## Healthcare

### Principles:

Sound healthcare policy should have the following characteristics:

- **Transparency** – The effectiveness of market-based systems depends on an abundance of information that is easily available and understood by consumers. If properly integrated into care, information can be as important to personal health and healthcare as a medical test, medication or treatment. With precise information, people can achieve better health outcomes at lower costs.
- **Patient-centered** – Putting economic purchasing power and decision-making in the hands of participants minimizes third-party reimbursements, which foster an environment of entitlement and unlimited demand for healthcare services.
- **Security for the sickest** – Any reform must work for the healthy as well as those who are sick or chronically ill.
- **Equitable tax treatment** – Tax policy should not favor healthcare purchased by employers over policies purchased by individuals, should not favor financing healthcare through insurance rather than out-of-pocket and should not favor high-income employees over low-income individuals and families.
- **Personal responsibility** – Healthcare reform should combine personal responsibility with financial involvement to incentivize program participation, reward compliance and support better personal health management. Incentives that reinforce a culture of health, well-being, self-help and shared responsibility can have a significant effect on outcomes.
- **Access for all** – Targeted solutions such as high-risk pools for those with pre-existing conditions and subsidies for low-income individuals are more efficient than top-down regulations.

### Recommendations:

Most of the healthcare issues brought forth in state legislation are likely to affect the development of a competitive free market in health insurance, payment and delivery of healthcare services. Without the presence of normal free-market forces, rather than natural cost and quality competition, each special interest seeks to use legislation and regulations to create an advantage and capture market share.

Three areas are crucial and should be the focus of any state-based health reform efforts.

1. Free-Market Competition
2. Consumer Empowerment
3. The Patient-Provider Relationship

### Free-Market Competition

All players in the healthcare system – insurers, hospitals, doctors and other providers – need to support, encourage and participate in a competitive free market. Currently, their incentives are not aligned toward this action.

**Consumers want price transparency.** Recent polling reflected that 88% of Americans favor an initiative by the government to mandate insurers and hospitals disclose the charges of their services, or negotiated rates.[1] In 2019, President Trump issued an executive order on healthcare pricing transparency. Its stated aim was to "distinguish between the charges that providers bill and the rates negotiated between payers and providers; give patients proper incentives to seek

[1] https://harvardharrispoll.com/wp-content/uploads/2019/05/HHP_May2019_RegisteredVoters_Topline.pdf

information about the price of healthcare services; and provide useful price comparisons for 'shoppable' services (common services offered by multiple providers through the market, which patients can research and compare before making informed choices based on price and quality)."[2] Hospitals, either by choice or inability, have notably struggled with providing price transparency. According to a Reuters article from 2018, "Healthcare Price Transparency in U.S. Not Improved in Recent Years," the percentage of hospitals that could provide complete pricing information was in the minority in 2011 (16%) and that percentage dropped by more than half by 2016, to 7%.[3]

**Pricing transparency alone is insufficient to correct the rising costs of healthcare**. Consumers tend to equate a higher list price with better quality. An additional problem is that once annual deductibles have been met, consumers are even less likely to price shop, given that the difference in price among providers is now negligible to them. Reference-based pricing (RBP) is one cost-containment strategy that should be considered as it pays doctors, hospitals, labs and clinics a market-adjusted percentage of an established benchmark. The reimbursement rate is typically 120-300% of Medicare pricing for a procedure, adjusted to account for the local market.[4] Reference-based pricing has thus far proven to be one tool that has helped employers mitigate the rising cost of providing health insurance to employees (in addition to reducing premiums and deductibles for plan beneficiaries), and should be considered to reduce costs within the State Health Benefit Plan.

**Insurers have not been subject to free-market forces.** Insurers have a valuable role in pooling risks and providing insurance coverage. In order to establish their position, however, the insurance industry has long heavily influenced state legislative and regulatory decisions. As third-party payers for medical services, insurers can distort normal free-market purchasing decisions. Contractual arrangements between providers and insurers have led to a loss of consumer trust. The hegemony has crowded out competitive health and information support services that offer alternatives to a "one-stop shop." Restrictions on integration or coordination of outside services combined with strict control over consumer care and treatment options reduce competition and limit choices.

**Competition has narrowed**. As national insurance companies and associations merged, many smaller regional companies have exited the market. Consumers are harmed when an insurer exits (even when premiums are predicted to fall) because restricted choices and the consequent reduction in product variety can have substantial effects on consumer welfare.[5] The most recent market data show the top three insurers in Georgia have a combined 76% market share (Anthem 37%, Kaiser Georgia 21%, UnitedHealthcare 18%).[6] The lack of competition is exacerbated on the provider side as health systems and physician practices in Metro Atlanta and Georgia continue to consolidate, and independent physician practices are acquired by hospitals and health systems.

