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Common-sense Healthcare Reforms for Wisconsin

with overview at the state and federal level

By Daniel Sem and Scott Niederjohn

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A PREFACE TO

Common-sense Healthcare Reforms for Wisconsin

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To improve the healthcare that Wisconsinites receive, we need to grasp that, as with most goods and services, the surest way to enable people to get the greatest satisfaction at the most favorable price is via a free and transparent market.

And that the healthcare market in Wisconsin is far from free and transparent.

Here, scholars Daniel Sem and Scott Niederjohn lay out concrete steps that Wisconsin policymakers can take to change that, to enable medical professionals and the patients who need them to meet directly — reforms to what they term "the patient-provider interface." It means removing barriers to providing individualized and innovative care, while letting patients choose services and getting them the information they need to make decisions.

Sem and Niederjohn specifically address new, better options for buying healthcare, reforms Wisconsin can undertake to moderate drug prices and improve availability, ways to expand access to doctors, tools to let patients find better care at a better price and changes to ensure that enough providers will be available when Wisconsinites need them.

These reforms center on reducing the role and influence of third parties such as insurers and governments, and shifting power to patients and the providers they choose. Reforms need to happen at the federal level, too, but as the authors make clear, state policymakers have a great many tasks — and can accomplish great things now.

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Introduction and Background

In Wisconsin, as in the other 49 states, the cost of healthcare is a growing problem, and our healthcare delivery system is arguably at a breaking point. Healthcare costs nationally are the highest in the developed world, at 19.7% of gross domestic product.[1] As we outlined in a July 2022 report for the Badger Institute,[2] the underlying problem is uncontrolled cost of care, due to the lack of a functioning healthcare market. What we have instead is a dysfunctional market focused on sick-care rather than healthcare.[3] And increasingly, this market is vertically integrated (such as insurers buying the providers that they reimburse for),[4] horizontally integrated (such as large providers buying small physician groups, then merging with each other) and overregulated.[5]

In that report, "A Roadmap for Healthcare Reform in Wisconsin," we described the economics of healthcare delivery with a focus on Wisconsin and then charted a path forward for the state. *(Read the report at badgerinstitute.org/Mandate.)* Wisconsin can lead the nation in empowering patients as consumers, enabling them to seek care in a functioning market with transparent pricing. The goal is to provide the value-based care that the healthcare industry says it wants but in a more flexible way that empowers patients as consumers.

We turn here to Wisconsin healthcare policies and legislative priorities to guide policymakers and providers on this path forward. Solutions must be suitable for all — from wealthy to middle class to poor, and for both urban and rural populations. That is the goal.

Report Objective

The objective of this report is to provide information, resources and support to all parties, including policymakers, healthcare innovators, patients and providers. The move toward consumer-focused healthcare depends on enabling patients and providers so they can make their own healthcare decisions. Only then can market forces drive down cost and increase accessibility while maintaining or increasing quality.

The focus of our proposed reforms is on the direct interaction between patients and provid-

ers —what we call "the patient-provider interface." In free and transparent markets, assigning priority to the patient-provider interface would be expected to require less government involvement and regulation. However, an important caveat is that healthcare in America currently does not function with free and transparent markets because there is often "rent-seeking" behavior of large players. Rent-seeking is an economic term where, in this case, large companies or organizations use regulatory barriers to create anticompetitive advantages for themselves. It typically refers to lobbying for laws or regulations that benefit narrow corporate financial interests. Thus, deregulation without market reform is not advisable.

Direct Primary Care

Direct primary care (DPC) is healthcare obtained directly from a provider with cash rather than insurance. It is affordable and is distinct from more costly concierge medicine. It is typically less expensive, with monthly fees of $50 to $150, compared to the high copays and deductibles of using insurance.[6] DPC is provided without the intervention of insurance and without the bureaucracy found in our current medical system, which former American Medical Association president Barbara McAneny referred to as the "medical industrial complex."[7]

DPC focuses on the interface between patient and physician (or other provider), delivering care the way it was done many years ago, as preferred by patients. Physicians prefer this also, as they get to spend more time with patients. There's a reason that 65% of physicians say burnout is a serious problem,[8] due largely to the medical bureaucracy. The average patient load in a traditional practice is 2,000, whereas with DPC, a physician may manage 345 patients on average (although up to 800 is easily manageable).[9] The greater attention benefits both patient and provider.

