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Health Care Reform: Why State Officials Should Take the Lead

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Abstract: *Government regulation at both the state and federal level targets plans and providers, ranging from hospital construction and expansion to quality reporting and provider compliance with state laws and regulations. Those who make legislative or regulatory decisions should rethink our administration or oversight of public-sector health programs to promote change and reward innovation, provide as much latitude as possible for our citizens as patients, and respect the independence and professionalism of those who practice medicine. We have the opportunity both to change the law by pursuing waivers to federal regulations that contribute to middle-class Americans' rising health care costs and to improve health care markets among medical professionals, allowing them to compete more effectively, improve their performance, and innovate in delivering high-quality care for our citizens.*

In 2018, millions of Americans are rightfully concerned about the future of their health care. Those enrolled in the individual markets face an average increase of 34 percent nationwide for the standard health plans in the Obamacare exchanges,[1] as well as many thousands of dollars in annual deductibles.

Because of heavy taxpayer subsidies, approximately 8 million lower-income persons enrolled in the exchanges are insulated from these premium rate shocks and burdensome out of pocket costs, but approximately 9 million—mostly middle-class persons—in the individual markets have no such federal assistance. Worse, under the inefficient and inequitable tax law that governs health insurance, those middle-class workers and their families are denied individual federal tax relief for the purchase of individual health

Key Points

- While Congress should return to health reform, states should secure HHS waivers and reduce federal regulatory costs in their health insurance markets.
- Competition drives innovation, and innovation starts from the ground up, stimulated by suppliers of goods and services responding to individual and family wants and needs.
- Competition can secure the same results in health care that it does in every other sector of the economy, and state officials can take several steps to improve their health care markets.
- Specifically, the states can promote price transparency; review, reform, or repeal certificate of need laws; eliminate barriers to telemedicine; enroll state employees in private health insurance exchanges; promote direct primary care; and roll back restrictions on care delivery.

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insurance—tax relief they otherwise would have gotten if they had secured their insurance coverage through an employer. For these Americans, the rapidly rising health insurance costs in some states are so high that enrolling their families in health coverage is akin to financing a second mortgage.

Meanwhile, the continuing decline in carrier and plan participation in the individual market, down from 395 in 2013 to an estimated 181 in 2018, undercuts the viability of the exchanges as functioning markets. Rather than collapsing altogether in death spirals, the state exchanges will more likely be reduced to large, mostly stagnant health risk pools that will be maintained and heavily subsidized by the federal taxpayers. As a practical matter, they will be devoid of the genuine choice and robust competition that characterize normal, functioning markets.

Millions of Americans, particularly in 2010, 2014 and 2016, voted for change in federal health policy and are justly frustrated at the poor performance of the United States Senate in 2017. The Senate failed to deliver even a watered-down version of desperately needed health care reform legislation. The good news is that we have a federal system of government, where the people can still act through their governors and state legislators and secure at least some measure of consequential change.

Washington's Key Policy Debate

The key issue in health policy is control: control over dollars and decisions. Obamacare transferred an enormous amount of regulatory power from the states to the federal government. The people of the states are largely on the receiving end of Washington's decisions, and today, what the people of the states can and cannot do in health policy is, under Obamacare, constrained by Washington. Federal insurance rules, especially age rating, actuarial value, and benefit mandates, significantly increase premium costs. The good news is that President Donald Trump and his officials are determined to maximize state authority within existing law and have already taken decisive steps to do so. Expect more administrative actions to come.

Key House and Senate members, despite their legislative setbacks in 2017, nonetheless appear determined in 2018 to grant state officials new broad flexibility and allow them to accomplish their mission on the ground: improving the damaged health insurance and health care markets within their states. Combined executive and legislative action can achieve a central policy goal: allowing individuals and families more choice of health care options by giving back to state officials the flexibility to respond directly to their personal wants and needs.

