CHOICES FOR ALL PROJECT

Expand the Available Supply of Healthcare

Healthcare Reforms for the Future

Lanhee J. Chen, PhD, Tom Church, and Daniel L. Heil

Cumbersome federal and state regulations burden the supply of both medical care and health insurance. These regulations are intended to protect patients and restrain costs, but they often do the opposite. Government regulations have restricted the supply of medical care, depriving Americans of choice. These restrictions lead to longer wait times, reduced availability of services, and increased costs. Likewise, federal and state insurance regulations prevent innovative new insurance models that can lower costs and expand access.

Supply-side solutions should be aimed at increasing healthcare choices. That will require reducing federal and state regulatory burdens. To that end, the Choices for All Project proposes key incremental improvements that remove these barriers.

KEY PLAN ELEMENTS

HEALTHCARE PROVIDERS

- Standardize and expand on COVID-era telemedicine reforms.
- Expand scope of practice for nurse practitioners (NPs).
- Expand the recognition of medical licenses across states.
- Increase reciprocity of medical licenses for foreign-trained physicians to address the shortage of primary-care physicians.

- Repeal certificate-of-need laws to increase the supply of hospitals and specialized outpatient facilities.

- Reverse Affordable Care Act restrictions that prevent new physician-owned healthcare facilities.

HEALTH INSURANCE OPTIONS

- Allow payments to providers of direct primary care to count as qualified medical expenses.

- Expand access to association health plans.

- Allow "copper" plans to be sold on state exchanges.

THE PROBLEM: RULES AND REGULATIONS ARTIFICIALLY RESTRICT THE AVAILABLE SUPPLY OF MEDICAL CARE

Government rules and regulations affect the cost of healthcare by influencing the prices that providers can charge, the payments they receive, and the overall cost of delivering care. They also artificially restrict the supply of healthcare and health insurance options available to consumers.

Regulations that are overly burdensome or complex make it difficult for providers to deliver high-quality care and may even lead to unintended consequences such as reduced access to care. For example, regulations that limit the number of medical residency slots or restrict the scope of practice for certain healthcare providers limit available care, particularly in underserved communities. Restrictions on who can build and own hospitals, likewise, mean some areas are underserved. Similarly, regulations that restrict the types of insurance plans that can be offered limit access to affordable coverage for some patients.

Blame does not fall to the federal government alone. States have long held jurisdiction over public health and insurance markets more generally. The McCarran-Ferguson Act of 1945 gave states the authority to regulate insurance markets and exempted companies from certain antitrust provisions, allowing behavior that would have typically violated federal laws. As a result, offering insurance across state lines is next to impossible. It has led to a patchwork of insurance regulations, stifling competition, and increasing prices. The Competitive Health Insurance Reform Act, bipartisan legislation signed in 2019, walked back some of the McCarran-Ferguson antitrust protections for health and dental insurers.[1] The full impacts remain to be seen.

Today, we are told what types of health plans we can buy, what health services must be covered, which providers we may see, and which facilities we can access. The regulations may have originally been intended to protect patients, but many have devolved into mere barriers to entry or to a more competitive healthcare landscape. They now serve an anticompetitive purpose: protecting existing players in the healthcare economy, rather than improving patients' health.

THE IMPORTANCE OF EXPANDING SUPPLY

Rather than this one-size-fits-all approach, we need a regulatory system that embraces consensus without uniformity. Artificial restrictions on the provision of healthcare can lead to predictable outcomes: higher costs, less access, lower quality, and fewer choices. Progress toward our goals of lower costs, improved access, and better-quality medical care will come from removing restrictions so that patients have more choices in how they receive care.

Many of the solutions presented here are not novel, but they represent key incremental improvements that add to available choices rather than restrict them. Several other scholars and analysts have written extensively on many of them, and we encourage readers to examine the work that has been completed before us.

To be clear: these supply-side solutions aren't painless. Each reform will face opposition from incumbent players that benefit from the status quo.

We divide these reforms into two categories: reforms to regulations affecting the supply of healthcare providers and reforms affecting the types of health coverage available to Americans. In both cases, we identify reforms that could be championed by policymakers at the federal or state levels.

THE FUTURE: MORE HEALTHCARE PROVIDERS AND FACILITIES

There are only two effective ways to keep healthcare costs down while expanding access to care: reduce the demand for or increase the supply of healthcare services. In other essays in this series, we focus on the demand-side reforms that would improve patients' incentives to consider the cost of their healthcare consumption.

Fixing our healthcare system will also require increasing the supply of medical care. That means more physicians, nurses, and health facilities. But expanding the supply means more than just increasing the number of providers. Our economy is filled with examples of industries that have met a growing demand with fewer workers each year. From agriculture to automobiles, we have benefited from remarkable gains in worker productivity. Healthcare shouldn't be any different. Too often, however, regulations prevent the efficient use of our medical system and stifle innovations that can deliver better, more affordable care. The

reforms we highlight in this section are thus aimed at increasing the number and efficiency of medical providers.

PERMANENTLY EXPAND TELEMEDICINE AUTHORITY

The COVID-19 pandemic kick-started a wave in telemedicine across the United States. Waivers for existing rules surrounding telemedicine—including across state lines—were granted, and patients were able to access efficient and effective care.[2] Making these changes permanent should be a key goal for federal and state policymakers.

While states have broad jurisdiction over the regulation of health insurance within their borders, the federal government controls reimbursement rates and pricing decisions for a large part of medical care through Medicare. Moreover, Medicare policies set important benchmarks for state Medicaid programs and private plans. Consequently, changes in Medicare can reverberate throughout our healthcare system.

This was evident during the pandemic. The Centers for Medicare and Medicaid Services waived several regulations regarding telehealth services.[3] This included a March 2020 waiver that permitted states to allow out-of-state doctors to provide telehealth services to Medicare recipients. States quickly followed with similar waivers. During the pandemic, all fifty states and Washington, DC, enacted waivers allowing telehealth services across state lines.[4] Many of these waivers, however, were temporary; by December 2022, the waivers had expired in thirty-nine states and in Washington, DC.[5]

A handful of states, however, have permanently changed their rules allowing out-of-state providers to provide telehealth services. Meanwhile, the federal government has extended many of its telehealth waivers. The Consolidated Appropriations Act in 2023 included a two-year extension of COVID-related waivers for Medicare telehealth services, including the elimination of the geographic restriction on where telehealth services originate.[6] It also allowed federally qualified health centers and rural hospitals to provide telehealth services.[7] Flexible pay arrangements can be a boon for rural health clinics that struggle to remain open and that routinely receive higher federal payments.