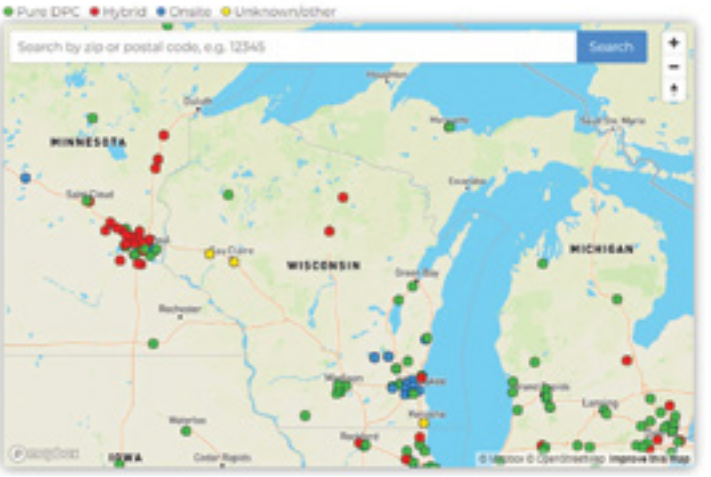
Given that DPC is better for providers and for patients, who might lose from a move toward more DPC? Large hospitals and insurance companies that benefit from the opaque reimbursement-driven system that has led to unrelenting increases in healthcare costs.

For a low cost, typically about $70 per month, patients get unlimited electronic access to the provider (e.g., physician) along with expanded in-person time and care. So, for less than the cost of a single emergency room visit ($1,500 in Wisconsin[10]), patients get personal and more comprehensive care for a year. DPC practice members also receive routine follow-up lab tests, prescriptions and even imaging for a nominal extra cost. This is more affordable, more accessible and better care for over 90% of the medical problems that people have. Given that DPC is better for providers and for patients, who might lose from a move toward more DPC? Large hospitals and insurance companies that benefit from the opaque reimbursement-driven system that has led to unrelenting increases in healthcare costs in a system that is anything but a well-functioning market.

DPC is taking off across the country, with average annual growth of 36% per year.[11] It works better for many consumers than existing insurance-based care, including what is delivered through the Affordable Care Act (ACA). Even with subsidies, low-end ACA

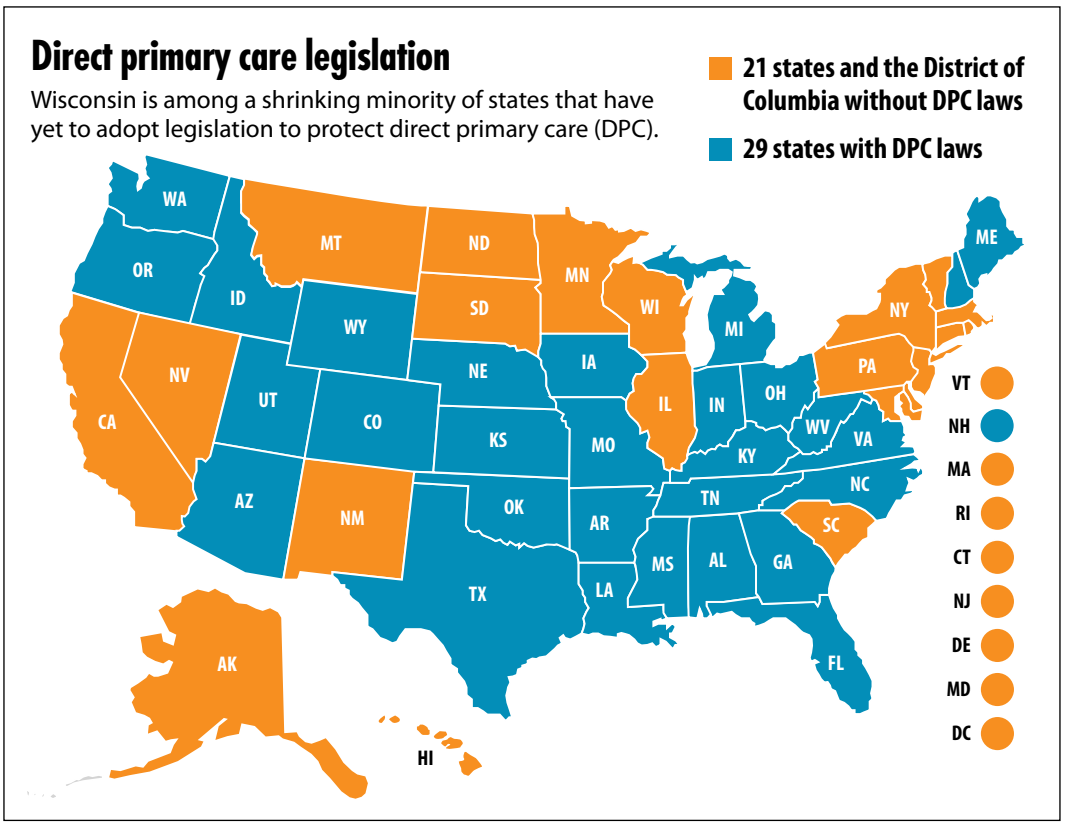
bronze plans can be unaffordable (in Wisconsin, premiums in 2021 were $328 per month, with the minimum deductible for a family of $2,800 and maximum out of pocket of $14,000[12]). It seems logical to let patients get affordable DPC care ($70 per month) at far less than the cost of deductibles (that is, $2,800) and copays with insurance — and then use insurance only for more expensive things. In other words, it makes more sense to use health insurance like we use other insurance and

