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Modernizing Health Care Regulations to Lower the Costs of Medical Services

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This essay presents supply-side initiatives to curb rising health care costs in the United States. Proposed reforms include modernizing occupational licensing requirements for nurse practitioners, physician assistants, and doctors. Expanding accessibility to health care services is an empirically effective and politically bipartisan policy tool to drive down costs without sacrificing quality.

BACKGROUND

Health care in America is expensive. Although medical innovation in the United States outpaces that of its OECD peers, leading to some of the best population-adjusted outcomes in the world[1], these outcomes vary widely among different racial, socioeconomic, and geographic groups[2]. Experts agree that America's advances in medical technology are responsible for much of the 5.5% average annual growth in real health care spending over the past five decades; today, total health care spending in the United States accounts for nearly one-fifth of national GDP.[3]

In response to these growing costs and distributional inequities, the Patient Protection and Affordable Care Act (ACA) of 2010 implemented the widest-reaching reforms of American health care since the introduction of Medicare and Medicaid in 1965. Republicans and Democrats deeply disagree on the merits of the ACA's individual mandate, the costs of its subsidies for the poor and taxes on the rich, the wisdom of its Medicaid expansion, the status of its state-based exchanges, and the sustainability of its insurance regulations (outlining essential health benefits, banning annual and lifetime limits, capping medical loss ratios, and requiring guaranteed issue and community rating). Yet their legislative standstill over the ACA obstructs a clearer opportunity for consensus in driving down health costs and improving patient access.

Supply-side approaches to spending reduction are underused. Today, arcane and outmoded occupational licenses restrict the availability of medical services. Physicians, who spend close to a decade or more in medical training, are bound by state licensing requirements that inhibit mobility and care delivery across state lines. Scope of practice laws often prohibit nurse practitioners (NPs) and physician assistants (PAs) from delivering basic services such as vaccines and blood tests. When done well, licensing protects consumers by ensuring higher quality service providers. However, overly restrictive requirements harm consumers by limiting supply, which consequently increases prices.[4]

Technology may be the biggest driver of health care spending growth, but health policy ought not to restrain innovation as a default cost-cutting strategy. Instead, modernizing regulations that limit the availability of health services from trained professionals will help to reduce spending while maintaining quality.

ANALYSIS AND POLICY CONSIDERATIONS

As in any other market, supply and demand govern health care prices.

Policy makers have two overall strategies to rein in spending: increase the supply of health services or decrease the demand for them. American health policy has pursued a hybrid of both approaches, capping provider reimbursement and increasing consumer cost-sharing to respectively lower the price and the quantity of health services delivered. However, these traditional tools are inadequate. Physician payment can only be cut so much before triggering an exodus from insurance networks, just as increasing patient out-of-pocket costs too much risks forcing Americans to decide between their health and their financial solvency.

Over twenty million newly-insured Americans will strain the capacity of the system.

The ACA dramatically increased demand for health services by slashing the uninsured rate from 16% in 2010 to 9% in 2016.[5] This is an issue because the share of general medical practitioners per 1,000 people in the United States ranks near the bottom of comparable high-income countries.[6] Recent data shows that Medicaid expansion states, which experienced the largest coverage gains, met the increase in demand with more appointment slots per physician, albeit with longer waiting times per appointment.[7] While encouraging, these results do not change the fact that increasing appointments per physician is an unsustainable strategy.

Americans are open to receiving care from NPs and PAs

Market research surveys show that patients care most about cost and accessibility when it comes to their health care provider.[8] While about half of Americans prefer going to a primary care doctor for routine visits, nearly two-thirds would choose an NP or PA instead if it reduced their wait time for a visit and/or if it involved a less expensive co-pay.[9] Indeed, retail clinic use increased tenfold from 2007 to 2009,[10] revealing consumers' preference for basic health services at less expensive, more accessible locations.

NPs and PAs deliver routine medical services at lower cost and comparable quality to primary care physicians.