The federal and state waivers should be made permanent to allow healthcare providers to provide services—at lower costs—to the patients who need them. States can do this by creating streamlined registration processes for out-of-state practitioners. For example, Florida in 2019 authorized providers not licensed in the state to "provide healthcare services to a patient located in this state using telehealth if the healthcare professional registers with the applicable board, or the department if there is no board, and provides healthcare services within the applicable scope of practice established by Florida law or rule."[8] Arizona enacted similar legislation in 2021.[9]

As we discuss below, states could also join the Interstate Medical Licensure Compact or the Nurse Licensure Compact if not party to either of them. These actions make it easier for out-of-state practitioners to provide services to a state's residents. That would remove

barriers for telemedicine to originate from other states to expand access to their own residents. Alternatively, Svorny (2020) suggests that Congress could establish the physician's state as "the site of care of a physician-patient interaction" in telehealth settings.

Removing unnecessary regulations in telehealth is a key step in extending access to cost-saving health treatments. But policymakers should exercise caution before implementing heavy-handed rules that may undermine the cost-saving features of telehealth. Specifically, some states have implemented pay parity requirements that require private insurers to pay the same rate for care provided in person versus via telemedicine. The idea behind the requirements is that healthcare providers will be less likely to offer telemedicine services if they are paid less. By enacting pay parity rules, lawmakers hope to encourage greater investment in telehealth services.

That line of thinking, however, restricts the choices available to consumers and raises their prices. Pay parity requirements should be avoided, as telemedicine that can offer the same quality care at lower costs should pass along savings to patients. If policymakers believe such requirements are necessary, they should insist on including legislative sunsets of pay parity requirements to ensure that the long-term cost savings from telehealth are realized.[10]

Increasing the supply of medical care means more than just adding more providers. It means ensuring that providers' time is used efficiently, and that geography is not a factor that prevents a patient from accessing a provider. Telemedicine accomplishes both goals. If patients receive the care they need from qualified medical professionals, they should not be prevented or disincentivized from using telemedicine options that work for them.

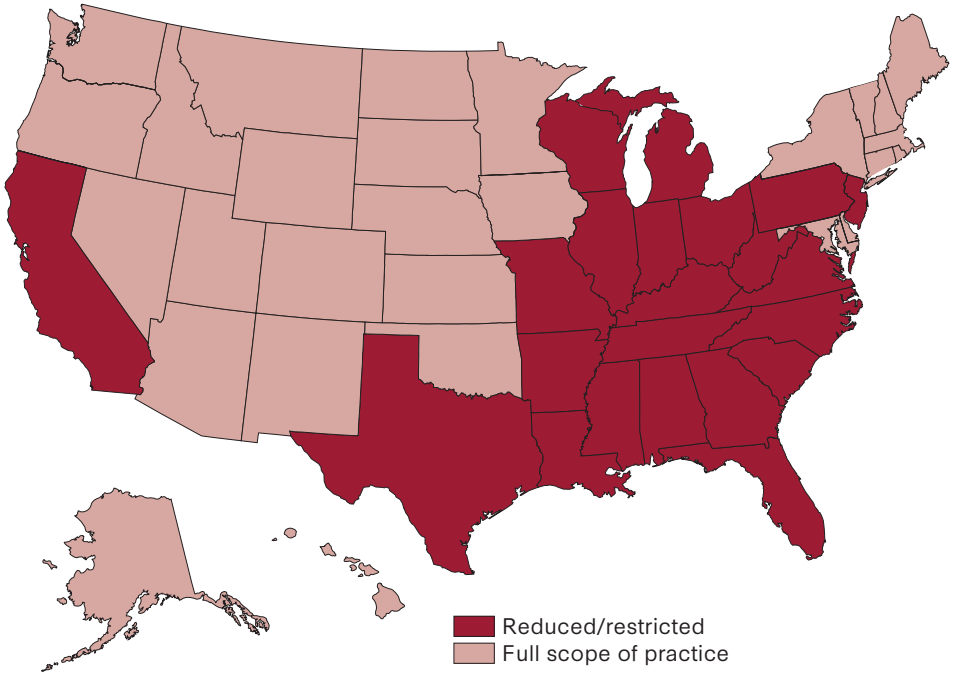
ELIMINATE SCOPE-OF-PRACTICE RULES

Currently, twenty-three states still restrict or reduce the "scope of practice" allowed to be performed by nurse practitioners (NPs), advanced registered nurse practitioners (ARNPs), and physician assistants (PAs).[11] Given the shortage of primary-care providers in the United States, restricting the allowable level of care that NPs, ARNPs, or PAs are allowed to provide to a level lower than that of their training is unwise. These scope-of-practice rules limit the available supply of healthcare workers and lead to longer wait times for nonemergency services.[12]

During the COVID-19 pandemic, many states with restrictions acknowledged the shortcomings of these rules.[13] They were quick to relax scope-of-practice rules to ensure an adequate supply of providers during the emergency. The guidance by then secretary of the Department of Health and Human Services (HHS) Alex Azar to states regarding state licensure and scope of practice is a model to follow. HHS recommended that states relax requirements to encourage retired or discouraged healthcare providers to reenter the workforce and recommended that state licensing fees be waived.[14]

Some defenders of scope-of-practice rules point to concerns over safety and the quality of care provided to the patient. But multiple studies conclude that there is no association between restrictions on scope of practice and an increase in the quality of primary care

FIGURE 1 States with reduced or restricted scope of practice



Note: Scope-of-practice rules are available at https://www.aanp.org/advocacy/state/state-practice-environment.