The Trump Administration's Initiatives

On January 20, 2017, the President also issued an executive order to all federal agencies to "minimize" Obamacare's economic and regulatory burdens, specifying that the relevant federal agencies should waive, defer, or delay rules and regulations that would impose such burdens.[2] Since taking office, the President has unveiled several administrative initiatives of his own to provide additional avenues for Americans to secure more affordable insurance coverage and care:

- The expansion of association health plans (AHPs);
- The expansion of health reimbursement accounts (HRAs), particularly their use as a vehicle to finance tax free purchases of health insurance coverage; and
- Restoration of limited-duration coverage for persons who need less costly coverage options, particularly when they are between jobs.[3]

The President's critics may claim that he is undermining current law; in fact, he is practicing a policy of addition, not subtraction, and allowing individuals and families to choose for themselves the kind of coverage that they want.

1. Caroline F. Pearson and Chris Sloan, "Silver Exchange Premiums Rise 34% on Average in 2018," press release, Avalere Health, October 25, 2017, http://avalere.com/expertise/managed-care/insights/silver-exchange-premiums-rise-34-on-average-in-2018 (accessed January 16, 2018).
2. President Donald J. Trump, Executive Order 13765, "Minimizing the Economic Burdens of the Patient Protection and Affordable Care Act," January 20, 2017, in *Federal Register*, Vol. 82, No. 14 (January 24, 2017), pp. 8351–8352, https://www.gpo.gov/fdsys/pkg/FR-2017-01-24/pdf/2017-01799.pdf (accessed January 16, 2018).
3. See President Donald J. Trump, Executive Order 13813, "Promoting Healthcare Choice and Competition Across the United States," October 12, 2017, in *Federal Register*, Vol. 82, No. 199 (October 17, 2017), pp. 48385–48387, https://www.gpo.gov/fdsys/pkg/FR-2017-10-17/pdf/2017-22677.pdf (accessed January 16, 2018).

In the prevailing spirit of openness to change, Seema Verma, Administrator of the Centers for Medicare and Medicaid Services (CMS), made it abundantly clear to state officials that the Administration is ushering in a new era of state flexibility, especially in the use of Section 1115 Medicaid waivers: "We will move away from the assumption that Washington can engineer a more efficient health care system from afar—that we should specify the processes health care providers are required to follow."[4]

Verma has promised that states will get Medicaid waivers more quickly; that waivers will be available for 10 rather than five years; and that the Administration, through a streamlined process, will expedite Medicaid state plan amendments. Moreover, through their updated Medicaid waiver process, Trump Administration officials also support states that wish to experiment with work requirements through demonstration projects if they wish to do so.

Taxpayers can also expect greater transparency and accountability in the Medicaid program because the Trump Administration will publish the results of their measures of the performance of state Medicaid programs in delivering quality care. Medicaid clearly needs improvement. Given the growing federal and state expenditures for this enormous health and welfare program—$554 billion in fiscal year 2016—taxpayers deserve to know exactly how well their state Medicaid programs are actually working.

Using Current Law to Advance State Reforms

America's governors and state legislators, meanwhile, should use the existing and significant legal powers available to them and, to the best of their ability, reform their own health insurance markets and reduce their citizens' health insurance costs.

Under Section 1332 of the Affordable Care Act (ACA), state officials can apply to the Secretary of Health and Human Services for a five-year waiver from 11 statutory requirements of the national health law.[5] Given the strong disposition of the Trump Administration to use its own administrative discretion under current law to maximize state flexibility, state officials applying to the Secretary of HHS for waivers should be aggressive and "push the envelope" for consequential change. They should press the Administration to allow them to pursue new policy options and thus begin the process of restructuring their own health insurance markets. The Trump Administration should match its rhetoric with the reality of the states' willingness to initiate change and permit states to give their citizens the right to choose affordable health care options they want and need.

Exemption and Experimentation. Obamacare imposed a mandate on all employers with 50 or more workers to offer a federally approved health plan or face a tax penalty ranging from $2,000 to $3,000 for every employee without the required employer-sponsored coverage.[6] Under current law, however, states can secure a waiver from the imposition of the employer mandate and its tax penalties. The employer mandate, it should be noted, is unpopular not only among businesses, but also even among "progressive" policy analysts at the Urban Institute and elsewhere who doubt its efficacy in increasing coverage and fear its potential for disruption of the labor markets.[7]