Figure 1



This screen capture from DPC Frontier's mapper tool shows the location of direct primary care clinics in Wisconsin and neighboring states as of September 2022, based on data from DPC Frontier (https://mapper.dpcfrontier.com/).

Figure 2



Source: American Academy of Family Physicians

to pay out of pocket with cash, like for DPC, for routine medical problems.

This approach was favored by David Goldhill in his book "Catastrophic Care."[13] Goldhill followed up on his writing by launching Sesame, a national-level portal to DPC providers.[14] DPC is becoming available across the United States and soon will become a widely available healthcare option for most consumers. Even the president of the Wisconsin Medical Society, Dr. Wendy Molaska, has switched to dealing with her patients via DPC, and she loves it.[15] There are now more than 1,700 DPC practices in the U.S., including dozens in Wisconsin (Figure 1), up from 250 five years ago.[16] A recent validation of this trend in healthcare delivery is Amazon's acquisition of DPC provider One Medical for $3.9 billion.[17] This continues a wave of market enthusiasm for DPC such as the $340 million investment in growing Everside Health.[18]

The insurance industry potentially has much to gain by preventing DPC and the empowerment of the patient-physician interface that delivers better care more efficiently without insurance.

So why would DPC need to be protected with legislation in Wisconsin? Simply stated, as in other states, legislation is needed to clarify that DPC is not insurance. According to the American Academy of Family Physicians, 29 states already have adopted this kind of DPC legislation[19] (Figure 2). The objective is to ensure that doctors can continue to provide care this way and not be blocked by the insurance industry. The risk is that DPC may be characterized as insurance and, therefore, become subject to insurance-like regulation and be restricted in its use. The insurance industry potentially has much to gain by preventing DPC and the resulting empowerment of the patient-physician interface that delivers better care more efficiently without insurance.

The Wisconsin legislation that was introduced in early 2022, SB 889,[20] contains the major elements of model legislation put forth by the DPC Coalition,[21] a nonprofit focused on research and sharing information about DPC. Such legislation, passed in many other states, is needed in Wisconsin to protect DPC providers from the regulatory constraints of the insurance industry. SB 889 did not advance.

Recommendation: Legislation to protect DPC is essential to achieving more affordable and accessible healthcare in Wisconsin. It merely needs to state that *DPC is not insurance.* This should be a priority.

Drug Prices: White Bagging

Drug prices are another serious concern of healthcare consumers. The most expensive drugs, those used to treat cancer and some chronic illnesses, carry an average price tag as high as $1 million per year.[22] The reason is complicated, which includes the expense of developing the drugs as well as expenses associated with market dysfunctions. Some studies have shown that 80% of hospitals may charge over 200% of their acquisition cost for these drugs.[23] For this reason, the insurance industry is proposing a cost-containment process called "white bagging."

White bagging requires direct delivery of drugs from preselected, negotiated compounding pharmacies to providers (for example, hospitals).[24] "Brown bagging," by contrast, calls for delivery directly to the patient. Some groups — including Wisconsin Manufacturers & Commerce (WMC), the state's chamber of commerce — argue that white bagging would decrease drug costs.[25] Others, notably physicians and pharmacists, argue that white bagging severely limits their flexibility in delivering drugs to patients.[26]

In Texas, anti-steering legislation (HB 1919[27]) was passed to block the anticompetitive practice of pharmacy benefit managers (PBMs) to vertically integrate to control where drugs come from (especially if the pharmacy is owned by the PBM).[28] The true cost impact of white bagging is unclear, even as insurers look to mandate white bagging in some cases. In Wisconsin, a bipartisan group of legislators in 2022 introduced AB 718/SB 753,[29] which would ban mandatory white bagging by insurance companies.