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[2] https://www.whitehouse.gov/presidential-actions/executive-order-improving-price-quality-transparency-american-healthcare-put-patients-first/

[3] Study Reports: Healthcare Price Transparency Becoming Worse, Dr. Eric Bricker - Posted on June 7, 2018. Compass Navigating Healthcare Blog | Health Navigation. https://www.compassphs.com/blog/health-navigation/lack-price-transparency-harder-shop-healthcare/

[4] Employers Cut Health Plan Costs with Reference-Based Pricing. May 17, 2019. https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/reference-based-pricing-lowers-health-plan-costs.aspx

[5] 22 June 2017 Health, Organisation of Markets. Authors: Kate Ho (Columbia University), Robin S. Lee (Harvard University) Health insurance competition: effects on premiums, hospital rates, and welfare. http://microeconomicinsights.org/health-insurance-competition-effects-premiums-hospital-rates-welfare/

[6] Kaiser Family Foundation 2018. State Facts. Market Share and Enrollment of Largest Three Insurers-Large Group Market. https://www.kff.org/other/state-indicator/market-share-and-enrollment-of-largest-three-insurers-large-group-market/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

**Market entry for new insurers is difficult**. Potential entrants must contend with large capital requirements,[7] existing market control of providers and their current volume discount contracts. The Trump Administration has encouraged more competition in the health insurance industry. Additional capital requirements for health insurers are no way to achieve this goal. On top of raising costs for consumers, such regulations would make it much more difficult for new insurers to enter the market and possibly push some existing players out.[8] There are 23 active health maintenance organization (HMO) licenses in Georgia; as of September 2020, nine of these were home-based in Georgia.[9]

**"Most Favored Nation" – guaranteed lowest contractual prices for medical services – limits lower pricing.** (This is used by some private plans and Medicare and Federal Employees Health Benefits Act contracts). Through such contracts between providers and health plans:

> (1) A dominant health plan raises rivals' costs and/or abuses its monopsony power (a dominant buyer's ability to set terms); and
> (2) A cartel of providers imposes a most favored nation clause on members to facilitate cartel pricing. In addition to prohibiting the guarantee of the best rates, 10 states including Georgia prohibit a plan from requiring a participating provider to disclose the rates the provider negotiates with any other plan.[10]

**Providers do not work within a free market**

Providers often control healthcare services offered to consumers and exclude competitors through state-issued, Certificates of Need (CON). These CONs have discouraged price transparency by facilitating market dominance for a handful of health systems, limiting competition through local market mergers, reinforcing service line limitations, and strengthening territorial advantages.

**The merging of hospital systems and the purchasing of physician practices reduce competition, alternatives and choice**. Hospital prices in monopoly markets were more than 15% higher than prices in areas with four or more competitors. Hospitals with just one or two competitors charged between 5% and 6% more than hospitals with more than four rivals, said Edith Ramirez, former chairwoman of the Federal Trade Commission. Providers can then use their market dominance to negotiate higher claims reimbursement rates.[11]

A study by researchers from Harvard Medical School's Department of Health Care Policy determined that physician-hospital integration has led to higher prices with no evidence of offsetting reduction in the use of care. The findings, published in JAMA Internal Medicine, suggest that integration between physicians and hospitals strengthens their bargaining position with insurers, particularly for prices of outpatient care, but has not led to more efficient care.[12] In

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[7] 2018 National Association of Insurance Commissioners. STATUTORY MINIMUM CAPITAL AND SURPLUS REQUIREMENTS.
https://www.naic.org/documents/industry_ucaa_chart_min_capital_surplus.pdf
[8] Insight. September 6, 2018.FORTHCOMING GROUP CAPITAL REQUIREMENTS INAPPROPRIATE FOR U.S. HEALTH INSURERS. Thomas Wade.
https://www.americanactionforum.org/insight/forthcoming-group-capital-requirements-inappropriate-for-u-s-health-insurers/
[9] Office of Insurance and Safety Fire Commissioner. Georgia.
https://www.oci.ga.gov/Insurers/CompanySearch.aspx
[10] Issue Brief: Most Favored Nation Clauses. June 2015. http://sourceonhealthcare.org/issue-brief-most-favored-nation-clauses/
[11] How Hospital Merger and Acquisition Activity is Changing Healthcare.
https://revcycleintelligence.com/features/how-hospital-merger-and-acquisition-activity-is-changing-healthcare
[12] Unintended Costs of Health Care Integration. When hospitals acquire physician practices, prices go up. By Jake Miller, October 19, 2015. https://hms.harvard.edu/news/unintended-costs-health-care-integration