4. Seema Verma, "Medicare and Medicaid Need Innovation," *The Wall Street Journal,* September 19, 2017, https://www.wsj.com/articles/medicare-and-medicaid-need-innovation-1505862017 (accessed January 16, 2018). "Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations." U.S. Department of Health and Human Services, Centers for Medicare and Medicare Services, "About Section 1115 Demonstrations," https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html (accessed January 16, 2018).
5. For detailed information on the Section 1332 waiver process, see U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, "Section 1332: State Innovation Waivers," 2017, https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_state_Innovation_Waivers-.html (accessed January 16, 2018).
6. In 2015, through unilateral administrative action, the Obama Administration delayed the employer mandate's reporting requirements and the imposition of its tax penalties for one year.
7. See Linda J. Blumberg, John Holohan, and Matthew Buettgens, "Why Not Just Eliminate the Employer Mandate?" Urban Institute *In-Brief*, May 2014, https://www.urban.org/sites/default/files/publication/22096/413117%20-%20Why-Not-Just-Eliminate-the-Employer-Mandate-.pdf (accessed January 16, 2018).

Under current law, states can seek to make substantial structural changes by getting waivers from federal insurance rules. For example, state officials can:

- Get waivers to redefine a "qualified health plan" for participation in the individual and small-group markets;
- Get waivers from the 10 categories of federally mandated health benefits (known as "essential health benefits"); and
- Get relief from the ACA's actuarial value mandate that specifies the metallic levels of coverage (Platinum, Gold, Silver, and Bronze) that participating health plans must offer within their states.

State officials can also get waivers from the rules governing health insurance exchanges and federal requirements governing the risk pooling. Of perhaps even greater significance, state officials can get waivers that would allow them to make crucial changes in the financing of coverage within their state health insurance exchanges, such as the eligibility and rules for cost-sharing subsidies and the so-called premium tax credits. With such waivers, they could alter the premium payment amounts, reset the benchmarks for calculating the subsidy payments, and change the rules governing family size and income eligibility for the insurance subsidies.

Coping with Obstacles. Under current law, state officials offering alternatives for their people must meet certain statutory conditions.

First, state officials must enroll as many persons in their alternative coverage programs as they would under the ACA. The good news for state officials is that this condition is getting easier and easier to meet, since Obamacare coverage projections have routinely fallen far below expectations. Over the past six years, the Congressional Budget Office (CBO) projections have been persistently inaccurate, well below CBO's anticipated enrollment.[8] State officials therefore should have little trouble meeting Obamacare's enrollment levels in designing coverage alternatives for their citizens.

Second, state officials must meet Obamacare's standards for "comprehensive" coverage. While these standards would pose more of a challenge in pursuing significant change, HHS has broad administrative authority to interpret and apply them.

State officials should be mindful of the fact that administrative agencies, assuming that their rules are "reasonable," legally enjoy a privileged position in their interpretation of the rules that they promulgate and apply. The United States Supreme Court has ruled that federal courts should defer to an agency's interpretation of the law in issuing regulations unless that interpretation is unreasonable.[9] Regardless of the wisdom of this judicial policy, it nonetheless opens up new opportunities for the Trump Administration and innovative state officials who want to pursue consequential changes in existing health care arrangements.

Third, the states' proposed alternatives must not contribute to an increase in the federal deficit. For fiscally conservative governors and legislators, that should be no problem.

States should have plenary control over their own health insurance markets. Short of congressional repeal of Obamacare's statutory obstacles, through the waiver process, state officials can still make significant progress in reducing the federal regulatory costs in their individual and small-group markets and improve, to some extent, the functioning of the damaged health insurance exchanges within their borders.

Beyond Obamacare: Pursuing Bold Health Policy Innovations

Ideally, states should be incubators of policy innovation in health care financing and delivery. This cannot, *ipso facto,* be a top-down process, with state officials, through various boards, panels, or commissions, determining and then ordering what their citizens *should* want or need. Rather, state officials can and should use their legislative and regulatory authority as a mechanism to promote diversity of health care options and policy experimentation in

8. For an excellent summary of the data, see The White House, "CBO's Failed Obamacare Enrollment Projections," June 30, 2017, https://www.whitehouse.gov/articles/cbos-failed-obamacare-enrollment-projections/ (accessed January 16, 2018).
9. See the Court's ruling in *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), https://www.law.cornell.edu/supremecourt/text/467/837 (accessed January 16, 2018).

health care. In short, state officials can and should promote competition among doctors, hospitals, and medical professionals in whatever way they can and eliminate longstanding barriers to competition in state health markets wherever they can.[10]

Competition drives innovation, and innovation in every sector of the general economy starts from the ground up, stimulated by suppliers of goods and services responding to what individuals and families want and need. Competition in health care can secure the same results in health care that it does in every other sector of the economy. State officials can take several steps to improve their health care markets.

