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American Health Care Plan

STATE SOLUTIONS



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INTRODUCTION



In 2021, The Heartland Institute released the American Health Care Plan (AHCP), which focused exclusively on federal reforms to lower health care costs, increase access to high-quality care, and introduce market forces to a health care system that has become overly bureaucratic and too-focused on a one-size-fits-all approach.

Unlike the 2021 version of the AHCP, the 2024 edition emphasizes how states can implement reforms that would accomplish the same goals of lowering health care costs, increasing access to first-rate care, and using market forces to drive a more patient-centered approach.

While we continue to advocate for passage of the national reform plan, the current landscape in Washington, DC makes it difficult to foresee sweeping federal reforms happening anytime in the near future. Of course, the 2024 election could change the current dynamic in the nation's capital, but that is far from a guarantee.

Meanwhile, there are many things that states can do to make health care more accessible and affordable on the way to a hoped-for federal plan to replace the outdated, overly expensive, access-denying, government-warped health care system.

As the laboratories of democracy, states can provide 50 different solutions for the many challenges we face in realizing the goals of the ACHP, primarily greater access, more patient control, and lower prices for high-quality health care.

“Unlike the 2021 version of the American Health Care Plan, the 2024 edition emphasizes how states can implement reforms that would accomplish the same goals of lowering health care costs, increasing access to high quality care, and using market forces to drive a more patient-centered approach.”

State-level reforms are urgently needed even as we await national level reform due to the fact that the federal government has been placing increasing burdens on patients and health care providers. Since 2021, the Biden administration expanded federal government power over health care decisions through ever-tighter regulations under the Affordable Care Act, Medicaid expansion, and various pandemic-era orders.

In this paper, we outline reforms from which all states could benefit, several of which some states have already begun to implement. We suggest a variety of policies states can adopt to empower patients and health care providers, increase access to care, lower

prices, raise quality, encourage innovation, and protect individual rights.

Specifically, this paper outlines a series of state-based reforms that seek to reverse elements of federal health care overreach while reinvigorating the role of the states regarding a number of health care issues.

First and foremost, we advise states to address Medicaid expansion, which has resulted in massive amounts of waste, fraud, and abuse.

Second, we call for increasing health care price transparency through the implementation of reference-based pricing.

Third, states should repeal outdated certificate of need laws, which are a remnant of a bygone era and stifle innovation.

Fourth, states should strengthen the provider-patient relationship by protecting providers' free speech rights and reforming the antiquated system of prior-authorization mandates.

Fifth, we advise states ease restrictions on direct primary care agreements, a patient-friendly subscription-based model of health care.


Sixth, states should expand access to telemedicine so patients can conveniently seek care and medical advice without the hassle of making an in-person appointment.

Seventh, we suggest states expand Right to Try legislation, a commonsense measure that allows terminally ill patients to access medications that have passed Phase One FDA safety trials but are not available on the general market.

Eighth, we call for expanding existing interstate physician compacts in order to resolve the increasing shortage of care providers.

Ninth, we recommend states combat federal overreach by applying for state waivers to unshackle them from burdensome federal regulations while spurring innovative and unique state-based solutions to common health care problems.

1 VERIFY MEDICAID ELIGIBILITY, CUT FRAUD AND WASTE



If a state legislator, governor, or policy advocate were to take only one suggestion to implement from this plan for immediate positive results, it would be to find and eliminate Medicaid corruption. Policy initiatives aimed at this are often put under the heading of “eliminating waste, fraud, and abuse.” However, that subject heading has grown stale after years of inaction. Corruption is a more fitting term because it is inherently systemic and captures the urgency of the situation.

The United States has the best health care in the world. However, the supply of care is scarce, and access to it is often controlled by a labyrinthine and unfair payment system that forces too many Americans into state and federal bureaucracies that consume trillions of dollars in tax payments while delivering care through government programs in an inefficient manner. Some people pay more so that others can pay little or nothing. Medicaid was designed in 1965 to care for the disabled, but the program has since ballooned to cover a growing number of able-bodied working adults and their children.

“The supply of care is scarce, and access to it is often controlled by a labyrinthine and unfair payment system that forces too many Americans into state and federal bureaucracies that consume trillions of dollars in tax payments while delivering care through government programs in an inefficient manner.”

The centerpiece of the Affordable Care Act, also known as Obamacare, was the expansion of Medicaid to include middle-income families and single adults. Forty of the 50 states have accepted expansion, increasing their Medicaid rolls significantly. The COVID-19 pandemic greatly accelerated this increase when the federal government “temporarily” expanded Medicaid enrollment by 23 million people, as eligibility requirements were relaxed and states were given enhanced payments to load more people onto the program.¹

When the federal emergency formally ended and Medicaid returned to pre-pandemic eligibility requirements, states began disenrolling up to 24 million people who were on Medicaid but no longer qualified for it.

Now that the COVID-19 emergency is over, states must reverse Medicaid expansion and transition non-eligible enrollees back to private health insurance and taxpayer-supported exchanges. The Urban Institute predicts as many as 15 million Americans will “lose” insurance as pandemic-era emergency

¹ Chris Lee, “As States Prepare to Resume Disenrollments, Medicaid/CHIP Enrollment Will Reach Nearly 95 million in March, and the Pandemic-Era Enrollment Growth of 23 million Accounts for 1 in 4 Enrollees,” KFF News, March 2, 2023. <https://www.kff.org/medicaid/press-release/as-states-prepare-to-resume-disenrollments-medicaid-chip-enrollment-will-reach-nearly-95-million-in-march-and-the-pandemic-era-enrollment-growth-of-23-million-accounts-for-1-in-4-enrollees>

declarations expire and states can resume disenrolling people who do not qualify.² However, the Institute acknowledges that “almost all” are eligible for state-supported exchanges, employer-sponsored health insurance, or Medicaid itself through redetermination. As COVID-era stimulus dollars dry up and hospitals scramble to balance their books, states must clean up their rolls to ensure that those who no longer qualify for Medicaid move to alternative health insurance options.

To provide care to those who truly need it and keep insurance premiums affordable for businesses and families who pay for private health insurance, states must stop paying for people who do not qualify for Medicaid because they earn too much money, live in another state, or are deceased. Bloated Medicaid rolls are unfair

to the truly needy, who must wait longer for care. It’s also unfair to the doctors who must care for patients through a Medicaid repayment system that reimburses them at or below the cost of care. It’s also unfair to taxpayers who end up footing the bill.