provided. Perloff et al. (2019) examine the quality of primary care provided to Medicare beneficiaries across states with varying levels of scope-of-practice rules. They find no consistent relationship between the quality of care and states with scope-of-practice rules, concluding that "state regulations restricting NP [scope of practice] do not improve the quality of care."[15]

Of course, there may be unobserved differences in the quality of care between providers with different credentials. Scope-of-practice rules, however, don't guarantee patients access to those with the highest credentials; instead, the rules often mean patients aren't able to see a provider when they need one. Studies have found that states with full-practice authority for NPs have a larger supply of NPs, and patients therefore benefit with shorter wait times, more access to primary care, and a fewer number of emergency room visits. In a summary of the research, Spetz (2019) concludes, "Numerous studies have found that state regulations requiring physician oversight of NPs and other restrictions on NP practice are associated with decreased access to care for patients, particularly in rural regions and for Medicaid enrollees."[16]

Removing scope-of-practice limits could produce large cost savings. NPs and ARNPs provide care at below the average cost associated with physicians and other primary-care providers. Spetz et al. (2013) estimate $1.3 billion in annual cost savings if states eliminated all restrictions preventing NPs from practicing and prescribing independently in retail clinic settings. Chattopadhyay and Zangaro (2019), meanwhile, find that removing scope-of-practice limits could save Medicare $44.5 billion annually.

The nation has been running an experiment for years regarding limits on the scope of practice of NPs, ARNPs, and PAs. Roughly half of states allow full-practice authority, and half do not—and there is no clear difference in health outcomes. The only meaningful difference is in the artificial restriction of supply and the price, quality, and access problems that come with it. States should thus consider permanently ending these unnecessary restrictions.

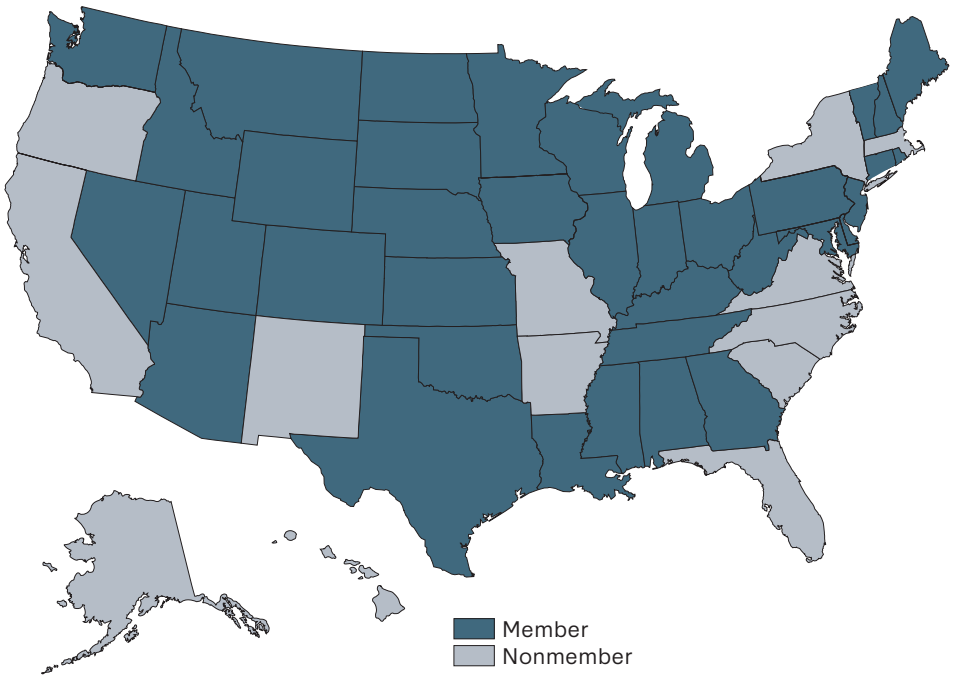
EXPAND RECOGNITION OF MEDICAL LICENSING ACROSS STATES

Medical licenses are issued by individual states, and there is currently no universal recognition of licenses across state lines. This can be a barrier to healthcare professionals who want to practice in multiple states, particularly for those living near state borders or providing telemedicine services to patients in other states.

The recognition of medical licenses across state lines promotes competition and expands the pool of available healthcare professionals, particularly in underserved areas. It also reduces administrative burdens and costs for healthcare professionals who practice in multiple states, allowing them to focus more on patient care.

Some progress has occurred through the Interstate Medical Licensure Compact. Under the compact, physicians can apply for a license in one state and have it recognized in other participating states if they meet certain eligibility requirements and pay a fee. Currently, thirty-seven states have joined the compact, with several additional states considering legislation that would allow them to join.[17] The Nurse Licensure Compact provides a similar interstate recognition

FIGURE 2 States that have joined the Interstate Medical Licensure Compact



Note: The current status of Compact states is from https://www.imlcc.org/participating-states/.

for nurses; thirty-nine states have joined the compact.[18] States that have yet to enter both of these compacts—large ones like California, Florida, and New York, particularly—should consider joining.

Beyond the compacts, Congress should look for opportunities to reduce the harmful effects of unnecessarily strict state licensing rules. The Center for American Progress has voiced support for national licensing.[19] There are legitimate concerns regarding whether such changes would undermine the principles of federalism. Nevertheless, Congress has a role in ensuring licensing rules do not undermine interstate commerce. Beyond national licensing, there are piecemeal reforms Congress should consider. For example, as we discuss in the telehealth section above, Congress could designate the "site of care" for telehealth visits as the physician's state rather than the patient's state.

REDUCE BARRIERS FOR FOREIGN-TRAINED MEDICAL LICENSE HOLDERS

America is not training and producing enough physicians. The Association of American Medical Colleges projects a shortage of up to 124,000 physicians by 2034.[20] As we discuss above, part of this gap could be filled by ending scope-of-practice rules on NPs and other practitioners.[21] The gap can be further narrowed by relying on foreign-trained doctors and other practitioners. Unfortunately, it is difficult and costly for foreign-trained physicians or nurse practitioners to move to the United States and help fill this gap.