Georgia, hospitals charge private insurers on average nearly three times the rate of Medicare, the ninth highest in the country.[13]

**The continued dominance of fee-for-service reimbursements and defensive medicine increases unnecessary use of medical services**. Usually, defensive medicine raises the cost of healthcare for patients. Practicing defensive medicine is not good for patients or physicians. The adverse effects of defensive medicine are not limited to the increased cost of healthcare, but also affect the overall quality of the healthcare system.[14]

**Licensing restrictions can limit the use of alternative and ancillary medical professionals.** The generally stated purpose for licensing, and the primary justification, is to ensure quality in services offered to the public. Rarely considered by licensing agencies, however, are shortages of licensed personnel, underutilization of allied personnel and discrimination against minority-group members seeking licensure.[15] The state should consider making permanent the Governor's executive orders issued during the COVID-19 pandemic, which allowed for out-of-state physicians, nurses and other medical personnel in good standing from other states to practice in Georgia. Physicians in good standing from other states were previously granted the ability to practice telemedicine in Georgia in 2019.[16]

**Legal and regulatory restrictions should be consistent with improved technology and service expertise.** According to a Cisco global survey, 74% of patients are comfortable with easy access to healthcare services through technology instead of in-person interactions with providers.[17] An increase in telemedicine services offered by providers during the COVID-19 pandemic has also helped to ease familiarity among patients.

**Health-care consumers and patients do not act as they normally would in a free market.** Few patients terminate provider relationships when provided poor service, nor do most patients know how to shop for prices or seek quality reports for physicians and hospitals.

**Consumers do not effectively seek medical alternatives.** Despite generally understanding that you don't get what you pay for in healthcare, Americans still have limited awareness that prices vary in the first place. More than one in three surveyed (37%) believe doctors charge the same prices for the same services, while 32% believe hospitals charge the same prices for the same services.[18]

**Consumers do not adequately save for minor and/or preventive care that would encourage financial involvement in shopping for medical services.** Health Savings Accounts (HSAs) are plan designs that allow for consumer health savings to pay for medical expenses on a tax-advantaged basis. A leading HSA investment advisor notes however, that 16% of HSA accounts at the end of 2018 were unfunded. While this represents an improvement over 20% of unfunded accounts in 2017 and 24% in 2016, this reduction is largely attributed to an increase in account closures by consumers.[19]

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[13] Whaley, Christopher M., Brian Briscombe, Rose Kerber, Brenna O'Neill, and Aaron Kofner, Nationwide Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative. Santa Monica, CA: RAND Corporation, 2020. https://www.rand.org/pubs/research_reports/RR4394.html.

[14] Defensive Medicine: A Bane to Healthcare. Annual Medical Health Sciences Research. 2013 Apr-Jun; 3(2): 295–296. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3728884/

[15] Cato Institute Policy Analysis No. 79: Professional Licensure and Quality: The Evidence. https://object.cato.org/sites/cato.org/files/pubs/pdf/pa079.pdf

[16] http://www.legis.ga.gov/Legislation/en-US/display/20192020/SB/115

[17] 10 Pros and Cons of Telemedicine. May 25, 2018. https://evisit.com/resources/10-pros-and-cons-of-telemedicine/

[18] 2018 Public Agenda. How People Use Health Care Price Information in the United States. https://www.publicagenda.org/pages/still-searching

[19] https://www.devenir.com/wp-content/uploads/2018-Year-End-Devenir-HSA-Research-Report-Executive-Summary.pdf

**Georgia is not producing enough physicians to handle a growing and aging population.** Physician concierge services and other alternative models can offer competition and new consumer choices, but also further reduce access to primary care services for the general population. Multiple studies have shown that Georgia is 10,000 physicians short statewide, mostly concentrated in rural areas. In response, all five medical schools in Georgia have increased medical student enrollment. In 2012, Georgia funded increased residency slots, with hospitals matching dollar for dollar. This resulted in 400 additional residency slots, with 613 projected by 2025. Georgia also offers a state tax credit of $5,000 per year up to five years for physicians in rural areas, and additional student loan incentives for rural physicians through the Georgia Board for Physician Workforce.

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