States are responsible for determining who is eligible for federal Medicaid and routing that care through the agencies, hospitals, and complex repayment systems that entangle patients and doctors in paperwork and delays. Unfortunately, there is little incentive for states to reject federal dollars to pay for the enhanced federal Medicaid match. This has divided the country among states that are working hard to disenroll and those that are not.

\$80.6 billion
was improperly spent in 2022

\$98 billion
was improperly spent in 2021

Iowa serves as a good example for how states can approach Medicaid disenrollment. In 2023, Iowa stopped paying for ineligible Medicaid enrollees. During the height of the pandemic, nearly 900,000 Iowans were enrolled in Medicaid. However, Iowa reported catching only 287 cases of improper payments the year before redeterminations began. That tiny number is the tip of the iceberg, with the vast majority of wasted dollars going to insurance companies to pay for Medicaid policies for people

who do not qualify. In January 2023, more than 90 million Americans were enrolled in Medicaid. According to CMS data, \$80.6 billion was improperly spent in 2022, and a staggering \$98 billion in Medicaid funds was misspent in 2021. The vast majority of these improper payments (66.4 percent for Medicaid) were for ineligible recipients.³

Iowa now seeks to retrieve these dollars thanks to reform of the state’s eligibility determination process. Eligibility determination involves verifying who someone is and constructing a clear picture of their financial need. For people who have unstable housing or may not routinely use a bank, this can be so burdensome that states may simply deem it too difficult and focus on other areas of program integrity. Iowa, by contrast, “requires that prior to the HHS awarding public assistance benefits to an applicant, the applicant shall complete, through a variety of available methods, a computerized identity authentication process to confirm the identity of the applicant through [a] knowledge-based questionnaire consisting of financial and

2 Buettgens, Green, “What Will Happen to Unprecedented High Medicaid Enrollment after the Public Health Emergency?,” Urban Institute, September 2021, https://www.urban.org/sites/default/files/publication/104785/what-will-happen-to-unprecedented-high-medicare-enrollment-after-the-public-health-emergency_0.pdf

3 “2020 Medicaid & CHIP Supplemental Improper Payment Data.” Centers for Medicare and Medicaid Services, November 2020, <https://www.cms.gov/files/document/2020-medicare-chip-supplemental-improper-payment-data.pdf>

personal questions ... tailored to assist persons without a bank account or those who have poor access to financial and banking services.”⁴

Beginning in 2026, it is assumed that 8,000 Iowa Medicaid enrollees will lose eligibility throughout the eligibility redetermination due to discrepancies.⁵ Iowa partners with a private vendor to help administer sections of the legislation dealing with enrollee outreach. The price of the vendor contract is assumed to be \$500,000 plus a 10 percent contingency payment based on total savings.

Using vendors to help locate vulnerable enrollees and manage their health care makes sense. Managed care providers should embrace this concept and work with states to integrate this as part of their charge. States should look for ways to communicate meaningfully with Medicaid enrollees to help improve their overall care and determine their eligibility for scarce resources. As unemployment increases, so does the size and cost of Medicaid. Troublesome clouds on the economic

horizon may give state legislators little choice but to stop paying for the health care of people who don't qualify for it. For the sake of all the groups named above, states should reform their Medicaid eligibility systems now.

Recommendations for states to tackle Medicaid corruption and fraud:

- **Increase the pace and frequency of regular eligibility redeterminations for public programs and measure their progress.**
- **Partner with private industry to capture misspent dollars.**
- **Prevent waste by developing upstream application procedures to stop ineligible enrollment and payments.**

4 An act relating to public assistance program oversight, 2023, Iowa Senate File 494

5 “PERM Error Rate Findings and Reports,” Centers for Medicare and Medicaid Services, <https://www.cms.gov/data-research/monitoring-programs/improper-payment-measurement-programs/payment-error-rate-measurement-perm/perm-error-rate-findings-and-reports>

2 INCREASE HEALTH CARE PRICE TRANSPARENCY



A 2023 study by PatientRightsAdvocate.org (PRA) found that a patient could be charged 10 times more than a fellow patient in the same hospital for the same procedure, and more than 30 times as much across hospital systems. Patients should be able to find the price of their care for common procedures to anticipate costs and compare prices. New federal and state efforts aim to increase transparency and bring down the cost of care through competition.

Executive order 13877, signed by President Trump in 2019, was designed to “increase the transparency of health care price and quality information on negotiated rates and for common or shoppable items and services.” This directed hospitals to post the prices for commonly accessed services in an easily readable format and provide patients with access to a machine-readable, comprehensive list of all charges. Hospitals can be fined if they do not comply.

In 2022, Colorado passed legislation to do just that. HB22 limits the ability of hospitals to collect medical debt if they are not in compliance with federal price transparency laws.

In the 2023-2024 session, Ohio introduced similar

legislation. House Bill 49 would codify federal price transparency laws at the state level and provide additional sanctions if hospitals do not conform. If hospitals don’t properly post their pricing, the bill “prohibits hospitals from referring, assigning or selling medical debt to debt collectors. It prohibits hospitals from accessing the state court system to obtain judgment for an outstanding medical debt. It prohibits hospitals from filing negative credit reports against patients for outstanding medical bills.”

“Patients should be able to find the price of their care for common procedures to anticipate costs and compare prices.”

Colorado and Ohio are likely responding at least in part to complaints from constituents that their medical bills are causing financial stress and bankruptcy. According to a 2022 report from the Consumer Financial Protection Bureau, Americans owed \$88 billion in outstanding medical

debt, accounting for 58 percent of all third-party debt collection.⁶ Medical debt contributes to most personal bankruptcies, according to a three-year study of the post-Obamacare pre-pandemic years (2016 to 2019).

Hospital debt disproportionately affects low- and middle-income earners, who are less likely to have health insurance. A study published in *The Wall Street Journal* found that 21 percent of hospitals

6 “Medical Debt Burden in the United States,” Consumer Financial Protection Bureau, February 2022, https://files.consumerfinance.gov/f/documents/cfpb_medical-debt-burden-in-the-united-states_report_2022-03.pdf

billed cash-paying patients at the highest rate for the majority of services when compared to bills paid through third-party insurance.⁷

Rapid changes in hospital networks and affiliations have caused skyrocketing debt through “surprise billing,” which causes patients to receive out-of-network bills. For example, a patient may undergo surgery in an in-network facility, but unknowingly be treated by an out-of-network anesthesiologist. The federal No Surprises Act has responded to this effort, and several states are proposing additional protections against surprise billing.⁸

Many hospitals are still not in compliance with price posting since the federal transparency law took effect. Some claim that the technical difficulties of sharing costs, pricing complexity, and the history of not sharing patient and plan-specific pricing arrangements that have been traditionally regarded as “trade secrets” makes it nearly impossible for them to comply.