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Recommendation: Since cost savings are uncertain, giving insurers absolute power to require white bagging — which closes off the possibility in a more robust direct care market of a doctor and patient choosing a drug supplier that they judge best — may not be worth it. However, small companies with fewer employees that self-insure need mechanisms to control costs; a rare but expensive drug for an employee could bankrupt the company if there is no upper limit on what they must pay out from their plan. Thus, the bipartisan bill that was introduced in Wisconsin addressed real concerns but should have taken into account other interests, such as those of self-insured small companies that need to control costs, sometimes effectively done through white bagging. Lawmakers should do more to address this concern of those small businesses, which could break under the strain of healthcare costs.

Drug Prices: Pharmacy Benefit Managers

Much has been written about the pricing behavior of pharmacy benefit managers (PBMs), including notably by Antonio Ciaccia[30]and his 46brooklyn project.[31] PBMs serve as middlemen between pharmaceutical companies and pharmacies. While they serve a useful purpose in the drug supply chain, they sometimes take a disproportionate share of drug profits via "spread pricing" (pricing arbitrage). Recent abuses uncovered by Ciaccia and others have led to proposed drug transparency rules,[32] initially introduced under the Trump administration. More recently, a bipartisan bill was introduced by U.S. Sens. Charles Grassley (R-Iowa) and Maria Cantwell (D-Wash.), the Pharmacy Benefit Manager Transparency Act of 2022,[33] to address the problem of PBMs that participate in spread pricing.

Under this practice, PBMs charge health plans and payers more for a prescription drug than the amount they reimburse to the pharmacy. They then simply pocket the difference, which is known as the spread. Many states have adopted legislation limiting spread pricing

by requiring disclosure of spreads. In Wisconsin, Gov. Tony Evers in 2021 signed into law Act 9,[34] which goes beyond PBM price transparency to include price controls.

Recommendation: While legislation to force price transparency by PBMs in an inherently opaque and anticompetitive market, thereby mitigating spread pricing, is a positive development, forced price controls are always questionable if a goal is well-functioning markets. We are in favor of price transparency mandates, which should be used as a tool to stop spread pricing. However, we oppose outright price controls, which would introduce market dysfunctions with unintended consequences. Lawmakers should consider modifying statutory language resulting from Act 9 in a way that retains price transparency elements while eliminating price controls.

Drug Prices: Price Controls

It is tempting but potentially counterproductive to address the high cost of drugs with price controls. Price controls stand in opposition to market-based approaches, which rely on drug prices to motivate the development of new and better branded drugs, especially for untreated or poorly treated conditions (development that now costs an estimated $2.6 billion per new drug[35]). Thanks to the pricing power granted by patents, the pharmaceutical innovator recoups its research and development (R&D) expenses by charging a price for branded drugs that far exceeds bare manufacturing costs. In contrast, manufacturing cost is the price-determining factor for generic drugs.

The high pricing of branded drugs stems from the monopoly power granted by patents. To some extent, this was a central and important concept of our country's founders. Patents are in the U.S. Constitution (Article 1, Section 8, Clause 8) and exist to foster innovation such as drug development. Like many tools, patents are mostly good but sometimes are abused. Price controls usurp the intended effect of patents and run the risk of hindering innovation because they can prevent companies from recovering their R&D expenses.

Furthermore, countries outside the U.S. have price controls, which typically means their consumers pay less than U.S. consumers for the same drug, often discovered and made in the U.S. In this sense, the domestic consumer is financing drug development for the rest of the world, which seems unjust. This pricing pattern also motivates U.S. patients to purchase drugs from Canada, which has price controls.

Policy efforts to address this price disparity between the U.S. and other countries have been unsuccessful. Under the Trump administration, the Centers for Medicare & Medicaid Services (CMS) issued an emergency rule[36] to attempt to cap drug prices at the lowest price charged in a pool of 16 countries (i.e., the Most Favored Nation Model), which themselves have price controls. Federal courts blocked the rule, holding that the CMS did not follow proper rulemaking procedures. Later, efforts to address price disparity generated some support in the Biden administration, although the proposed rule was withdrawn by the CMS under President Joe Biden.[37]

The concept of drug price controls reappeared in a different form in the Build Back Better