Currently, international medical graduates account for nearly one-quarter of practicing US physicians.[22] Graduates of medical schools outside of the United States or Canada are required to undergo a complicated licensing process overseen by the Educational Commission for Foreign Medical Graduates (ECFMG). The ECFMG requires these foreign-trained physicians to undergo at least one year of graduate medical education in the United States or Canada. This training is required regardless of the applicants' existing postgraduate education or experience.

While additional training may be necessary for some international graduates, the rules represent an unnecessary restriction for those educated in developed nations with medical education systems like the United States and Canada. For this reason, Canada exempts those with specific postgraduate schooling or specialty certifications from certain jurisdictions.[23]

Expanding the supply of foreign-trained practitioners would be especially effective in areas with large immigrant populations, where foreign medical professionals would be able to more effectively cross linguistic or cultural barriers that might exist in the current treatment of patients. Unfortunately, this policy idea has become part of the highly polarized and broader discussion over immigration reform in the United States; thus, little progress has been made.

Lawmakers should embrace the reciprocity of medical licenses, in conjunction with other requirements, to encourage foreign medical professionals in good standing to practice in the United States. The recognition of foreign medical licenses could be combined with a push to increase placements in rural or underserved areas. For example, Flier and Rhoads (2020)

highlight efforts by the Minnesota Department of Health to increase pathways for foreign graduates to practice in the state. Minnesota's International Medical Graduates Assistance Program, enacted in 2015, was intended "to increase access to primary care in rural and underserved areas of the state." Among other policies, the program relaxes residency program recency requirements for international medical graduates.[24]

ELIMINATE CERTIFICATE-OF-NEED LAWS

Certificate-of-need (CON) laws are state-level regulations requiring healthcare providers to obtain approval from a governing body before expanding, building new facilities, or offering certain services, based on demonstrated community need and financial viability. They gained popularity as a cost-saving measure when Medicare began and medical spending was rising rapidly. Congress soon passed the National Health Planning and Resources Development Act in 1974, which tied federal funding to states passing their own CON laws. Within years, nearly all states had adopted these rules.[25] Their aim was to restrict new spending by verifying there was a "need" for new medical facilities.

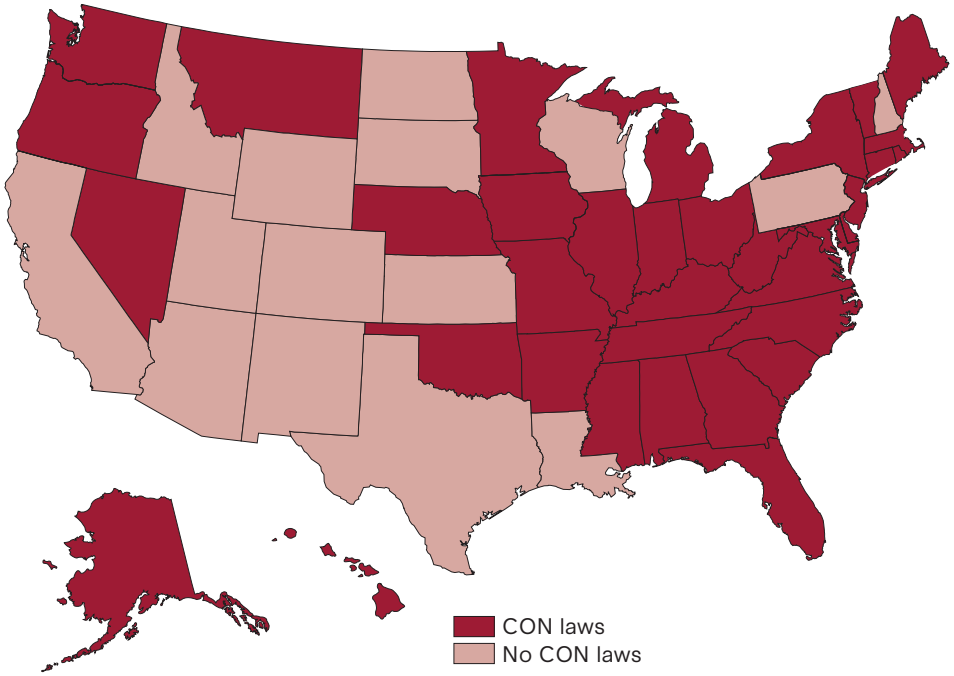
Over time, however, CON laws have been used primarily by existing medical providers to prevent new competition. By 1987, Congress repealed the federal mandates for CON laws.[26] Despite the decades-old repeal, as of May 2020, thirty-five states and the District of Columbia still had some form of rules that stifle the supply of medical facilities and specialized care that could otherwise be offered to patients.[27] In a review of the literature, Mitchell (2016) finds that projected cost savings from CON laws never materialize; instead, "the overwhelming weight of evidence suggests that CON laws are associated with both higher per unit costs and higher total expenditures." A separate review of the literature found that in 2008, the supposed benefits of CON laws were 8 percent lower than their estimated costs.[28]

An issue closely related to CON laws is the increased use of certificate-of-public-advantage (COPA) laws by states.[29] These laws shield hospital mergers from certain federal antitrust rules. Under COPA laws, states allow hospitals to merge but in exchange exercise increased regulatory oversight of their postmerger prices and policies. In evaluating COPA laws, the Federal Trade Commission (2022) has found that commercial inpatient prices rise after the introduction of COPA laws.

Competition is the only force that reliably leads to lower prices and better quality. Removing CON laws and avoiding the creation of new COPA laws would thus lead to lower costs through increased competition. The result would expand the quantity of healthcare facilities, including ambulatory surgery centers, imaging centers, dialysis centers, hospice facilities, and substance abuse centers. This idea is not new. The Federal Trade Commission (FTC) has long advocated for eliminating CON laws to improve competition. Former FTC commissioner Maureen Ohlhausen (2015) notes that "the FTC has tirelessly advocated for the repeal of these laws for many years, with strong support from Commissioners of both parties."

States should lift existing CON restrictions, a move that would drive healthcare costs down by removing the barriers to entry for new facilities. There are examples that can be followed.

FIGURE 3 States with certificate-of-need (CON) laws



Note: CON laws by state are available at https://nashp.org/50-state-scan-of-state-certificate-of-need-programs/.