The Center for Medicare and Medicaid Services (CMS) found that as of November 2022, only 27 percent of hospitals were complying with the new posting mandates. CMS then began issuing correction letters and assessing fines for noncompliance. CMS also notes that almost all flagged hospitals have corrected the deficiencies. Some hospitals have, however, begun to suffer stiff penalties and public disclosure of fines. CMS

leaders now report that the second year of price transparency is going smoother, with 70 percent of hospitals in compliance.⁹

Bringing health care prices out of the dark and into the sunlight helps consumers. Policymakers should, however, consider the unintended consequences. The Mercatus Center’s “do no harm” proposal calls for balance and caution when capping or setting prices of drugs.

Reference-Based Pricing

Reference-based pricing (RBP) seeks to improve value in health care payment systems by setting a budget for consumers based on an external benchmark. Using RBP (also referred to as value-based purchasing) a payer (such as a private employer or state agency) will establish an upper payment limit based on set prices such as Medicare rates. Payers can set a budget for the consumer by agreeing to pay up to three times the Medicare rate. Often, payers use RBP to steer consumers to cheaper providers, or pay the difference if the patient decides the higher price is worth paying extra for. The goal is to cap prices by setting a reasonable budget for drugs, devices, and services by introducing market forces to bring down prices charged by outliers into line with other providers.

“The Center for Medicare and Medicaid Services (CMS) found that as of November 2022, only 27 percent of hospitals were complying with the new posting mandates.”

7 Evans, Matthews, McGinty, “Hospitals Often Charge Uninsured People the Highest Prices, New Data Show,” The Wall Street Journal, July 6, 2021, https://www.wsj.com/articles/hospitals-often-charge-uninsured-people-the-highest-prices-new-data-show-11625584448?mod=hp_lead_pos5

8 O’Brian, Hoadley, “States Act to Strengthen Surprise Billing Protections Even After Passage of No Surprises Act,” The Commonwealth Fund, March 16, 2023, <https://www.commonwealthfund.org/blog/2023/states-act-strengthen-surprise-billing-protections-even-after-passage-no-surprises-act>

9 Robert Graboyes and Jessica McBirney, “Price Transparency in Healthcare, Apply with Caution,” Mercatus Center, August 19, 2020, <https://www.mercatus.org/research/research-papers/price-transparency-healthcare-apply-caution>

States have more than a decade of experience in legislation aimed at improving value for state purchasing. It makes sense for state payers to evaluate providers by cost and quality. If a provider is high cost and low quality, it makes little sense to continue to send patients there.

An independent study recently found that Montana saved \$47.8 million from 2017 to 2019 using RBP.¹⁰ The reference-based pricing for Montana was calculated using a cap of 220 percent to 250 percent of Medicare prices to arrive at a budget for state-purchased services for employees and their families. Recent tweaks to that policy have provided flexibility to the sweeping plan that covered all services (as opposed to readily shoppable procedures such as knee replacements) to allow for even more flexibility.

Likewise, Oregon's 2017 RBP legislation capped enrollee payments to 200 percent of Medicare for in-network care and 185 percent for out-of-network care. In 2021, \$112.7 million was saved utilizing the cost containment method.¹¹

Most recently, in March 2024, Indiana enacted HB 1004, which requires the state to compare certain nonprofit facility pricing with a benchmark of 285

percent of Medicare rates and report back to a newly created health care cost oversight board.

“An independent study recently found that Montana saved \$47.8 million from 2017 to 2019 using reference-based pricing (RBP).”

In a 2018 study, the American Academy of Actuaries projected that as much as 28 percent of service costs could be saved through RBP.¹² The value of state experience in legislation enacted over the past decade highlights the need for policymakers to be intentional about goals and mindful of

rational market forces that occur in the years following enactment.

Recommendations for states to improve price transparency:

- **Work with hospitals to develop the most effective ways of enabling patients to compare prices and understand their bills.**
- **Prevent surprise billing by enacting state-specific legislation to protect patients from out of network charges.**
- **Institute value-based purchasing standards that reward quality and price.**

10 Steve Schramm and Zachery Aters, “Estimating the Impact of Reference-Based Hospital Pricing in the Montana State Employee Plan,” Optumas, April 6, 2021, <https://www.nashp.org/wp-content/uploads/2021/04/MT-Eval-Analysis-Final-4-2-2021.pdf>

11 Adney Rakotoniaina, “Oregon Saves Millions Using Reference-Based Pricing,” National Academy for State Health Policy, March 3, 2023, <https://nashp.org/oregon-saves-millions-using-reference-based-pricing/>

12 American Academy of Actuaries, “Estimating the Potential Health Care Savings of Reference Pricing,” November 2018, https://www.actuary.org/sites/default/files/files/publications/ReferencePricing_11.2018.pdf

3 ELIMINATE CERTIFICATE OF NEED LAWS



Social disparities in health care, such as the lack of access to modern care facilities within rural, poor communities became part of a broad civil rights agenda growing out of the 1964 Civil Rights Act. This very real problem and the public's willingness to do something about it grew into the social welfare and public health care entitlements that we know today. Policymakers believed that the government was best-suited to decide where to build hospitals, nursing homes, and even whether to allow certain pieces of expensive equipment such as imaging machines, to make things fairer for low-income people. To build these facilities, a certificate of need (CON) would have to be approved by a state-defined regulatory bureau.

Beginning in 1964 with New York and extending to nearly every state throughout the 1980s, legislatures began to restrict the licensing of new medical facilities in the hopes of improving access to affordable care by controlling where and when new facilities could be built. Despite the good intentions of those efforts, it soon became apparent that the certificate of need restrictions (like so many of the social welfare programs they were connected to) were doing more harm than good in terms of improving the lives of the people they were designed to help.

“If a small, rural nursing home wants to add an additional 12-room wing, it must seek state approval. This process can take years and is quite expensive.”