Act, which has since transformed into the Inflation Reduction Act, passed in August 2022. While not setting price controls per se, it allows the government to negotiate prices for certain drugs under Medicare Part D.[38] This would apply to 10 Part D drugs in 2026, 15 Part D drugs in 2027, 15 Part B and Part D drugs in 2028, and 20 Part B and Part D drugs in 2029 and later years. It would impose a $2,000 out-of-pocket spending cap for drugs. Some impact (estimated at 10% to 15%) on pharmaceutical company revenue is expected, with potential modest impact on new drug development predicted but not as significant as the price referencing that was proposed under the Trump administration's Most Favored Nation executive order.[39]

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Recommendation: Outright price controls are a questionable strategy that runs counter to market principles and could disincentivize new drug development. Allowing the government (that is, Medicare) to negotiate prices in some limited cases may be reasonable. But the implementation of this new federal legislation may be very similar to a price control, which would have unintended negative consequences on pharmaceutical R&D efforts and perhaps limit access to desirable drugs where prices have not been "negotiated." A longer-term and more strategically formulated solution is needed.

Drug Access, Regulations and Right to Try

It takes on average 10 years and $2.6 billion to develop a new drug. Consider patients who have a cancer that is expected to be lethal within six months. Shouldn't they be allowed to try an unapproved drug? If there are no other options, perhaps the risk-benefit ratio justifies their use of an experimental drug if they fully understand and accept the risk. Or what if a treatment is being developed for only a small number of patients (or even just one, as in personalized medicine, called N=1 trials)? The cost of drug development for such rare diseases is prohibitive, suggesting that reduced regulation for drugs to treat a very small number of patients is warranted. Recently adopted legislation addresses these two situations.

Right to Try

Drugs ordinarily cannot be sold until they are approved by the U.S. Food and Drug Administration (FDA), based on clinical trials that establish safety and efficacy. With these trials requiring on average 10 years and thousands of patients (with some modest simplifications for rare diseases), patients with a terminal illness may see little hope for new treatments in a useful timeframe. This long regulatory approval process recently has been waived or simplified for terminal patients who are fully informed and consent to the risks. Due to efforts led by the Goldwater Institute, 40 states have passed Right to Try laws.[40] Wisconsin's Right to Try Act was signed by Gov. Scott Walker in March 2018.[41] The federal Right to Try Act became law in May 2018.[42]

Right to Try 2.0

In Arizona, Gov. Doug Ducey signed into law the Goldwater Institute's Right to Try for

Individualized Treatments (Right to Try 2.0; SB 1163) in April 2022.[43] The legislation, which had bipartisan support, enables faster adoption of personalized treatments based on a patient's own genetic makeup (sometimes called personalized medicine, precision medicine or N=1 medicine). There is no need for lengthy clinical trials that simply are not possible in these single-patient cases and for very rare diseases. At present, Wisconsin has no such legislation.

Recommendation: Right to Try 2.0, a logical extension to Right to Try, would allow flexibility to try experimental medicines in situations where there are too few patients to justify full clinical trials such as in precision or personalized medicine. A safe and rational implementation of Right to Try 2.0 is a positive step that adjusts the FDA regulatory process to keep pace with innovations in genomics and personalized medicine.

Telehealth

One of the unexpected positive outcomes of COVID-19 was the broad use and acceptance of telehealth as an alternative to in-person healthcare. Still, various challenges make delivery of care via telehealth difficult. These challenges include medical licensure restrictions that prohibit delivery of care across state lines as well as privacy regulations that can restrict electronic communication between provider and patient such as texting or interactive computer sessions (as via Zoom).

These regulations were intended to protect patient privacy under the Health Insurance Portability and Accountability Act (HIPAA) but may have the effect of preventing the straightforward delivery of telehealth services. State policies are being updated to enable more ready and safe delivery of care through telehealth, as through Michigan's HB 4356 to facilitate electronically delivered exams and contact lens prescriptions.[44]