Since the 1980s, fifteen states have fully repealed their CON laws. Even partial repeals can reduce the burden of CON laws. In 2019, Florida repealed the rules for general or long-term acute-care hospitals and for "tertiary services," including neonatal intensive care units, organ transplantation, and comprehensive rehabilitation.[30]

REMOVE LIMITS ON PHYSICIAN-OWNED HOSPITALS

Physician-owned hospitals (POHs) are healthcare facilities such as hospitals, clinics, and surgery centers that are owned, in part or whole, by physicians. In the United States, physician-owned medical facilities have been a source of controversy due to concerns that they may lead to self-dealing that would result in higher healthcare costs and unnecessary procedures.

In 2010, the Affordable Care Act (ACA) included provisions (Section 6001) that placed restrictions on physician-owned hospitals. This included a prohibition on the expansion of existing POHs and a requirement that new POHs meet certain criteria to be eligible for Medicare payments. These restrictions were intended to reduce the potential for conflicts of interest and to encourage the use of more cost-effective treatments. Instead, the result has been to limit competition by freezing the size of existing POHs and preventing the creation of new medical facilities. Miller et al. (2021) note that in light of the restrictions, forty-five hospital expansion projects were canceled, while an additional seventy-five planned new hospital projects were "terminated."

Opposition to new or existing POHs comes from non-physician-owned hospitals or existing trade associations representing those hospitals. But the bans constitute an anticompetitive regulation that limits the supply of new medical facilities. The arguments against POHs are that they will be more likely to employ cost-intensive treatments that drive up healthcare spending and potentially create conflicts of interest for referring physicians. Nevertheless, these worries should be balanced against the benefits from increased competition among medical providers, which would result from a larger supply of medical facilities available to patients.

One comprehensive literature review finds that physician-owned hospitals "generally provide higher-quality care at a lower or comparable cost than do non-POHs."[31] The authors find quality benefits within surgical specialty care facilities but no definitive evidence of differences in cost of care. They also note that POHs could be used to lower costs, improve quality of specialty care, expand access at community hospitals, and increase competition in hospital markets. The authors conclude that "in the absence of evidence that POHs provide services of lower quality or higher cost, Medicare's ban on new POH participation and expansion of preexisting POHs lacks justification."

New POHs can be built with waivers from the US secretary of the Department of Health and Human Services, but it is a political hurdle that is difficult to clear. Policymakers should instead reevaluate Section 6001's ban on physician-owned hospitals to increase choice and produce competition among healthcare providers, particularly in rural and other areas where healthcare facilities are limited. For example, the Patient Access to Higher Quality Health Care Act of 2023 would repeal Section 6001 of the ACA and related provisions that currently prevent physician self-referral in the Medicare program.[32]

THE FUTURE: PERSONALIZING HEALTH COVERAGE

Few sectors of our economy are as heavily regulated as healthcare is. Policymakers have enacted countless rules affecting what insurers may charge and the services they must provide. But insurance is complex, which makes rulemaking difficult. To simplify the process, lawmakers have often resorted to reducing plan options. They argue that simplification is good for consumers, who would otherwise be paralyzed with too many choices. But this one-size-fits-all or, more charitably, "few-sizes-fits-all" regulatory regime has left significant gaps in our system that deprive Americans of insurance coverage that works for them. Here, we propose reforms that would fill these gaps.

ENCOURAGE DIRECT PRIMARY CARE

Direct primary care (DPC) is a new and growing method of providing primary care to patients at a potentially much lower cost, with increased access and higher levels of satisfaction for both patients and physicians. Akin to "affordable concierge care," DPC patients pay a monthly fee (averaging around $80 a month) for expanded access to their personal physician. The monthly fee covers routine screenings, preventive care, chronic care services, and

care coordination. Prescription drugs are often included at cost, and DPC doctors regularly arrange discounted access to lab tests and imaging services.[33] More than two thousand practices currently exist, serving hundreds of thousands of Americans.[34] DPC is not insurance. There are typically no third-party payments allowed for services. Most patients are advised to pair a DPC arrangement with catastrophic or low-premium, high-deductible insurance to cover services and treatments not provided by one's primary-care physician.

Despite their popularity, DPC arrangements face significant barriers to expansion. One barrier is federal regulation. The IRS does not treat DPC membership fees as a qualified health expense. In fact, the IRS currently concludes that individuals or families that qualify for a health savings account (HSA) but participate in a DPC arrangement are ineligible to contribute to their HSA. In its proposed rule from June 2020, the IRS states that standard DPC arrangements "would constitute a health plan or insurance that provides coverage before the minimum annual deductible is met, and provides coverage that is not disregarded coverage or preventive care."[35] Notably, it did make room for employers to use health reimbursement arrangements (HRAs) to pay for employees' DPC membership payments.

Several attempts have been made to allow membership fees to be counted as qualified health expenses, including in the bipartisan Primary Care Enhancement Act of 2021.[36] Notably, the act only applied to HSA holders, ostensibly to codify that a DPC membership does not count as having a non-high-deductible health plan and therefore making purchasers ineligible for health savings accounts.

The regulatory obstacles facing DPCs serve as another example of how the cumbersome rules governing HSA and other existing health subsidy programs deprive many Americans of innovative healthcare solutions. In our essay in this series on individual health accounts (IHAs), we offer an alternative savings vehicle that would better fit the health needs of many Americans. IHAs would give more Americans an opportunity to save for their healthcare future while ensuring they can participate in DPCs and other healthcare delivery services that don't fit into the one-size-fits-all system we have today.

But even without enacting IHAs, policymakers can still improve access to DPCs. Expanding the recognition of DPC membership fees as qualified medical expenses for all taxpayers would help to increase the number of DPC practices available nationwide and help shift predictable and routine care to a more cost-efficient setting. Improving access to DPCs isn't just for those with employer coverage; in our essay on Medicaid and ACA reforms, we highlight how expanding access to DPC can be particularly useful for low-income Americans who currently face long waits and poor outcomes in their state Medicaid programs.