1. **Promote price transparency.** Today, Americans know more about the price of a gallon of gasoline than they do about the price of routine medical procedures, even though health care will soon consume almost one out of every five dollars spent in America's enormous economy. Ordinary citizens generally do not have a clue about the costs of their health insurance package. They are shocked to find out the costs of skilled nursing care, and they find hospital charges downright mystifying. State officials can directly empower consumers with sound information, help them make informed decisions, and take much of the mystery out of this process.

   There are exemplary models for reform. The State of Maryland is taking a small but significant step in promoting the transparency of hospital prices. The Maryland Health Care Commission, which I chair, has recently created a novel website dubbed "Wear the Cost" that provides Maryland citizens information on the average total cost of a select set of episodes of care at Maryland hospitals.[11]

The Maryland commission's website details cost information on episodes of care for hip replacement, knee replacement, vaginal deliveries, and hysterectomies. The commission is working to make this valuable information accessible to all of Maryland's citizens, including employers, who can directly benefit from it. Following Maryland's example, other state officials can initiate similar efforts and then incorporate the best available pricing information, plus quality information, into regular consumer reports for health insurance, home health, and nursing homes, as well as hospital performance.

The key for the consumer is the nexus between price and quality. Quality information without price information is more than incomplete; price data without quality information tell us the *value* of nothing. The right policy initiative is to combine them in an easy-to-understand consumer-friendly format. Over time, Maryland will be refining the methodology.

Markets cannot work unless consumers can get good information from reliable sources so that they know what it is that they are buying and how much their benefits or services really cost. With the passage of time and the refinement of the metrics, state officials can go well beyond hospital pricing for procedures into the provision of price information on common medical services delivered in an outpatient setting. Scott Atlas of the Hoover Institution at Stanford University argues that price transparency in this area would make a "huge difference," noting that patients in the private insurance market today spend about 60 percent of their health care dollars on elective outpatient care.[12]

10. For an excellent discussion of the potentially powerful role of competition in improving health care markets, including hospital markets, see Martin Gaynor, Farzad Mostashari, and Paul B. Ginsburg, "Making Health Care Markets Work: Competition Policy for Health Care," Brookings Institution, Center for Health Policy; Carnegie Mellon University, Heinz College; and University of Southern California, Leonard D. Schaeffer Center for Health Policy and Economics, April 2017, https://www.brookings.edu/research/making-health-care-markets-work-competition-policy-for-health-care/ (accessed January 16, 2018).
11. For an overview of the initiative, see Robert E. Moffit, Marilyn Moon, Francois DeBrantes, and Suzanne Delbanco, "The Next Chapter in Transparency: Maryland's Wear the Cost," *Health Affairs* Blog, October 19, 2017, https://www.healthaffairs.org/do/10.1377/hblog20171023.671259/full/ (accessed January 16, 2018).
12. Scott W. Atlas, "The Health Reform That Hasn't Been Tried," Hoover Institution *Daily Report*, October 4, 2017, https://www.hoover.org/research/health-reform-hasnt-been-tried (accessed January 16, 2018).

To the extent that policymakers promote direct payment through health savings accounts, the use of health reimbursement accounts, as President Trump is proposing, and increased use of flexible spending accounts, the price of medical services becomes even more vitally important. With knowledge of up-front costs, patients shelling out their own dollars at the point of medical service can stimulate intense price competition.