In 1987, federal mandates requiring CON were removed. Since then, states have begun to reform or repeal their CON laws, as many legislatures have determined that prohibiting construction, facility improvements, and technology purchases has not helped and may have harmed access to care.¹³

For example, if a small, rural nursing home wants to add an additional 12-room wing, it must seek state approval. This process can take years and is quite expensive. In many instances, applications for much-needed facilities and upgrades to existing care centers are rejected due to aggressive lobbying efforts by competitors that seek to maintain the status quo.

Rep. Mike Burns (R-SC), who represents rural, sparsely populated portions of Greenville County in the South Carolina House of Representatives, provides an enlightening example of how outdated CON laws have harmed his constituents. “We’ve got 350 or 400 square miles if you live up where we do and you get sick, you’re going to wait 45 minutes for an ambulance a lot of times,” Burns said, noting that an emergency room might be another 30 minutes away.

Fortunately for the people of Greenville County, South Carolina recently repealed the state’s

¹³ “Certificate of Need State Laws,” National Conference of State Legislatures, February 26, 2024, <https://www.ncsl.org/health/certificate-of-need-state-laws>

onerous CON laws. In 2023, South Carolina Gov. Henry McMaster signed Senate bill 164, the Certificate of Need Repeal, which eliminates “the requirement for most healthcare facilities to obtain a Certificate of Need (CON) from the Department of Health and Environmental Control before building a new facility, purchasing certain medical equipment or providing additional medical services.”

The COVID-19 pandemic confirmed the urgent need for CON reform. As the coronavirus took hold in early 2020, hospital beds filled quickly, and a top priority for every governor became finding more beds and ventilators to handle the coming wave of critically ill patients. A system that concentrated care into fewer, larger facilities had the unanticipated effect of rapidly spreading COVID-19 to the very people least able to survive it. In fact, during the throes of the crisis, 20 states quickly set aside certificate of need laws, and more followed suit.

Outright repeal of CON laws is beneficial for patients because it allows providers, not government bureaucrats, to determine whether to build new facilities or expand existing centers. Moreover, repealing CON is good for state budgets. Not long after CON laws were instituted, legislators began

to wonder whether the bureaucracies created to control the supply of care were making health care less accessible and more expensive. In a recent study of states that have repealed their CON laws, the Mercatus Center found that after five years, hospital charges were 5.5 percent lower than they would have been with CON laws in effect.¹⁴

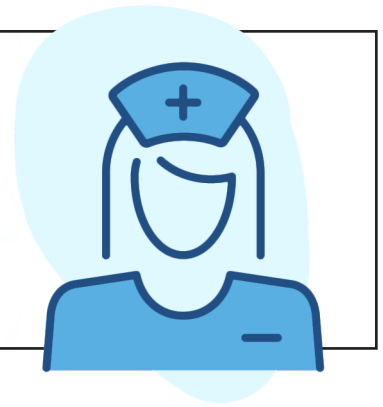
States abandoning 1970s Soviet-style health care facility moratoria are looking for ways to create less-concentrated care delivery models that focus on the best interests of the patient. Replacing CON laws with market-driven supply and demand will improve care and save money.

To allow for greater access to care where it is needed most, states should:

- **Scrutinize CON approval processes for all health care facilities in light of the overwhelming amount of data showing that they do more harm than good.**
- **Implement comprehensive CON reform to remove unnecessary barriers to care.**

¹⁴ Matthew Mitchell, “Do Certificate of Need Laws Limit Spending?,” Mercatus Center, September 2016, <https://www.mercatus.org/research/working-papers/do-certificate-need-laws-limit-spending>

4 STRENGTHEN THE PROVIDER-PATIENT RELATIONSHIP



Strengthening the doctor-patient relationship begins with honoring informed consent, the cornerstone of that relationship. As doctors come under attack by state attorneys general, licensing boards, and the courts for simply trying to take care of patients, physicians are increasingly being overruled and sometimes threatened for treating their patient with an FDA approved drug, or publicly espousing an opinion that some may deem “dangerous misinformation.”

California passed legislation in 2022 banning “misinformation” by physicians. Assembly Bill 2098 seeks to prevent unsanctioned speech by physicians through monitoring and sanctioning of “inappropriate” communications on social media platforms as well as with direct patient contact. According to the law, a doctor who questions the effectiveness of vaccines or suggests unapproved treatments could have his or her license revoked or suspended. The bill was aimed beyond the doctor-patient relationship to public speech generally on platforms like X and Instagram. After immediate and persistent challenges in court, the law was repealed within a year of passage.

Florida responded to this emerging threat by protecting the ability of doctors to prescribe FDA-approved medications as well as publicly challenging the effectiveness of treatments or

recommendations made by the government or anyone else. Senate Bill 1580 and Senate Bill 252 provide some of the strongest protections for both patients and doctors, primarily regarding out-of-control licensing boards.

Another good example of how to strengthen the sacred relationship between patients and providers is Ohio’s House Bill 73, which prevents pharmacies and hospitals from denying patients doctor-prescribed, FDA-approved medications for off-label treatments. During the COVID-19 pandemic, patients were prevented from receiving medications such as hydroxychloroquine for use in treating COVID-19. According

to the bill’s sponsor, “this bill will allow medical professionals to provide the best care possible for their patients.”

Some physicians have endured multiple anonymous complaints for simply questioning the effectiveness of treatments on social media.¹⁵ These complaints to the state boards of medical practice cost countless hours and dollars to defend the physician’s license to practice.

The federal Food and Drug Administration (FDA) isn’t the only group that is holding back medications people want or need. Sometimes insurance

“Strengthening the doctor-patient relationship begins with honoring informed consent, the cornerstone of that relationship.”

15 Harry Painter, “Families File Lawsuit Over Hospitals COVID-19 Treatment,” Heartland Daily News, February 26, 2024, <https://heartlanddailynews.com/2024/02/families-file-lawsuit-over-hospital-covid-19-treatment/>

companies prohibit patients from getting the drug their doctor prescribes because they want patients to try something cheaper (and perhaps less effective) first. Prior authorization (PA) has become increasingly common as insurance companies try to keep a lid on skyrocketing drug costs. PA requires that doctors receive permission from an insurance company before prescribing (typically more expensive) medication that may be the choice of the doctor and best for the patient.

Patients are often put through a trial of inferior or even unhelpful drugs while precious time ticks away. This forces doctors and staff to take valuable time to lobby for the appropriate medication through the convoluted prior authorization process.