Congressman Dan Crenshaw's Direct Primary Care for America Act serves as a model of legislation to expand DPC access.[37] It proposes expressly allowing HSAs to be used to pay for DPC memberships, allows state waivers to provide Medicaid using DPC arrangements, and permits healthcare facilities to participate in various federal assistance programs if they offer direct primary care arrangements in officially designated areas with health professional shortages.

EXPAND ACCESS TO ASSOCIATION HEALTH PLANS

Association health plans (AHPs) are group health insurance arrangements allowing businesses, especially small and midsize enterprises, and self-employed individuals, to band together and purchase health coverage collectively. By pooling resources and spreading risk, AHPs aim to provide more affordable and accessible insurance options for enrollees. They also allow small businesses the ability to negotiate like a larger employer with insurers on cost and obtain medical claims data, too, if the AHP is self-funded.

However, AHPs are limited by numerous rules and regulations. The Employee Retirement Income Security Act of 1974 (ERISA) strictly limits the definition of an employer or association, making it difficult for multiple businesses to form AHPs. State insurance regulations prevent AHPs from forming across state lines or offering consistent coverage for mobile employees. In California, the Health and Human Services Agency imposed a 2019 rule preventing the sale of group coverage to individual subscribers directly or "indirectly through any arrangement," cutting off any new AHP associations.[38] Federally, the ACA's requirement of minimum essential health benefits limits possible AHP plan designs and raises costs.

In response, the US Department of Labor, under President Donald Trump, proposed a rule to expand the use of AHPs by small businesses and self-employed individuals.[39] That rule was finalized in June 2018 but was invalidated the following year by a federal district court, which argued it failed to set meaningful limits on AHPs. The court took issue with the provision that allowed AHPs to be formed based on geography but no other ties, and it ruled that self-employed individuals without employees were not supposed to be considered as employers under ERISA.[40]

Senator John Kennedy (R-LA) proposed the Association Health Plans Act of 2021 to remedy some of the objections of the district court. His bill would have permitted "groups or associations to sponsor fully insured group health plans as if they were employers."[41]

Expressly permitting association health plans to be formed by self-employed individuals or small businesses in similar industries would lower participants' costs while giving them more options for insurance coverage. Congress should go further by exercising its right to regulate interstate commerce and expressly allowing AHPs to form across state lines. In conjunction with expanded deductibility of out-of-pocket medical spending or individual health accounts (see our essays in this series on reforming the tax code for more details), more families and individuals would be able to get coverage that better matches their needs.

EXPAND ACCESS TO CATASTROPHIC ("COPPER") PLANS

Catastrophic insurance plans are rare in America, yet they make sense for many young and healthy Americans. As discussed in our essay in this series on Medicaid and the ACA, these plans are often labeled "copper" plans because insurance companies cover only 50 percent of expected health costs (as compared to 70 percent for "silver" plans). The ACA clamped down on the ability of consumers to choose catastrophic coverage. To be eligible, individuals need to be under age thirty or qualify for an exemption based on hardship or affordability. On top of that, tax credits for premiums are generally not eligible for the purchase of copper plans.

The result is that existing ACA marketplace plans are a bad deal for many healthy individuals, whose expected healthcare costs are far below the premiums they must pay. Many of these individuals opt to forego coverage—a prospect made easier since the ACA individual mandate penalties were eliminated in 2019. Expanding access to copper plans for more individuals would fill an important need. And as we discuss in our Medicaid and ACA essay, subsidized ACA enrollees who choose copper plans could have any excess subsidy directed to their individual health accounts, giving them more control over their healthcare needs.

CONCLUSION

Fixing the way we regulate healthcare will expand the number of providers, fill gaps in coverage, and allow for more healthcare innovations. Most policies are initially passed or created with good intentions but fall short in the real world. Too often, these rules have been abused to protect concentrated interests in the healthcare industry that benefit from these barriers to entry, while offering little protections or few choices to patients.

It is long past time that we consider the supply-side reforms articulated here to lower costs and improve access to care for more Americans. There are many other reforms that also merit consideration. While each reform requires deliberation, policymakers should focus on those that expand consumer choice. Conversely, they should be skeptical of reforms that undermine competition.

NOTES

1. P.L. 116-327. The text is available at https://www.congress.gov/bill/116th-congress/house-bill/1418.
2. Gajarawala and Pelkowski (2021).
3. See CMS (2020) for an overview of these waivers.
4. Andino et al. (2022).
5. See Alliance for Connected Care (2022) for an overview of the waivers as of December 16, 2022.
6. P.L. 117-328.
7. See HHS (2023) for an overview of current federal rules governing telehealth.
8. See Section 456.47, Florida Statutes. Available at http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0400-0499/0456/Sections/0456.47.html.
9. Arizona House Bill 2454. Available at https://legiscan.com/AZ/text/HB2454/id/2391998/Arizona-2021-HB2454-Chaptered.html.
10. For a discussion on telehealth pay parity requirements and alternative reforms, see Dills (2021).
11. For a complete list, see American Association of Nurse Practitioners, "State Practice Environment," https://www.aanp.org/advocacy/state/state-practice-environment.
12. In a 2013 study, for example, Auerbach et al. find that potential shortages of primary-care physicians can be offset with additional NPs and PAs, but this would require "liberalization of scope-of-practice laws to allow nurse practitioners and physician assistants to perform expanding roles."

13. For an overview of these policies, see Poghosyan et al. (2022).

14. HHS (2020).

15. Similarly, Oliver et al. (2014) find improved health outcomes and lower hospitalization rates among Medicaid and Medicare recipients in states with full practice of NPs. Likewise, in a review of the literature, Newhouse et al. (2011) find "a high level of evidence that APRNs provide safe, effective, quality care to a number of specific populations in a variety of settings."

16. See table 2 in Spetz (2019) for a summary of the literature.

17. For a list of states in the compact and a summary of pending legislations, see https://www.imlcc.org/participating-states/.

18. The list of states is available at https://nursecompact.com/index.page#map.

19. Kocher (2014).

20. Association of American Medical Colleges (2021).

21. Auerbach et al. (2013).

22. Flier and Rhoads (2020).

23. For a list of the approved jurisdictions and specialties training, see https://www.royalcollege.ca/ca/en/credentials-exams/assessment-international-medical-graduates.html#jur.