2. **Review, reform, or repeal CON laws.** Today, 35 states, plus the District of Columbia, require hospital and other medical providers to get a "certificate of need" (CON) for the construction or replacement or expansion of hospitals and other health care facilities. It is long past time for state officials to carefully review, substantially reform, or repeal CON laws.[13]

   Rooted in the defunct Health Planning Act of 1974, CON laws are based on the theoretical premise that supply, rather than a normal interaction of supply and demand, drives higher costs in the health care sector of the economy. These laws seek to prevent oversupply in the form of excess capacity—i.e., excessive construction of hospitals and other facilities, which in turn directly contributes to excessive health care costs. The fundamental purpose of CON is therefore to restrain excessive supply, allow for coordinated health planning to meet state needs, and thus to control or reduce the state's overall health care and medical costs.

   Times have changed, along with the emergence of new care delivery options in both the public and the private sectors, and that systemic change is well reflected in economic theory and practice. Today's consumer is not merely a passive recipient of top-down decisions, but an increasingly engaged actor in health care financing and delivery. Since the 1970s, among liberal and conservative policy analysts, there appears to be widespread agreement that the consumer can be a big driver of major systemic change. In this transitional period, consumers are being given better information and greater power to choose among health plans, both in public programs and in the individual markets, a trend accelerated by the growth of defined-contribution health care financing arrangements and consumer-driven plans. Meanwhile, consumer reports on hospital, nursing home, and home health agency performance are becoming increasingly widespread.

   At the federal level, both the Department of Justice and the Federal Trade Commission, under Democratic and Republican presidential Administrations alike, have concluded that CON laws are anticompetitive.[14] These official views are increasingly confirmed in a large and growing body of professional literature, which holds that CON laws contribute to market consolidation, that they do not control cost or improve quality, and that they inhibit entry of new medical providers and undercut innovation in health care delivery.[15]

   Concerning CON laws, some of the specific findings are particularly interesting. For example, researchers found that the repeal of Pennsylvania's CON laws in 1996 improved patient access and the quality of care and reduced spending for cardiac surgery.[16] In terms of hospital costs, researchers found that CON laws had no significant effect on spending overall and, in certain cases, actually increased costs.[17] In a study of the

13. State reform measures will vary, of course, depending on the political circumstances and market conditions that prevail in any given state. In certain cases, such as hospital projects where there is a heavy investment of state taxpayers' money, it is perfectly reasonable for state officials, in protecting their taxpayers, to retain a CON process.
14. For a recent summary of the official views of federal officials on this topic, see U.S. Department of Justice and Federal Trade Commission, "Joint Statement of the Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission on Certificate-of-Need Laws and Alaska Senate Bill 62," released April 12, 2017, https://www.ftc.gov/policy/advocacy/advocacy-filings/2017/04/joint-statement-federal-trade-commission-antitrust-division (accessed January 16, 2018).
15. On these findings, see Gaynor et al., "Making Health Care Markets Work," p. 23.
16. David M. Cutler, Robert S. Huckman, and Jonathan T. Kolstad, "Input Constraints and the Efficiency of Entry: Lessons from Cardiac Surgery," National Bureau of Economic Research *Working Paper* No. 15214, August 2009, http://www.nber.org/papers/w15214 (accessed January 16, 2018).
17. Patrick Rivers, Myron Fottler, and Jemima Frimpong, "The Effect of Certificate of Need Regulation on Hospital Costs," *Journal of Health Care Finance*, Vol. 36, No. 4 (Summer 2010), https://portal.azoah.com/oedf/documents/2015A-EMS-0190-DHS/MA-114-The%20effects%20of%20Certificate%20of%20Need%20Regulation%20on%20Hospital%20Costs%20by%20Rivers.pdf (accessed January 16, 2018).

impact of CON laws on renal dialysis, researchers concluded that such laws increased industry concentration, reduced both patient access and the quality of patient care, and favored existing providers through a restriction of entry into the market.[18]

3. **Eliminate barriers to telehealth.** Chronic illness is the main driver of health care costs, and the quality of care for these patients requires special and more or less intense monitoring of the patients' condition by medical professionals.