Legislation to address prior authorization was introduced in 30 states in the 2023-2024 legislative session and passed in nine states and the District of Columbia.¹⁶ From red states like Tennessee to bright blue Massachusetts, many states have streamlined the process by allowing some providers to skip the prior authorization process altogether. “Gold card” legislation provides an exception to the PA process to providers who “would have been approved for not less than 90% of the prior authorization requests by the provider for the particular healthcare service.”¹⁷ This is a commonsense policy that prevents doctors from prescribing outrageously expensive medications while avoiding a great deal of aggravation for physicians and their staff and unnecessary suffering by patients who must endure the wrong medication in order to “earn” a move to

the right one. More states should follow suit.

Federal FDA reform aimed at speeding the approval process and improving access to new drugs will not come fast enough for many desperate patients. As reform works its way laboriously through the federal legislative quagmire, states can and should lead in reducing the harms of prior authorization.

Just as they did with Right to Try legislation, where

most states passed laws to allow emergency access to lifesaving drugs, states can lead the federal government by continuing to remove barriers between patients and the medications they need to cure or treat their suffering. Prior authorization reform puts patients first and allows doctors to put them on their recommended treatments without awaiting permission from bureaucrats.

As research and development of new drugs and treatments continues, advances will create possible cures beyond the budgets of states and private payers.

New exotic drug research in individualized medicine holds out

the hope of creating cures and therapies designed for a unique patient and disease. This research presents ethical dilemmas. Hepatitis C, when left untreated, can become a chronic infection that leads to a lifetime of health complications. A drug produced by Gilead called Sovaldi is currently the best chance Hepatitis C patients have of completely recovering from their infection. According to a 2014 study conducted by the Canadian Agency for Drugs and Technologies in Health, when taken over the course of 12 weeks, Sovaldi cures 90 percent of

“As reform works its way laboriously through the federal legislative quagmire, states can and should lead in reducing the harms of prior authorization. Just as they did with Right to Try legislation, where most states passed laws to allow emergency access to lifesaving drugs ...”

16 “Updated 2024 Prior Authorization State Law Chart,” American Medical Association, <https://fixpriorauth.org/sites/default/files/2024-02/Updated%202024%20Prior%20Authorization%20State%20Law%20Chart.pdf>

17 “Will Prescriber ‘Gold Cards’ Solve the Prior Authorization Problem?,” Accreditation Council for Medical Affairs, July 26, 2022, <https://www.priorauthtraining.org/prior-authorization-gold-cards/>

patients with Hepatitis C. The price tag on a full course of treatment is about \$84,000.¹⁸

Although the cost of a course of Sovaldi is high for both the individual and the system, when other factors are considered, this drug actually saves money over time. Many patients with chronic Hepatitis C undergo many expensive hospitalizations throughout their life and may experience liver cancer or liver failure. A liver transplant alone can cost \$300,000, and patients who have received organ transplants need a lifetime of treatment following their operation to ensure they do not reject the donated organ. That care puts additional strains and costs on the system.

Strengthening the provider-patient relationship begins with protecting informed consent and trusting medical professionals and patients to work together to make informed decisions.

States should:

- **Protect free speech of medical professionals to treat and promote robust debate.**
- **Reform prior-authorization mandates to stop forcing patients to endure treatments that don't work to earn the ability to get the one their doctor prescribed.**

18 "Sofosbuvir (Sovaldi): Sofosbuvir is Indicated for the Treatment of Chronic Hepatitis C Virus (CHC) Infection in Adult Patients With Compensated Liver Disease, Including Cirrhosis," Canadian Agency for Drugs and Technologies in Health, 2014, <https://www.ncbi.nlm.nih.gov/books/NBK253713/>

5 EASE ACCESS TO DIRECT PRIMARY CARE



Direct primary care (DPC) is a subscription-based model of health care that provides basic health care services such as examinations, tests, and routine care associated with office visits for primary care for a small monthly payment. Patients and care providers like the fact that preventative care and routine visits can be handled without the hassle of going through insurance companies and government bureaus for routine tests and office visits. DPC does not replace health insurance; members also have insurance for services not covered under the agreement, such as emergency and specialty care. Instead, DPC replaces many of the unnecessary burdens of payment for routine care. It is more like a gym club membership than an insurance plan.

For most people, DPC costs \$80 to \$150 per month. Patients pay less and enjoy longer office visits and less waiting for an appointment. A two-year study including 4,000 DPC patients found improved patient satisfaction and an overall reduction of 20 percent in medical spending, through better disease management. That translates into real savings for families.¹⁹

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per month.”**

DPC patients purchase separate health insurance for things like specialty care, catastrophic illness, emergency care, and prescriptions. Insurance plans to cover these items typically cost much less than soup-to-nuts coverage. The Affordable Care Act (ACA) mandates all Americans have a health insurance policy with a minimum benefit set defined as the bronze medal level. DPC

patients are willing to pay for both the cost of the DPC retainer and ACA-compliant insurance premiums because they have found the combined cost to be a better value than any single policy.

A DPC provider agrees to accept a fee for a variable amount of service and

is willing to treat a group of patients for a monthly rate instead of a negotiated rate with a third party. This arrangement is accepted in states that have determined this arrangement between provider and patient is not health insurance in need of regulatory control from the government and have passed laws that say so.

The legislation that states adopt to enact DPC does two things. First, the legislation defines in simple terms what DPC is. Second, it states this isn't insurance. That's it. The simplicity of the legislation

¹⁹ “New Primary Care Model Delivers 20 Percent Lower Overall Healthcare Costs, Increases Patient Satisfaction and Delivers Better Care,” PR Newswire, January 15, 2015, <https://www.prnewswire.com/news-releases/new-primary-care-model-delivers-20-percent-lower-overall-healthcare-costs-increases-patient-satisfaction-and-delivers-better-care-300021116.html>

makes it easy for lawmakers to understand and to pass. More states should do so.

Simply taking on unknown costs through DPC does not make a doctor a health insurance company. Insurance companies are highly regulated, and the Affordable Care Act is very prescriptive in its mandates. DPC providers contract directly with patients for care and eliminate insurance payments entirely for the care provided in the agreement between patients and their providers.

DPC is often confused with concierge care, even by advocates and policy experts. DPC does not take insurance, whereas concierge care can. Concierge care was generally developed to enable people to buy additional services not covered by insurance. This important difference highlights the need for states to carefully define DPC in statute.