24. For an overview of the program, see https://www.health.state.mn.us/facilities/ruralhealth/img/index.html.

25. Ohlhausen (2015) offers a summary of the history of CON laws.

26. P.L. 99-660, section 701.

27. For a summary of state laws, see Rakotoniaina and Butler (2020).

28. Conover and Bailey (2020).

29. COPA laws have been used for decades, but states increased their use after the 2013 Supreme Court decision in *FTC v. Phoebe Putney Health System*, which narrowed the state-action immunity doctrine that allows states to supersede federal antitrust rules.

30. Florida CS/HB 21. For an overview, see the Florida Senate 2019 Summary of Legislation Passed, Committee on Health Policy, https://www.flsenate.gov/PublishedContent/Session/2019/BillSummary/Health_HP0021hp_0021.pdf.

31. Cho et al. (2021).

32. The legislation is cosponsored by senators Bill Cassidy (R-LA) and James Lankford (R-OK). The legislative text is available at https://www.lankford.senate.gov/imo/media/doc/lankford_colleagues_patient_access_to_higher_quality_health_care_act.pdf.

33. Busch, Grzeskowiak, and Huth (2020).

34. See DPC Frontier Mapper, https://mapper.dpcfrontier.com, for a map displaying the locations of all of them.

35. IRS (2020).

36. S. 128. Primary Care Enhancement Act of 2021. Available at https://www.congress.gov/bill/117th-congress/senate-bill/128?s=1&r=28.

37. H.R. 8417. For more, see https://www.congress.gov/bill/116th-congress/house-bill/8417.

38. California Health and Human Services Agency (2019).

39. US Department of Labor (2018).

40. *State of New York, et al. v. United States Department of Labor, et al.*, No. 1:2018cv01747 - Document 79 (D.D.C. 2019), https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv1747-79.

41. S. 896. Association Health Plans Act of 2021. Available at https://www.congress.gov/bill/117th-congress/senate-bill/896?s=1&r=69.

WORKS CITED

Alliance for Connected Care. 2022. "COVID-19 State Telehealth and Licensure Expansion Dashboard" (December). https://connectwithcare.org/state-telehealth-and-licensure-expansion-covid-19-chart.

Andino, Juan J., Ziwei Zhu, Mihir Surapaneni, Rodney L. Dunn, and Chad Ellimoottil. 2022. "Interstate Telehealth Use by Medicare Beneficiaries before and after COVID-19 Licensure Waivers, 2017–20." *Health Affairs* 41, no. 6 (June): 838–45. https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01825.

Association of American Medical Colleges. 2021. "The Complexities of Physician Supply and Demand: Projections from 2019 to 2034" (June). https://www.aamc.org/media/54681/download.

Auerbach, David I., Peggy G. Chen, Mark W. Friedberg, Rachel Reid, Christopher Lau, Peter I. Buerhaus, and Ateev Mehrotra. 2013. "Nurse-Managed Health Centers and Patient-Centered Medical Homes Could Mitigate Expected Primary Care Physician Shortage." *Health Affairs* 32, no. 11 (November): 1933–41. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2013.0596.

Busch, Fritz, Dustin Grzeskowiak, and Erik Huth. 2020. "Direct Primary Care: Evaluating a New Model of Delivery and Financing." Society of Actuaries, Health Care Cost Trends (May). https://www.soa.org/globalassets/assets/files/resources/research-report/2020/direct-primary-care-eval-model.pdf.

California Health and Human Services Agency. 2019. "APL 19-024 (OLS) – Association Health Plans." Department of Managed Health Care (December 9). https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL%2019-024%20(OLS)%20%20Association%20Health%20Plans%20.pdf?ver=2021-05-07-095619-167.

Centers for Medicare & Medicaid Services [CMS]. 2020. "Medicare Telemedicine Health Care Provider Fact Sheet" (March 17). https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet.

Chattopadhyay, Sudip, and George Zangaro. 2019. "The Economic Cost and Impacts of Scope of Practice Restrictions on Nurse Practitioners." *Nursing Economics* 37, no. 6 (November–December): 273–83. https://www.proquest.com/scholarly-journals/economic-cost-impacts-scope-practice-restrictions/docview/2328560634/se-2.

Cho, Ted, Andrew Meshnick, Jesse M. Ehrenfeld, and Brian J. Miller. 2021. "Cost and Quality of Care in Physician-Owned Hospitals: A Systematic Review" (September 7). Mercatus Center. https://www.mercatus.org/research/research-papers/cost-and-quality-care-physician-owned-hospitals-systematic-review.

Conover, Christopher J., and James Bailey. 2020. "Certificate of Need Laws: A Systematic Review and Cost-Effectiveness Analysis." *BMC Health Services Research* 20, no. 748. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7427974/pdf/12913_2020_Article_5563.pdf.

Dills, Angela K. 2021. "Telehealth Payment Parity Laws at the State Level." Mercatus Center, *Policy Briefs* (November 30). https://www.mercatus.org/research/policy-briefs/telehealth-payment-parity-laws-state-level.

Federal Trade Commission [FTC]. 2022. "FTC Policy Perspectives on Certificates of Public Advantage." *Staff Policy Paper* (August 15). https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf.

Flier, Jeffrey S., and Jared M. Rhoads. 2020. "The US Health Provider Workforce: Determinants and Potential Paths to Enhancement." *Perspectives in Biology and Medicine* 63, no. 4 (Autumn): 644–68. https://pubmed.ncbi.nlm.nih.gov/33416803.

Gajarawala, Shilpa N., and Jessica N. Pelkowski. 2021. "Telehealth Benefits and Barriers." *Journal for Nurse Practitioners* 17, no. 2 (February): 218–21. https://www.sciencedirect.com/science/article/pii/S1555415520305158.

Internal Revenue Service [IRS]. 2020. "Certain Medical Care Arrangements." *Federal Register* 85, no. 112 (June 10): 35398–404. https://www.federalregister.gov/documents/2020/06/10/2020-12213/certain-medical-care-arrangements.

Kocher, Bob. 2014. "Doctors without State Borders: Practicing across State Lines." *Health Affairs* (Health Affairs Forefront), February 18. https://www.healthaffairs.org/content/forefront/doctors-without-state-borders-practicing-across-state-lines.