   In the case of Medicare, almost seven out of 10 Medicare beneficiaries suffer from some form of chronic illness. That is why Senator Ron Wyden (D–OR) and Senator Orrin Hatch (R–UT) have led a successful bipartisan effort to secure a unanimous Senate vote for the Chronic Care Act (S. 870), a bill to amend the Medicare law, particularly Medicare Advantage, and give private competing health plans and medical professionals new and reimbursable tools to cope with chronic illness. Telehealth was a major feature of this Senate effort to improve care among the chronically ill.

   There is strong evidence that telehealth improves medical outcomes and saves money. The Maryland Health Care Commission carried out demonstration projects for patients with chronic illnesses. In 2017, among the results of this effort was measurable progress in the management of diabetes (based on measurements of A1C lab values), congestive heart failure, hypertension, and hospital readmission rates. If there is any regulatory or legal barrier to the more widespread use of telehealth, such as overly restrictive licensure requirements, state officials should get rid of it.

4. **Enroll state employees in private health insurance exchanges.** In the private sector, we have seen the growth of private health insurance exchanges, where employers are increasingly engaging millions of employees through defined-contribution arrangements.[19] Major benefit firms such as Aon-Hewitt, Liazon, and Mercer are all sponsoring large, well-managed, private health exchange options. Firms enrolling employees include corporate giants such as Darden Restaurants, Sears Corporation, and Time Warner Company.

   Private exchanges are very different from the Obamacare public exchanges. Large self-insured company plans are not under the Obamacare "essential benefits" mandate, so they can be more flexible in their benefit offerings. Because these are all group plans, these companies and workers retain the tremendous tax advantages of group health insurance.

   Empowered with comparative information on price and quality, more and more private employers are enabling employees to pick among competing health plans. Competition among insurance plans, as evidenced by the experience of Medicare Advantage, Medicare Part D, and the Federal Employees Health Benefits Program (FEHBP)—all defined-contribution programs—has contributed to cost control.[20] While the data are limited for plans in private exchanges, similar cost savings are likely in a privately organized defined-contribution program, particularly if employees choose lower-cost health plans.[21]

   The key is state officials' commitment to a competition policy. In principle, there is no reason why

18. Jon M. Ford and David L. Kaserman, "Certificate of Need Regulation and Entry: Evidence from the Dialysis Industry," *Southern Economic Journal*, Vol. 59, No. 4 (April 1993), pp. 783–791, https://www.jstor.org/stable/i243590 (accessed January 16, 2018).
19. For an overview of this initiative, see Robert Emmet Moffit, "Private Insurance Exchanges: How New York Employers and Policymakers Can Leverage New Reimbursement and Delivery Reforms," in *New York's Next Health Care Revolution: How Employers Can Empower Patients and Consumers*, eds. Paul Howard and David Goldhill (New York: Manhattan Institute, 2015), pp. 81–106.
20. See Robert E. Moffit, "Expanding Choice Through Defined Contributions: Overcoming a Non-Participatory Health Care Economy," *Journal of Law, Medicine and Ethics*, Vol. 40, Issue 3 (Fall 2012), pp. 558–573, http://journals.sagepub.com/doi/pdf/10.1111/j.1748-720X.2012.00689.x (accessed January 16, 2018).
21. See Christine Buttorff, Sarah A. Novak, James Syme, and Christine Eibner, *Private Health Insurance Exchanges: Early Evidence and Implications for the Future* (Santa Monica, CA: The Rand Corporation, 2016), p. ix, https://www.rand.org/pubs/research_reports/RR1109.html (accessed January 16, 2018).

state officials could not broaden the state employees' options to include plans offered in one or more private health insurance exchanges. Just as in the FEHBP, state and local government health benefit programs often operate on a defined-contribution basis, and thus, the infrastructure of a robust system of choice and competition is already present.

The best policy would be simply to expand the universe of state government employee health plan options to include those currently available through private exchanges. State government employees would be able to keep the health plans they have and they like, but they could also purchase perhaps a different plan on the one or more private-sector exchanges that are available to private business or corporate employees within the state.