Routine medical services include administering vaccines, monitoring blood pressure, conducting blood tests, and dispensing inexpensive medications.[11] Because retail

clinics staffed by NPs and PAs bill less for the same services, states that relaxed scope of practice (SOP) laws between 2004 and 2007 saw declines in primary care spending without increasing hospitalizations or emergency department visits.[12] The RAND Corporation places estimates for total cost savings from the proliferation of these clinics as high as $4.4 billion annually.[13]

Doctors are also limited by SOP regulations on NPs and PAs.

SOP laws for NPs and PAs pose an opportunity cost to physicians. Instead of addressing patients with complex diagnostic and treatment challenges, doctors instead are required to divert time and appointments to routine medical services. As nurses and physician assistants take over routine primary care responsibilities, physicians will have greater availability to tackle cases that require their advanced skills.

A useful analog comes from research on dentists' case distribution and income in states that expanded Medicaid dental benefits. Responding to higher patient demand, dentists supplied more weekly visits (without working additional hours or substantially increasing wait times) by shifting the responsibility for routine service delivery to dental hygienists, especially in states with more permissive SOP laws.[14] This research suggests that relaxing SOP laws for NPs and PAs allows primary care doctors to similarly substitute other (less expensive) clinicians for the delivery of routine care, while they take on more difficult cases themselves. Together, this increased supply of services can help the health system to meet higher demand from the newly insured while stabilizing system-wide costs.

Nonreciprocal state physician licensing does not keep pace with advances in telemedicine.

Early adopters of remote patient monitoring systems have lower administrative costs, better patient access to providers, and modest improvements in health outcomes.[15] However, nonreciprocal state licensure stifles telemedicine's growth. By law, doctors must be licensed in each state that they practice medicine (with few exceptions), even though national standards ensure the quality of medical training and testing.[16] Because remote patient monitoring across state lines runs afoul of these licenses, Americans are losing out on a cost-saving innovation.

There is broad bipartisan support for modernizing licensing and SOP regulations.

Unlike with the ACA, where public opinion on the law (and its potential repeal) splits sharply along partisan lines,[17] these measures are palatable to different constituencies. Patients benefit by having easier access, lower prices, and shorter waiting times for comparable quality routine primary care. Physicians benefit by having more mobility with their services that would be applied towards more

advanced cases and challenges. NPs and PAs would see greater responsibility by taking on basic health service delivery, which their professional organizations have long advocated for. Finally, payers would see across-the-board cost reductions through less administrative overhead and lower unit prices for basic medical services provided by nonphysicians.

The Bipartisan Policy Center commissioned a working group in 2013 to evaluate the access and affordability of medical services. Their findings highlight a wide gap between the demand for primary care and the projected supply of doctors over the next decade.[18] Written jointly by former Republican and Democratic public servants, this bipartisan conclusion supports supply side reforms as necessary health policy measures.

RECOMMENDATION

The supply side solution has two key steps to reduce regulatory costs in American health care:

1. ***Incentivize states to revise SOP laws.*** Since 2012, the Center for Medicare and Medicaid Innovation (CMMI) has funded voluntary demonstration projects with nonphysician clinicians taking over routine aspects of patient care, where SOP laws allow.[19] CMMI should make use of its existing relationships with state health regulators to encourage them to adopt more flexible SOP limitations on NPs and PAs.

2. ***Accelerate mutual recognition agreements.*** Twenty-two states have taken the lead in streamlining the process of domestic, cross-border medical practice by joining the Interstate Medical Licensure Compact (IMLC), an agreement allowing licensed physicians to practice medicine in all other participating states. Actual implementation of mutual recognition, however, has been slow. To speed up this state-level reform, Congress should consider a current bipartisan proposal to fund a voluntary telehealth demonstration project through CMMI.[20] Tying federal funding for this telehealth program to participation in multi-state licensure agreements such as IMLC will expedite the ability of qualified physicians to deliver care remotely and across state lines.

CONCLUSION

Current health policy discussions center almost entirely on the Affordable Care Act. Yet the focus in today's polarized climate should instead be on fact-based areas of consensus to bring down health spending and improve patient access.

Supply-side reforms do just that. Increasing the responsibility of nonphysician

clinicians and allowing doctors greater mobility to deliver care across state lines represent two achievable and tangible steps to cut costs and maintain high quality in the health care system.

The administration, as well as state governments, can and should take the lead on these initiatives.

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