Miller, Brian J., Robert E. Moffit, James Ficke, Joseph Marine, and Jesse Ehrenfeld. 2021. "Reversing Hospital Consolidation: The Promise of Physician-Owned Hospitals." *Health Affairs* (Health Affairs Forefront), April 12. https://www.healthaffairs.org/content/forefront/reversing-hospital-consolidation-promise-physician-owned-hospitals.

Mitchell, Matthew D. 2016. "Do Certificate-of-Need Laws Limit Spending?" Mercatus Working Paper 07021. September. https://www.mercatus.org/media/45141/download.

Newhouse, Robin P., Julie Stanik-Hutt, Kathleen M. White, Meg Johantgen, Eric B. Bass, George Zangaro, Renee F. Wilson, et al. 2011. "Advanced Practice Nurse Outcomes 1990–2008: A Systematic Review." *Nursing Economics* 29, no. 5 (September–October): 30–50. https://pubmed.ncbi.nlm.nih.gov/22372080.

Ohlhausen, Maureen K. 2015. "Certificate of Need Laws: A Prescription for Higher Costs." *Antitrust* 30, no. 1 (Fall): 50–54. https://www.ftc.gov/system/files/documents/public_statements/896453/1512fall15-ohlhausenc.pdf.

Oliver, Gina M., Lila Pennington, Sara Revelle, and Marilyn Rantz. 2014. "Impact of Nurse Practitioners on Health Outcomes of Medicare and Medicaid Patients." *Nursing Outlook* 62, no. 6 (November–December): 440–47. https://www.sciencedirect.com/science/article/abs/pii/S002965541400150X.

Perloff, Jennifer, Sean Clarke, Catherine M. DesRoches, Monica O'Reilly-Jacob, and Peter Buerhaus. 2019. "Association of State-Level Restrictions in Nurse Practitioner Scope of Practice with the Quality of Primary Care Provided to Medicare Beneficiaries." *Medical Care Research and Review* 76, no. 5 (October): 597–626. https://pubmed.ncbi.nlm.nih.gov/28906171.

Poghosyan, Lusine, Joyce Pulcini, Garrett K. Chan, Lynne Dunphy, Grant R. Martsolf, Karen Greco, Barbara A. Todd, et al. 2022. "State Responses to COVID-19: Potential Benefits of Continuing Full Practice Authority for Primary Care Nurse Practitioners." *Nursing Outlook* 70, no. 1 (January–February): 28–35. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8346350/pdf/main.pdf.

Rakotoniaina, Adney, and Johanna Butler. 2020. "50-State Scan of State Certificate-of-Need Programs." National Academy for State Health Policy, May 22. https://nashp.org/50-state-scan-of-state-certificate-of-need-programs.

Spetz, Joanne. 2019. "California's Nurse Practitioners: How Scope of Practice Laws Impact Care." California Health Care Foundation, May 2. https://www.chcf.org/publication/californias-nurse-practitioners.

Spetz, Joanne, Stephen T. Parente, Robert J. Town, and Dawn Bazarko. 2013. "Scope-of-Practice Laws for Nurse Practitioners Limit Cost Savings That Can Be Achieved in Retail Clinics." *Health Affairs* 32, no. 11 (November): 1977–84. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2013.0544.

Svorny, Shirley. 2020. "Facilitating Interstate Telemedicine." Cato Institute, *Regulation* (Fall). https://www.cato.org/regulation/fall-2020/facilitating-interstate-telemedicine.

US Department of Health and Human Services [HHS]. 2020. "Guidance to States: Lifting Restrictions to Extend the Capacity of the Health Care Workforce during the COVID-19 National Emergency" (March). https://www.ncsbn.org/public-files/HHS_Guidence_to_States_on_Regulations_on_Healthcare_Workers.pdf.

———. 2023. "Telehealth Policy Updates" (last updated May 11). https://telehealth.hhs.gov/providers/telehealth-policy/telehealth-policy-updates.

US Department of Labor. 2018. "Definition of 'Employer' Under Section 3(5) of ERISA—Association Health Plans." *Federal Register* 83, no. 4 (January 5): 614–36. https://www.govinfo.gov/content/pkg/FR-2018-01-05/pdf/2017-28103.pdf.

29 28 27 26 25 24 23 7 6 5 4 3 2 1

ABOUT THE AUTHORS

LANHEE J. CHEN, PHD

Lanhee J. Chen, PhD, is the David and Diane Steffy Fellow in American Public Policy Studies at the Hoover Institution and the director of domestic policy studies in the Public Policy Program at Stanford University. He has advised four presidential campaigns and previously served as a member of the Social Security Advisory Board and at the US Department of Health and Human Services.

TOM CHURCH

Tom Church is a policy fellow at the Hoover Institution whose work focuses on healthcare policy, entitlement reform, income inequality, poverty, and the federal budget. He holds a master's degree in public policy with honors from Pepperdine University.

DANIEL L. HEIL

Daniel L. Heil is a policy fellow at the Hoover Institution whose work focuses on the federal budget, healthcare, tax policy, and antipoverty programs. Heil served as Florida governor Jeb Bush's economic policy adviser, counseling him on these issues, during the 2016 presidential campaign. He holds a master's degree in public policy from Pepperdine University.

The Choices for All Project: Healthcare Reforms for the Future

There is near-universal agreement that the US healthcare system fails to deliver affordable, accessible, and high-quality care for many Americans. Fixing our system requires putting more decisions in the hands of patients. That means introducing meaningful prices into the system, reducing supply-side regulations that limit the supply of medical care, and finding innovative ways to deliver insurance and medical care that better meet the demands of patients. The Choices for All Project offers healthcare reforms that would jump-start competition, encourage meaningful and transparent prices to patients, and bring consumer sovereignty to the healthcare market for millions of working-age Americans.

Hoover Institution, Stanford University
434 Galvez Mall
Stanford, CA 94305-6003
650-723-1754

Hoover Institution in Washington
1399 New York Avenue NW, Suite 500
Washington, DC 20005
202-760-3200

HOOVER INSTITUTION