# Healthcare Market Reform Analysis

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**Objective:**

Improve access to and quality of health care, increase price transparency, reduce cost.

**Goals:**

1) Repeal Certificate of Need (CON) laws which restrict the building of new healthcare facilities without state permission.
2) Develop recommendations/requirements for transparent and publicly available pricing for common healthcare needs so that patients can make informed choices.
3) Use tax policies to nudge better choices by patients and providers.
4) Incentivize Medicaid recipients (and improve access to needed care) by providing some of their benefits in the form of a HealthCare Debit Account. Provide options for Direct Primary Care subscription services as well.

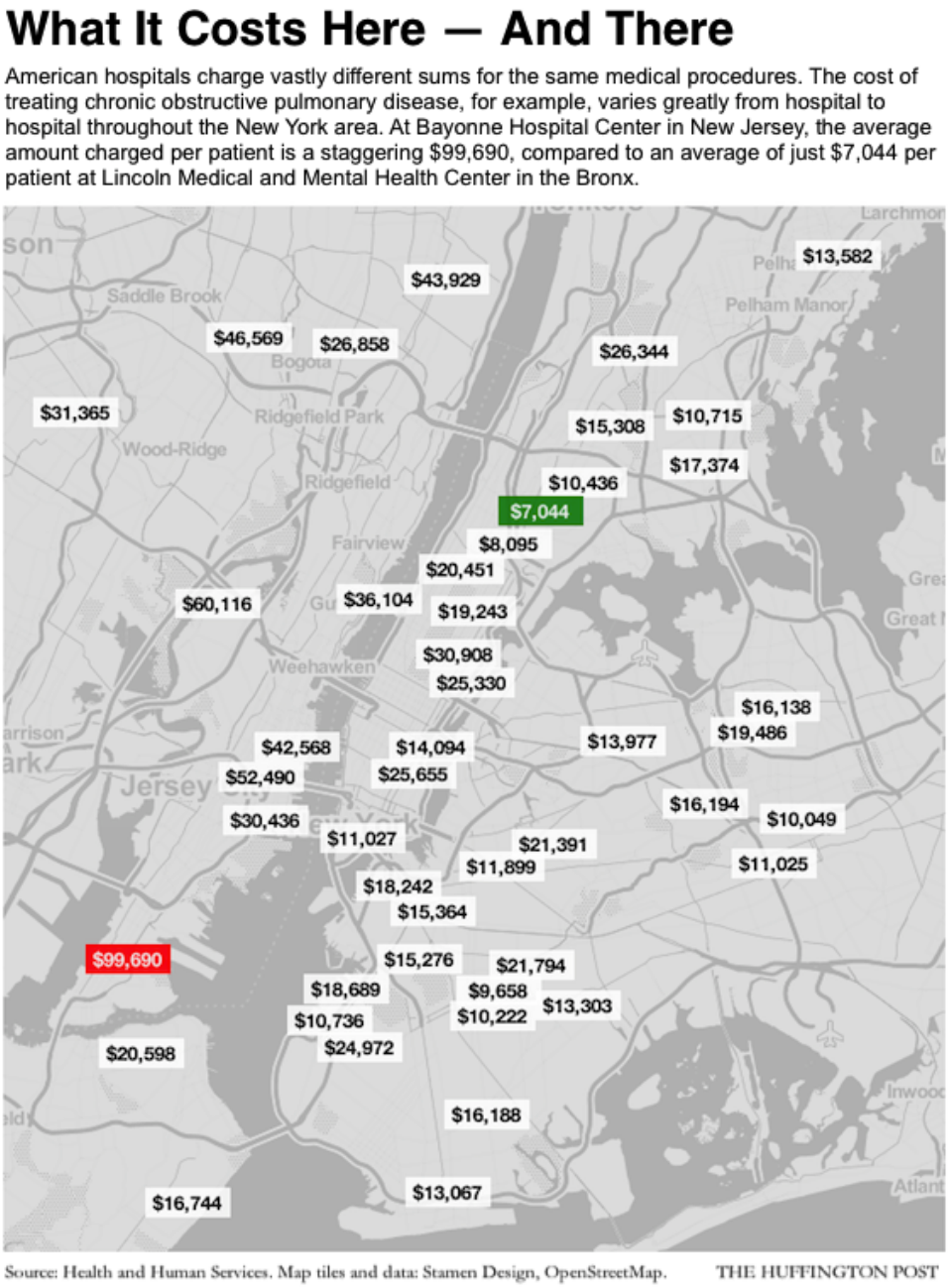
**Background:**

There is plenty of fault to go around in the issue of health care availability and cost: government meddling, collusion by hospitals and insurance company cartels, licensure restrictions/shortage, provider greed, patient problems, focus on access to insurance rather than getting health care.

1) Our current system of predominantly employer-owned health insurance was an accident of history. Before WWII, many Americans got health care through fraternal organizations hiring a lodge-practice physician (Beito, 1994), or in some industries, through company doctors hired by their employers. During the war, while wages were capped, health benefits were not, nor were they taxed. Offering health insurance then became a way to entice workers. (Rook, 2015) This system has resulted in separating patients from the true cost of their health care and administrative costs contributing to rising costs of care.

2) Part of the effect of third-party healthcare payment is that the prices are unknown to consumers. Even for non-urgent care, there's no shopping around. Therefore, market forces don't work, and even within a small area prices can vary wildly. As

seen in the illustration below, care for the same condition in the NYC area can vary by over $90K depending on the location.




https://www.huffingtonpost.com/2013/05/08/hospital-prices-cost-differences_n_3232678.html

3) Both provider organizations and government collude to keep the supply of providers and sites down, keeping prices high. Both the American Medical Association and state Boards of Medicine regulate the procedures by which doctors are licensed to practice in a state. Another part of this is the prevalence of state Certificate of Need laws, which require the approval of state planning agencies before building facilities or adding major equipment. These laws