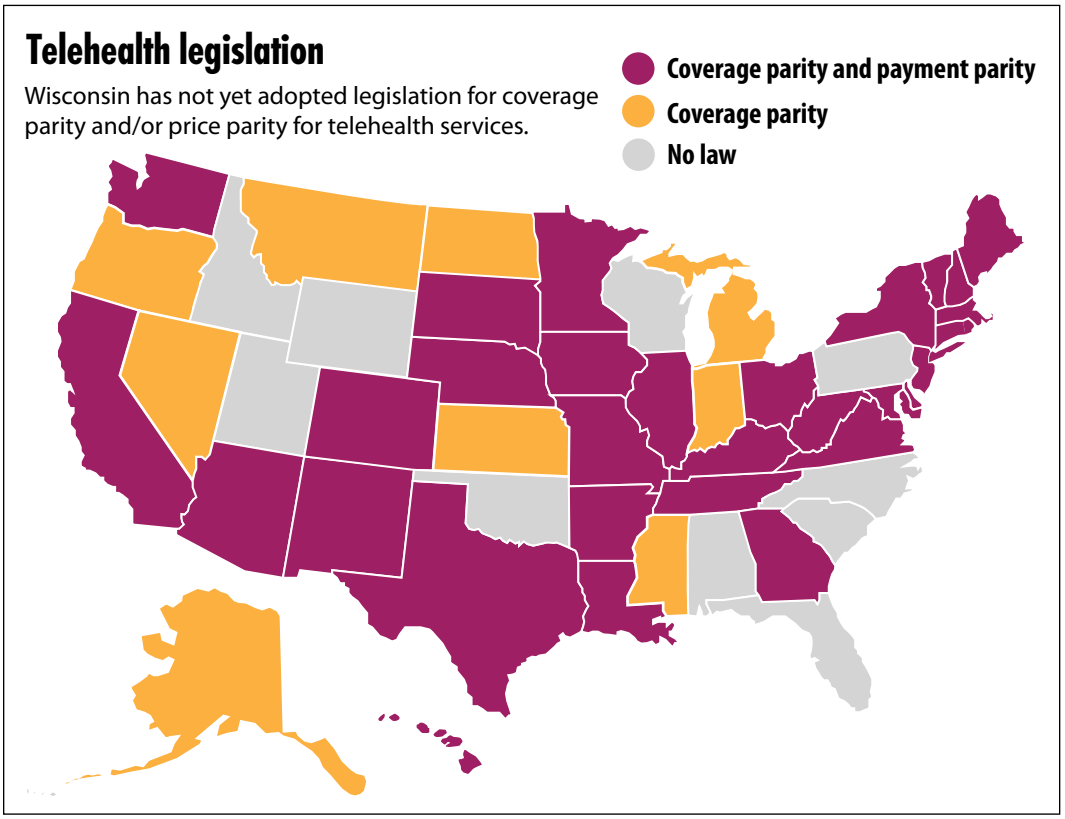
Telehealth may reduce cost of care delivery as long as the care received will be reimbursed or paid for at levels that reflect actual cost with telehealth's lower overhead.

Wisconsin is looking to make telehealth more accessible to Medicare patients.[45] More broadly, the state is also exploring legislation to make remote care more accessible, via AB 259 and SB 306, by requiring insurance companies to reimburse for care delivered via telehealth.[46]

Price Parity for Telehealth

Care via telehealth is often less expensive than in-person care, given that overhead costs are lower (no need for an expensive building). Laws in 43 states require insurers to reimburse telehealth,[47] a positive development toward empowering patients with choices. Within the context of these positive developments, so-called payment parity laws are being adopted in many states (Figure 3) to mandate equality of payments across telehealth and in-person visits. Such laws would effectively eliminate the cost saving to consumers. Why? These laws interfere with patient-oriented healthcare in free and open markets[48] and are not desirable for the stated goals of this report. If healthcare can be delivered more cost-effectively with lower overhead in some cases, those cost benefits should be realized.

Figure 3



Source: Mercatus (Nov. 30, 2021)

Recommendation: Healthcare services via telehealth is a positive development in that it introduces more flexibility for patients. It is part of a well-functioning healthcare market that may even reduce cost of care delivery — as long as the care received in this manner will be reimbursed by insurers or can be paid for with cash or health savings accounts at levels that reflect actual cost with telehealth's lower overhead, not artificially inflated prices (i.e., via price or payment parity). Anticompetitive forces will likely resist this. Wisconsin should consider coverage parity — mandating that insurers cover telehealth for a procedure or patient they already cover in-person — but not price or payment parity. Importantly, though, for the full benefits of telehealth to be realized across Wisconsin, something needs to be done urgently to provide more extensive broadband access in rural areas. Finally, medical licensure reforms are needed so that telehealth can be provided across state lines.

Flexible and Mobile Patient Medical Records

The full benefit of remote healthcare delivery in the hands of empowered patients can be achieved only if patients can give providers ready access to their medical records in a mobile and flexible way. Anticompetitive forces in the marketplace, supported by non-portable electronic medical records and sometimes overly restrictive HIPAA regulations, block this access. These same anticompetitive forces generate barriers to healthcare innovators

developing software tools and applications that empower patients to manage and control their care directly.