Physicians are increasingly burdened with excessive charting within mandated electronic medical records, and they are saddled with a layer of bureaucracy tied to increasingly obstinate insurance companies that wish to dictate care instead of simply processing payments for it. Doctors now spend more than half their time dealing with tasks associated with the electronic medical record.²⁰ That's not why they went into medicine. Such is why many physicians are turning to DPC so that they are able to spend more time with patients.

Longer office visits (typically 30 to 60 minutes rather than the typical 10 to 15 minutes for doctors who accept insurance) translate to better care and more meaningful relationships between caregivers and patients. A DPC provider will typically have a panel of 450 patients instead of the 2,500 in a traditional practice.²¹

Physicians and patient advocates are right to ask their state legislators for more free space for DPC to grow. Patients want access to more-personalized, less-expensive care, and DPC delivers exactly that. Providers are showing greater acceptance of the model and are increasingly demanding it, as they would rather spend their working hours treating patients than fighting with insurance companies.

Direct primary care gives patients greater access to doctors' care and helps prevent illnesses from worsening and becoming more costly in terms of pain, loss of life, and financial problems. To expand this beneficial approach, states should:

- **Define direct primary care in simple terms.**
- **Clearly state that direct primary care is not insurance.**

20 Joanne Finnegan, "Primary care doctors spend more than 50% of workday on EHR tasks, American Medical Association study finds," Fierce Healthcare, September 13, 2017, <https://www.fiercehealthcare.com/practices/primary-care-doctors-spend-more-than-50-workday-ehr-tasks>

21 Leona Rajaei, "The average number of patients for a DPC practice," Elation Health, June 28, 2022, <https://www.elationhealth.com/resources/blogs/the-average-number-of-patients-for-a-dpc-practice>

6 EXPAND ACCESS TO TELEMEDICINE



The Federal Communications Commission (FCC) defines telemedicine as “telecommunications technologies to support the delivery of all kinds of medical, diagnostic and treatment-related services,” while telehealth is defined more broadly to include all remote services by non-prescribers such as social workers. Many professional organizations use the terms interchangeably.

Patients, providers, and hospitals benefitted from a steep learning curve created by the COVID-19 pandemic. During the lockdowns, President Donald Trump eased restrictions on telemedicine to allow virtual treatment as a temporary replacement for in-person office visits. After the lockdowns ended and in-person nonemergency visits resumed, patients were allowed to resume in-person consults for nonemergency services. However, many patients preferred the convenience of virtual office visits, while others wanted to stay virtual because they feared entering hospitals and clinics due to the risk of contracting the coronavirus. A new demand for telehealth services formed the

“Telehealth improves convenience, access to care, and ability to schedule appointments. As more states have enacted laws to allow telehealth consultations as a substitute for in-person office visits, patients have responded favorably.”

basis for state action allowing the newly relaxed rules to remain in place through changes to state law. In the years since the pandemic, almost every state has enacted changes to telehealth access and payment systems through the lens of lessons

learned during the pandemic. Model legislation developed through the Council of State Governments’ National Center for Interstate Compacts offers patients and providers a way to connect across state lines.

Improvements in mental health access through telehealth were one clear COVID-19 experiment that seemed to be a home run because it addressed skyrocketing mental health demands as well as vast areas of (particularly rural) geographic mental health provider shortages.²²

Telehealth improves convenience, access to care, and ability to schedule appointments. As more states have enacted laws to allow telehealth consultations as a substitute for in-person office visits, patients have responded favorably.²³

Telehealth is not intended as a full replacement

22 Mitchell Hartman, “Remote mental health treatment boomed during the pandemic. It’s still going strong,” Marketplace, May 9, 2023, <https://www.marketplace.org/2023/05/09/telehealth-for-mental-health-here-to-stay/>

23 JoAnn Volk, Madeline O’Brian, Christina Goe, “State Telemedicine Coverage Requirements Continue to Evolve,” The Commonwealth Fund, December 20, 2022, <https://www.commonwealthfund.org/blog/2022/state-telemedicine-coverage-requirements-continue-evolve>

for in-person doctor visits, even for counseling, as it is sometimes preferable to have a face-to-face consultation with a mental health provider. However, telehealth can improve providers' ability to prioritize office visits for patients who need to be seen while offering convenience and privacy for those who don't.

With those advantages in mind, several states have pursued reform through adoption of the Interstate Counselors Compact. The compact allows patients from member states to connect with providers via telehealth from all participating states, and vice versa. On April 22, 2022, Gov. Pete Ricketts signed legislation making Nebraska the 10th signatory of the compact, which allowed states to begin issuing multistate licenses for mental health counselors. Patients can now benefit from a greatly expanding pool of licensed counselors and subspecialists across all of the participating compact states. Practitioners benefit by expanding their potential to reach patients across all the compact states as well.

States benefit by expanding the availability of mental health services to underserved areas as well as offering an attractive benefit for providers. Military spouses with state-based licenses to practice often pay a heavy price when they move across state lines. The compact specifically provides military spouses with the ability to continue working through moves with their enlisted spouse.

Proponents of the compact point to several advantages of extending mental health counseling licenses to multiple states. Three main advantages fuel the rapid expansion of this compact:

1. License portability improves access to hard-to-reach patients in each state.
2. Growing demand for mental health services can be met through telehealth.
3. States mutually benefit in cooperatively addressing workforce shortages in mental health services.

Gains made during the pandemic era to allow patients remote access to more health professionals through telemedicine should be shared and codified through simple changes to state law. Thirty-three states now have telehealth parity reimbursement legislation enacted, as Congress debates the federal Connect for Health Act, which seeks to expand access to telehealth services and create parity for reimbursement of services through telehealth services.

States should make permanent the successful expansion of telehealth services and reimbursement parity that were used during the state and federal emergency declarations of the COVID-19 pandemic:

- **Codify state-specific regulatory changes made to allow expanded telemedicine services.**
- **Explore interstate compacts to expand the reach of providers across state lines, while allowing greater access for patients.**

7 EXPAND RIGHT TO TREAT



In 2018, President Trump signed national Right to Try legislation, which allows terminally ill and untreatable patients the right to try medicines that have not yet gained final approval from the FDA establishing their effectiveness but have passed Phase One clinical trials that test the safety of the drug on humans.

Now, states are taking the next step to allow more patients access to investigational treatments to alleviate their suffering and improve their quality of life. Whereas Right to Try applies only to patients who are likely to die from their disease, Right to Treat legislation offers hope to those who suffer from an incurable and untreatable condition that is not immediately fatal. These patients, who suffer profoundly from painful, crippling, but not life-threatening diseases are due as much compassion as those who have a fatal diagnosis.