originated in New York in 1964, and were federally mandated from 1974-1987. Currently, these laws are still on the books in 35 states, including NY (National Conference of State Legislatures, 2018). Legal challenges to CON laws are underway in Virginia (Schencker, 2016), North Carolina (Scott, 2018), and Iowa (Boehm, 2018).

4) In 1965, Lyndon Johnson created the Medicare and Medicaid systems to address the issue of healthcare for retirees and for those working in low-paying jobs for companies that did not offer healthcare benefits (Rook, 2015). Now, 1 in 3 New Yorkers are on Medicaid (Faso, 2017). According to Ballotpedia (2017), "In 2013, the most recent year per enrollee spending figures were available as of June 2017, spending per enrollee in New York amounted to $9,845. Total enrollment in 2017 amounted to 6.3 million individuals. Total federal and state Medicaid spending for New York during 2016 amounted to about $62.56 billion. The federal government paid 54.7 percent of these costs, while the state paid the remaining 45.3 percent. Medicaid accounted for 31.7 percent of New York's budget in 2015."

5) Even with Medicaid coverage, difficulties remain in access to care for lower-income people. A variety of factors, including finding a nearby physician who accepts Medicaid patients, lead to ER usage remaining high. Transportation to care may also be a problem. Access to needed dental care is often limited and not timely (Pager, 2018). In addition, slight income variations may lead to "churn", where eligibility for coverage comes and goes (Shippee & Vickery, 2018).

**Solution:**

Health care is obviously a complex problem that will not be solved overnight, and legal changes will be needed at the federal level to address the Affordable Care Act's limits. There are changes possible at the state level to improve it.

1) Repeal Certificate of Need requirements. History has shown that the market outperforms planning boards in using signals to balance supply and demand. There are few industries where this kind of protectionism reigns.

2) Require all medical providers to provide transparent, easy to understand pricing. Encourage the establishment of cash-only, posted-price practices like that pioneered by the Surgery Center of Oklahoma.