At present, it is not easy for patients to get their medical records from providers in a usable form, and the information is held in proprietary electronic health record (EHR) databases such as those from Epic or Cerner. Federal legislation, the ONC Patient Cures Act, is being advanced to implement standards for mobile medical records that will permit this flexibility,[49] perhaps in databases external to a single provider. This would allow patients to go to whichever providers they want and to move readily between providers.

Recommendation: Just as the federal government has a role in creating interstate highways, and at one time facilitating electrical and communication networks and grids (at least initially), it may have some role in assisting patients in the mobile storage, control and movement of their medical records so that patients can go where they want. But less intrusive than serving as that information backbone would be to at least play a role in setting standards so that commercial vendors for mobile medical records can emerge as options to the current oligopoly controlled largely by Epic and Cerner.[50] This is an area that the market likely will solve on its own eventually, but initial creation of standards may help healthcare innovators break into an already anticompetitive market that is also protected by network effects (i.e., market penetration requires upfront broad adoption by many users[51]). In short, standards created via the ONC Patient Cures Act are a potentially positive development, within certain boundaries.

Hospital Costs: Price Transparency

Patients (or their employers, who often pay for their health insurance) cannot shop for healthcare if they do not know the prices. Meanwhile, prices vary in an arbitrary way that is surprisingly not correlated with quality or outcomes, which would suggest shopping would be futile — unless, of course, patients and payers knew prices and quality or outcome metrics and could shop for the best value (quality weighed against price).[52] There is no properly functioning market yet to normalize prices in this manner.

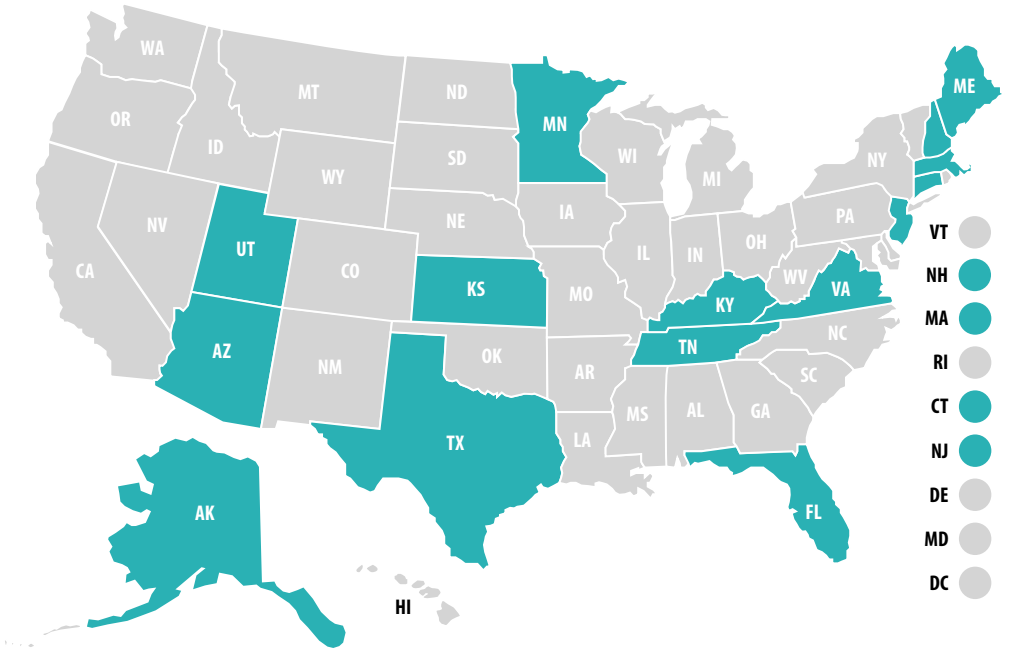
Yet when patients have to pay a deductible before insurance kicks in or go out of network, they are effectively uninsured and must pay these often-inflated prices that they never were informed of. This is when they encounter the so-called large surprise bills — based on these arbitrary and inflated prices that were never stated to them upfront. Prices often are inflated by providers that have unusually large overhead expenses such as costly buildings and administrative staff, for which they seek reimbursement when they bill insurance companies (or patients, before they hit their deductible).

In an attempt to address this problem based in market dysfunctions, federal regulations introduced by the CMS during the Trump administration[53] and continued in the Biden administration required hospitals to post prices in an easily accessible and understandable manner. The regulations went into effect on Jan. 1, 2021.[54] They were intended to prevent surprise bills to patients and to create a free and transparent market, conducive to competition.