Suffering patients deserve more access to investigational treatments. Nationwide, legislation is being considered to expand access to drugs and therapies that have not yet been completely approved by the FDA but could help patients who have no other options. Most states currently restrict use of investigational drugs to only those patients

who are near death.²⁴ Patients shouldn't have to wait for a winning lottery ticket to join a clinical trial. States should eliminate regulations that restrict access to investigational treatments for those who are living with untreatable, painful, and debilitating conditions. These patients should be able to try any

medication that has been proven to be safe, without the burden of demonstrating to the government that they are at death's door.

“Whereas Right to Try applies only to patients who are likely to die from their disease, Right to Treat legislation offers hope to those who suffer from an incurable and untreatable condition that is not immediately fatal.”

While the FDA seeks to approve drugs and therapies for patient populations in the thousands or millions, cutting-edge therapies and drugs are being created to treat a unique cancer in a single person. Individualized investigational treatment is “a drug, biological product, or device that is unique to and produced exclusively for use by an

individual patient based on the individual patient's own genetic profile.” Individualized investigational treatment includes but is not limited to individualized gene therapy, antisense oligonucleotides, and individualized neoantigen vaccines. The FDA cannot respond to this technology within its current approval process. However, states are addressing this problem with Right to Treat legislation.

The FDA's recommendations for informed consent

²⁴ Robin Opsahl, “Lawmakers rush over 100 bills through subcommittees ahead of ‘funnel’ deadline,” Iowa Capital Dispatch, March 1, 2023, <https://iowacapitaldispatch.com/2023/03/01/lawmakers-rush-over-100-bills-through-subcommittees-ahead-of-funnel-deadline/>

provide patient safety parameters that can be a starting point for states seeking to allow expanded use of investigational treatments.²⁵ The patient and doctor must agree and demonstrate that:

1. A list of FDA-approved treatments that are currently approved for the patient's condition do not properly treat the condition.
2. These treatments are unlikely to prolong the patient's life.
3. Both parties understand the range of outcomes expected using the investigational therapy (best and worst possible outcomes).

States should consider robust patient protections through informed consent, as well as protections for the prescriber against possible action regarding their medical license. Note that Right to Try legislation neither requires nor prevents insurance coverage of investigatory drugs. Right to Treat laws should follow that rule as well.

The marketplace has cautiously embraced Right to Try. A 2019 Government Accountability Office report found that 23 out of 29 drugmakers surveyed had information publicly available on their websites that said they “would consider individual requests

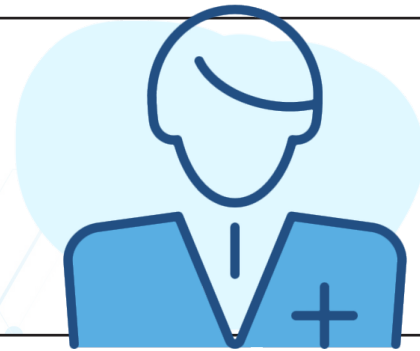
for access” from patients, though most said they would also require regulators to review the request. Since Right to Try was passed, the FDA's traditional Expanded Use program has more than doubled the total number of approved medications for use. We can expect similar results for Right to Treat. Patients who are suffering should never have their desperation drive inhumane or unethical trials that offer no more than false hope. However, it is also important to offer the same hope to suffering patients of nonlethal but debilitating conditions the same opportunities as those offered by Right to Try.

States should give hope to patients with nonfatal debilitating conditions by enacting Right to Treat legislation:

- **State legislatures should explore Right to Treat legislation that protects the doctor-patient relationship.**
- **Prohibit medical boards from restricting speech or use of off label prescriptions.**
- **Expand Right to Try legislation to include nonfatal but debilitating conditions.**

25 “Informed Consent, Guidance for IRBs, Clinical Investigators, and Sponsors,” U.S Food and Drug Administration, August 15, 2023, <https://www.fda.gov/regulatory-information/search-fda-guidance-documents/informed-consent>

8 ADDRESS THE DOCTOR SHORTAGE



Connecting doctors and their patients across state lines has become commonplace, thanks to the Interstate Medical Licensure Compact, which now includes 40 states, the District of Columbia, and Guam. The compact was designed to accommodate the explosive growth in telemedicine as well as interstate travel for both patients and providers. By allowing physicians to practice in multiple states, the compact has significantly increased access to doctors, particularly in rural areas. Even so, access-to-care gaps continue to widen. There are 7,200 federally designated professional shortage areas. Three in five of these are in rural areas. There are 13 physicians per 10,000 people in rural areas, versus 31 per 10,000 in urban America. As rural physicians increasingly retire, they are not being replaced, creating a widening gap of coverage for rural communities.²⁶

The COVID-19 pandemic added pressure to

this already brewing crisis. In the first year and a half of the pandemic, 18 percent of all medical professionals left the profession. In addition, a study published in the *Journal of Internal Medicine* in March 2023 found that 49.9 percent of the 40,301

health care workers surveyed met the criteria for burnout.²⁷

Nonphysician providers such as physician assistants (PAs) are now stepping in to fill those gaps. When enacted, the Interstate PA compact would allow PAs to step in and reach patients in their state and across state lines through telemedicine and in-person appointments.

Ohio is considering legislation that mirrors the Interstate Physician Compact by creating a program for multistate cooperation for licensure of PAs. Like the interstate counselors compact outlined above, the Interstate PA Compact would allow PAs to practice in other states that join the compact. In 2024, the necessary

“In rural areas, there are
**13 physicians per
10,000 people.**”

“In urban areas, there are
**31 physicians per
10,000 people.**”

26 Lucy Skinner, B.A., Douglas O. Staiger, Ph.D., David I. Auerbach, Ph.D., and Peter I. Buerhaus, Ph.D., R.N., “Implications of an Aging Rural Physician Workforce,” *The New England Journal of Medicine*, July 24, 2019, <https://www.nejm.org/doi/full/10.1056/NEJMp1900808>

27 Rotenstein, L.S., Brown, R., Sinsky, C. et al. “The Association of Work Overload with Burnout and Intent to Leave the Job Across the Healthcare Workforce During COVID-19,” 2023, *Journal of General Internal Medicine*, <https://doi.org/10.1007/s11606-023-08153-z>

seven states enacted the compact and thus began the process of operationalizing the compact, which will be enacted and officially “go live” after 12 to 18 months.

