraska	4	2
South Carolina	22	2
West Virginia	23	2
Georgia	20	3
Kentucky	21	3
Rhode Island	23	3
Tennessee	23	3
Missouri	18	4
Nevada	8	4
Massachusetts	19	5
New York	23	5
Florida	17	6
Iowa	17	7
Oregon	17	13
New Jersey	26	14

Source: Compiled from state laws, current regulatory documents, agency forms, and direct communication with regulators in each state.
Produced by Christopher Koopman, Anne Philpot, and Gregory Burns, September 27, 2016.



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RIGHT TO SHOP: THE NEXT BIG THING IN HEALTH CARE

By Josh Archambault and Nic Horton

(Editor's note: The idea outlined in this essay has caught the attention of the state of Virginia which did a study on this idea at the General Assembly's request. That report can be found here: https://rga.lis.virginia.gov/Published/2017/RD447/PDF. This policy can be initiated for state employees with a decision by the state to do so. However, legislation is likely required to bring both insurance companies and hospitals in line with this idea. Transparent pricing from hospitals and encouragement from insurance companies to reduce the cost of medical procedures will be required, and legislation may be needed to do so. Maine passed Right to Shop with unanimous bipartisan support, which is impressive given the Republicans control the Senate and the Democrats the House, and it became law in June of this year.)

Why should the exact same treatment for pneumonia cost $5,000 in one building and $124,000 in another? Or the exact same infusion drug for a chronically ill patient that requires them every six weeks cost $14,000 per shot in one setting, but $28,000 down the street? Why should patients have to pay so much more, simply based on where they park their cars? The answer is simple: they shouldn't.

But the black box of pricing leaves patients in the dark. As a result, the financial futures of too many American families are in jeopardy as their paychecksfail to keep up with skyrocketing health care costs.

The real shame is that Americans would shop for better prices if they could – a comparison shopping is part of the American way of life. In fact, according to a poll the Foundation for Government Accountability commissioned last year, 88% of voters say they regularly comparison shop for the best deal. Consumers shop for transportation, choosing between public transportation, conventional taxi services or new, innovative ridesharing through companies like Uber and Lyft. If they're looking for entertainment, Redbox, Netflix, Amazon Prime, and numerous other companies provide a multitude of choices at competitive prices.

But patients struggle to shop for health care, contributing to out-of-control costs across the board.

Unpacking the Health Care Crisis

In today's world, deductibles, co-pays, and premiums are rising. This means health care

costs are consuming more and more of the average family's budget. In fact, some experts project that, within 10 years, 30 percent of a family's budget will be consumed by health care costs. Within 20 years, it's expected to reach almost 50 percent.

And simply having insurance will not solve the problem because insurance is no longer a protection from medical debt. In fact, according to one national survey, **7 out of 10 people with medical debt have insurance.**

The number of consumers facing increased cost sharing has also spiked. Small business employees who faced $1,000 single-deductibles was just 16 percent in 2006. By 2014, the percentage spiked to 61 percent.

Amidst these changes, costs continue to grow, physician satisfaction is declining, and population health continues to decline.

This status quo hurts the most vulnerable, like the single mother struggling to pay for care for her kids or Americans with chronic health problems. And with no end in sight, health care costs are quickly becoming a national crisis that cannot be ignored.

In today's post-ACA world, how can policymakers reverse the tide?

Transparency Is Just One Piece Of Cost Puzzle

Price transparency initiatives have been all the rage over the last decade and for good reason. Transparency is a key component of any free market and it's visibly lacking in the health care system. And without it, providers within the same zip code, or even right across the street from each other, can charge significantly different prices for the exact some procedures – and they do.

A few examples of astronomical price variation taken from recent headlines include:

- Pneumonia treatment (without complications) ranging from $5,093 to $124,051;
- A knee MRI in New York City ranging from $440 to $4,500;
- Specialty drug infusions ranging from $3,500 to $22,000, within miles;
- An infusible drug ranges from $14,000 to $28,000 at two Maine hospitals in the same town.

States have tried to tackle this problem with robust transparency laws. But unfortunately, patients have struggled to engage. In fact, in Massachusetts – which arguably has the most sweeping transparency law in the country – since most providers have failed to even comply with the most basic requirements of the law, patients are unable to efficiently shop.

According to a survey by the Catalyst for Payment Reform, 98 percent of health plans around the country claim to have a cost calculator tools, but only 2 percent of patient members use them.
So what's missing? Incentives. And that's where Right To Shop comes in.

How Right To Shop Works

Right To Shop empowers patients with the knowledge they need to make smart choices about how and where they consume health care. They're given tools to find the best value providers and, when they choose those options, they get a share of the savings – in cash.

It's is so easy, even a caveman can use it. Here's how Right To Shop works:

Case Study: Right to Shop-Type Model In Practice

Just a few years ago, the state of New Hampshire commissioned Anthem Blue Cross and Blue Shield to setup a Right To Shop-style system that gave state employees shopping tools and incentives. Powered by Vital's SmartShopper, the outcomes of the program have been nothing short of impressive.

With three years of education and outreach under their belt, the program has produced over $12 million in savings with over $1 million paid out to patients as rewards.

Here are some of the top takeaways from a Right to Shop experience:

- ***Incentives drive shopping.*** Members are 11 times more likely to use a transparency program when incentive rewards are included.
- ***Incentives sustain shopping.*** Roughly 90% of program enrollees have shopped at least once, with two-thirds repeat shopping and earning incentives each year from 2011 – 2014. By contrast, most insurer transparency tools report 2% engagement.
- ***Incentives drive savings.*** The program averages approximately $650 in savings each time it is utilized.

- ***Incentives produce a return on investment.*** In 2015, New Hampshire's program achieved a 13:1 ROI (return on investment).

These results for state employees are even more remarkable given that this highly unionized workforce continues to have a very generous insurance, giving them little incentive to shop. If these employees faced sizable deductibles, their engagement would likely be even higher.

It's Not Just New Hampshire – Right To Shop Is Spreading

New Hampshire has blazed the trail, but thanks to their success, Right To Shop is now spreading across the map. Incentive-driven programs are springing up in Kansas, Kentucky, and Massachusetts. In addition, Right To Shop legislation has been filed in Florida, Maine, and South Carolina, with more to join them next year.

Private sector transparency vendors are also getting into the game. In addition to Vitals, companies such as Healthcare Bluebook and MyMedicalShopper already offer similar incentive-based programs.. Other transparency vendors such Castlight, HealthSparq, myEasyBook by UnitedHealthcare, and PokitDok can and should add incentives to take their transparency programs to the next level.

This momentum should come as no surprise. Right To Shop is a commonsense approach to addressing exploding health care costs. It's simple, flexible, and, best of all, it works. By extending these concepts to all insured consumers, Right To Shop will bring much-needed relief to patients.

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NOTE: To learn more about Right to Shop visit https://thefga.org/solution/health-care-reform/right-to-shop/

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"... a wise and frugal government, which shall restrain men from injuring one another, shall leave them otherwise free to regulate their own pursuits of industry and improvement, and shall not take from the mouth of labor the bread it has earned. This is the sum of good government, and this is necessary to close the circle of our felicities."

Thomas Jefferson, 1801

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