5. **Promote direct primary care.** In the private sector, more and more medical practices, especially primary care practices, are providing care for a monthly fee, cutting out third-party payment and reducing their administrative costs. What was once "concierge medicine," largely confined to the zip codes of wealthy residents, is increasingly accessible to middle-class patients. In a major study of these practices, researchers found that in a cohort of 116 of these practices, the average monthly cost to the patient was $93.26.[22]

   Direct primary care is an excellent option for persons yearning for a traditional relationship with their doctors and who are frustrated with the bureaucratic arrangements of conventional health insurance. Today, these practices are multiplying rapidly. Doubtless, this is a market response to the unfriendly policy prescriptions that many Americans perceive at the national level, as well as a deepening frustration with third-party payment rules and restrictions that govern the decisions of both doctors and patients.

   For state officials, the best way to promote the growth of direct primary care practices is by reducing uncertainty among physicians and eliminating any artificial regulatory barriers to their expansion. For example, state officials should clarify in statute that direct primary care transactions are *not* insurance transactions and thus are exempt from the state's regulation of insurance.[23]

   For state officials pondering a Medicaid waiver application to CMS, they would do well to consider the establishment of a direct primary care option within the Medicaid program. The Administration might consider such proposals under a Section 1115 Medicaid waiver or perhaps as a demonstration project under CMS's Center for Medicare and Medicaid Innovation. Given the friendly disposition of the Trump Administration to maximize state flexibility, it is an opportunity not to be missed.

6. **Roll back restrictions on care delivery options.** In the face of prospective physician shortages, particularly among primary care doctors, state officials should broaden the health care options for patients and allow a greater role for nurse practitioners and physician assistants. They can do this by reviewing and reforming "scope of practice" laws. As Brookings Institution scholars have recommended, state scope of practice laws should be amended so that the "only justification" for the restrictions on scope of practice is public safety.[24] That is sound advice.

Conclusion

Government regulation routinely restrains, guides, and directs. It targets the various activities of plans and providers, ranging from hospital construction and expansion to quality reporting and provider compliance with state laws and regulations.

Those of us who are charged with making legislative or regulatory decisions should rethink the

22. Philip M. Eskew and Kathleen Klink, "Direct Primary Care: Practice Distribution and Cost Across the Nation," *Journal of the Board of American Family Medicine*, Vol. 28, No. 6 (December 2015), pp. 793–801, http://www.jabfm.org/content/28/6/793.full (accessed January 16, 2018).
23. The State of Utah, for example, has enacted such legislation. For an overview of the potential of direct primary care, see Daniel McCorry, "Direct Primary Care: An Innovative Alternative to Conventional Health Insurance," Heritage Foundation *Backgrounder* No. 2939, August 6, 2014, http://www.heritage.org/health-care-reform/report/direct-primary-care-innovative-alternative-conventional-health-insurance.
24. Gaynor et al., "Making Health Care Markets Work," p. 25.

nature and scope of our regulatory powers. Specifically, we need to retorque our administration or oversight of health programs in the public sector to promote change and reward innovation, provide as wide a latitude as possible for our citizens as patients, and respect the independence and professionalism of those who practice the art and science of medicine.

In the private sector, we should look beyond our regulatory power as merely something that is prescriptive or restrictive, too often burdening medical professionals and health care organizations with counterproductive reporting and compliance requirements—paperwork exercises that often add little to the quality of patient care. Rather, as public officials, we should refocus on what we can do to reduce unnecessary or cost-ineffective regulation and how we can, within the law, focus on what it is that we can allow, promote, or permit.

The need to act is urgent. Our citizens really don't have the time, and our patients are running out of patience—as well as money.

We have the opportunity to make serious changes within the law, as restrictive as Obamacare is, by pursuing waivers to those federal regulations that contribute to middle-class Americans' rising health care costs. We also still have it within our powers to improve the health care markets among medical professionals, allowing them to compete more effectively, improve their performance, and innovate in delivering high-quality care for our citizens.

*—**Robert E. Moffit, PhD,** is a Senior Fellow in the Institute for Family, Community, and Opportunity at The Heritage Foundation and Chairman of the Maryland Health Care Commission. This lecture is adapted from Dr. Moffit's presentation to the national meeting of the American Legislative Exchange Council in Nashville, Tennessee, on December 7, 2017. The titles and affiliations here are for identification purposes only. The views expressed in this lecture are solely the views of the author and do not represent the official views of The Heritage Foundation or its Board of Trustees or the Maryland Health Care Commission.*