The compact effort is meant to improve licensure portability for PAs. All member states must pass enacting legislation, and the compact is administered through a commission of representatives from the member states.

The American Medical Association (AMA) urges that nonphysician providers work within a team approach with a physician lead. The AMA’s preference that PAs be required to work in a physician-led team is not a provision of the compact, but it could be included in specific state plans. The compact language leaves the details of management to each state.

Through both telemedicine and in-person care, PA interstate compacts will strengthen access to medical services and allow PAs to extend their license across state lines to work to address needs in other compact states as well.

In addition to improving patient access, the PA compact will provide meaningful workforce development opportunities. The outlook for PAs is extremely strong. With a median salary of \$121,000 and an unemployment rate of just 1.2 percent, PAs are among the highest-rated professions in the medical field. Growth is expected to remain strong, with an estimated increase of 28 percent over the next 10 years.²⁸

States should improve access to care by signing on to an Interstate Physician Assistant Compact.

28 “Physician Assistants,” U.S. Bureau of Labor Statistics, 2023, https://www.bls.gov/ooh/healthcare/physician-assistants.htm#TB_inline?height=325&width=325&inlineId=qf-outlook

9 SEEK FREEDOM FROM FEDERAL OVERREACH



When states expanded Medicaid under Obamacare, early critics compared the idea to adopting a grizzly bear cub as a pet. Many correctly predicted that private health insurance markets would collapse and expenditures would skyrocket through federalization of more than half of all health care expenditures.

As of mid-2024, all but 10 states have expanded their Medicaid population to include able-bodied working adults. The price states pay is significant. Financially, states must pay their portion of Medicaid payments through a federally controlled, top-down, Soviet-style system that offers below-cost reimbursement to doctors and a “choice” of only one plan for patients. A far bigger price is the loss of freedom to provide care to patients in ways that best fits their unique needs.

States don't have to wait for federal waivers or congressional action. State legislatures and governors can improve the quality and value of care by reintroducing competition and choice into the market. By strengthening the doctor-patient relationship and pushing decision making as close to the point of care as practicable, state

policymakers can lead national reform rather than follow it.

The 10 holdout states have an opportunity to lead the way to better health care by asserting their right and duty to wrest control away from federal regulators and empowering their counties and health systems to provide better options than expanded Medicaid.

Instead of caving to the significant political pressure to take the “free” federal money and expand Medicaid, holdout states should do the following:

- **Seek federal waivers to provide state-specific programs to give patients better care and more choices to opt out of one-size-fits-all Medicaid.**
- **Explore interstate agreements to join together to improve leverage in fighting back against federal overreach.**

BRIEF SUMMARY AND CONCLUDING REMARKS



This paper has covered much ground, making it appropriate to briefly summarize the main points.

As mentioned in the introduction, the odds of achieving overarching health care reform at the federal level seems unlikely given the constant gridlock of Congress. Therefore, the 2024 version of the American Health Care Plan has focused exclusively upon how states can enact commonsense health care policies under the bipartisan banner of lowering costs while simultaneously increasing access to high-quality health care.

This need not be a Herculean lift. Actually, several of the reform proposals outlined have been implemented to some degree in many states already. Moreover, they have been shown to accomplish the objectives that most Americans seek in making health care more affordable, more accessible, and less complex.

Further, like most public policy issues, there is no one-size-fits-all solution. Every state has unique circumstances and therefore should ascertain solutions that are best-suited to address the specific problems that plague their health care systems. With that being said, the proposed reforms summarized below may differ substantially in how they are implemented depending on the distinct characteristics and circumstances across the 50 states. However, the philosophical approach remains the same: these nine policies are free-market solutions that seek to reduce health care costs, increase access to high-quality health care, and redevelop a more doctor-patient oriented approach.

1. **Verify Medicaid Eligibility, Cut Fraud and Waste:** states should address Medicaid expansion, which has resulted in massive amounts of waste, fraud, and abuse. This can be done by increasing the pace and frequency of regular eligibility redeterminations for public programs and measure their progress, partnering with private industry to capture misspent dollars, and preventing waste by developing upstream application procedures to stop ineligible enrollment and payments.
2. **Increase Health Care Price Transparency:** states should increase health care price transparency through reference-based pricing, work with hospitals to develop the most effective ways of enabling patients to compare prices and understand their bills, prevent surprise billing by enacting state-specific legislation to protect patients from out-of-network charges, and institute value-based purchasing standards that reward quality and price.
3. **Eliminate Certificate of Need Laws:** states should repeal/reform outdated certificate of need laws, scrutinize CON approval processes for all health care facilities in light of the overwhelming amount of data showing that they do more harm than good, and implement comprehensive CON reform to remove unnecessary barriers to care.

4. **Strengthen the Provider-Patient Relationship:** states should strengthen the provider-patient relationship by protecting providers' free speech rights and reforming the antiquated system of prior-authorization mandates. Specifically, they should protect free speech of medical professionals to treat and promote robust debate and reform prior-authorization mandates to stop forcing patients to endure treatments that don't work to earn the ability to get the one their doctor prescribed
5. **Ease Access to Direct Primary Care:** states should lift restrictions on direct primary care agreements, a patient-friendly subscription-based model of health care. This can principally be achieved by defining direct primary care in simple terms and clearly stating that direct primary care is not insurance.
6. **Expand Access to Telemedicine:** states should expand access to telemedicine so patients can conveniently seek care and medical advice without the hassle of making an in-person appointment. Primarily, this can be done by codifying state-specific regulatory changes made to allow expanded telemedicine services and joining interstate compacts to expand the reach of providers across state lines, which would allow greater access to care for patients.
7. **Expand Right to Treat:** states should allow terminally ill patients to access medications that have passed Phase One FDA safety trials but are not available on the general market by passing Right to Treat legislation that protects the doctor-patient relationship, prohibit medical boards from restricting providers' freedom of speech or use of off label prescriptions, and increase the scope of Right to Try legislation to include nonfatal but debilitating conditions.
8. **Address the Doctor Shortage:** states should improve access to care by signing on to an Interstate Physician Assistant Compact.
9. **Seek Freedom from Federal Overreach:** states should apply for federal waivers to provide state-specific programs to give patients better care and more choices to opt out of one-size-fits-all Medicaid and consider joining interstate agreements to improve their leverage in fighting back against federal overreach.



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