3) Use state policies to encourage the establishment of more Direct Primary Care clinics. In this model of care, patients pay a monthly subscription fee (similar to a gym membership) which covers extended provider visits and many lab services. In addition, look for ways to extend this model to the Medicaid population, either by direct payments, or by encouraging the "Robin-Hood Practice", which provides paid and charity concierge care in equal measures (Forester, 2008).

4) Medicaid needs a complete overhaul to reduce costs to healthcare providers and the state while delivering better healthcare to recipients. This will be done by turning Medicaid benefits into a HealthCare Savings Account (HCDA) with an

insurance backend. It will be a type of HSA (Health Savings Account.) Co-pays will be retained for most healthcare services before the HDCA funds are used. Co-pays will be raised, but below what ordinary insurance expects people to pay. Some form of price controls will remain under the new system, but they will be adjusted as needed. If the HDCA runs out, then the Medicaid insurance option will kick in. However, the reimbursement rates for providers will be reworked. Any funds not spent will roll over even if the recipients get off of Medicaid. Also, employers and the self-employed will be expected to pay into HDCAs. If recipients opt into making these contributions, then Medicaid will match funds until the maximum federal limit is reached. This will be a requirement for Medicaid premium assistance for individuals who are not on Medicare. Many existing healthcare programs like CHIP will receive similar reforms.

5) Studies should be conducted to determine ways to promote healthy lifestyles and reduce use of costly resources. For example, ER misuse might be mitigated by having an urgent care facility within walking distance. A Department of Health website can direct New Yorkers to the cheapest treatment options appropriate for their needs. The same site can provide cost comparisons. Providers can be encouraged to provide group visits where patients can be educated and discuss managing their chronic disease such as diabetes or hypertension. On-call care specialists could provide advice on whether an office visit is needed.

**Potential Results:**

Implementation of these ideas can both save money and improve access to care.

1) Price transparency. Burns (2014) cites a study indicating that price transparency may save more than $100 billion over 10 years. The Robert Wood Johnson Foundation (2016) sees transparency as an important cost-lowering tool, and states that 69% of people want prices to be disclosed, and 89% of people who have comparison shopped for healthcare will do so again.

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3) Providing part of Medicaid allowances as cash in a HCDA will allow for streamlined and easy processes to use and accept Medicaid that will yield cost savings for both the state and healthcare providers. It will open up options for recipients, including the creation and participation in low-cost cash-only practices and clinics, Direct Primary Care and telehealth. Recipients would even have access to doctors who otherwise don't accept Medicaid. The fact that 1/3 of New York residents are on Medicaid means even small savings per recipient would have a large impact. A survey in California found that cash prices for procedures could be as much as 1/17$^{th}$ the stated price for the insurance covered procedure, and 1/10$^{th}$ the cost of the negotiated insurance rate (Terhune, 2012). Providing a

similar HDCA plus high-deductible option for state employees would offer additional savings. Payments using cash and HDCA would require barely any more administrative overhead than cash only. Recipients would be able to get care more often and stay on top of their health, leading to shorter visits. Doctors would receive the money right away, instead of having to wait for reimbursement. Recipients would no longer have to travel nearly as far to get treatment. It would even help reduce the problem of poverty traps since the money rolls over to the next year, even after they get off of Medicaid.

4) The repeal of Certificate of Need laws would allow for providers who want to offer lower cost service, and also exert downward market pressure on existing providers. There are studies showing that health care costs are from 11-14% higher in states which have CON laws. (Stark, 2016) Additional providers would also provide more options for consumers.

5) Encouraging the establishment of more cash practices could save in the administrative costs for billing and collecting. Estimates are that for each 10 physicians, nearly 7 employees are required for insurance billing (Frakt, 2018). Some models show that simplified billing in the US could save nearly 15% of spending (Jiwani, Himmelstein, Woolhandler, & Kahn, 2014).

**Summary:**

Many critics think that consumer-driven reforms can't work in healthcare and suggest an increasing amount of regulations and central planning. However, many initiatives show that empowering consumers to take charge of their own care and empowering doctors to practice without undue interference can improve both cost and quality.

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