Figure 4

Healthcare price transparency reforms

Wisconsin is not among the dozen-plus states that have implemented healthcare price transparency reforms.



- Requirement for price estimates by request – **ME, AK, MN, MA**
- Implemented shared savings programs for public employees – **ME, TX, VA, NH, UT, CT, FL, KS, KY**
- Requirement for shared savings programs for portion of commercial plans – **ME, VA, TN**
- State laws allowing price estimates for out-of-network procedures – **ME, TX, NJ, AZ**

Source: State Policy Network (June 16, 2022)

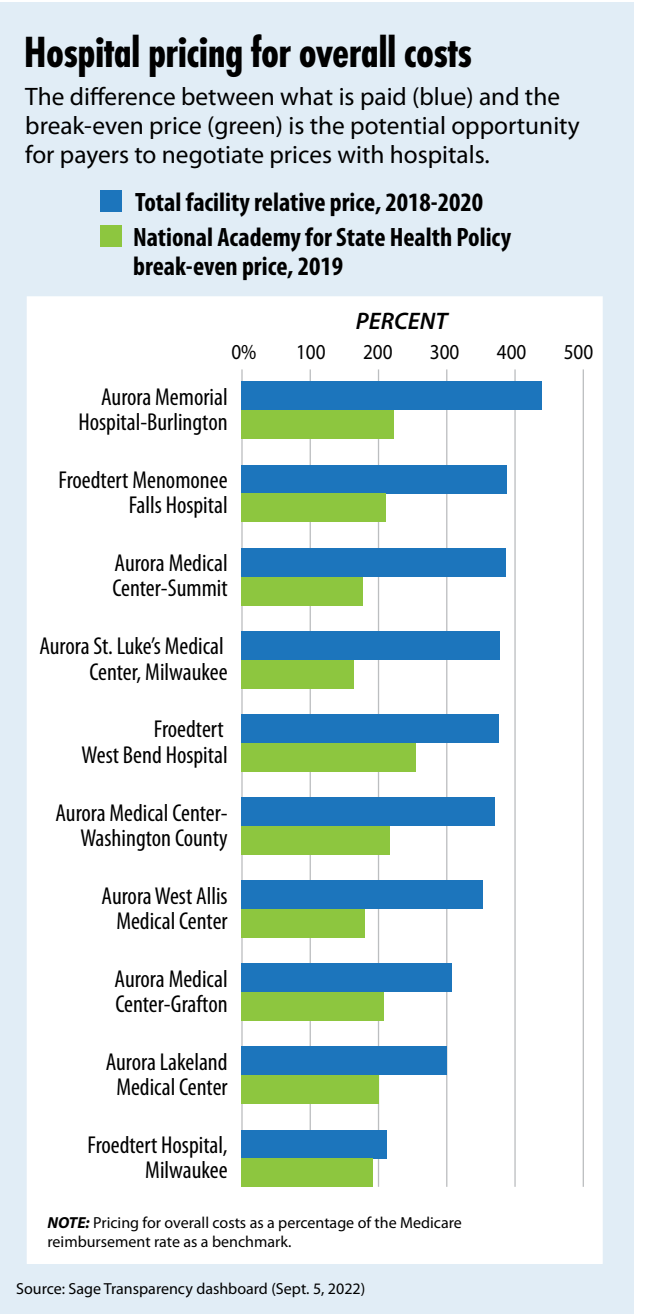
One year after that regulatory mandate, 85% of hospitals were not compliant, arguing that the rules are hard to comply with and opting instead to pay the penalty rather than tell patients the costs upfront.[55] As noted above, at present, market forces are not operating properly in healthcare, due to the opaque reimbursement-driven market. In this setting, the noncompetitive nature of the marketplace is reinforced by an already overregulated industry.

This is another example of the rent-seeking behavior of the medical industrial complex, which benefits financially from opaque markets. But things are changing slowly, as hospitals begin to post prices and patients will begin to demand to know upfront what things will cost. To facilitate this trend, a number of states have price transparency measures in place (Figure 4).[56] Notably, Texas SB 1137[57] codifies much of what was in the original Trump administration regulations and strengthens aspects of it, adding stacking penalties for noncompliance.

Once hospital price data is available, consumers (especially employers that self-insure) can shop, and hospitals will begin to be held accountable to the quality of services they provide at a given price — that is, value-based care. A software tool, Sage Transparency, was developed by the Employers' Forum of Indiana to mine for these prices for thousands of hospitals in the Employer Hospital Price Transparency Project.[58] It is the first such tool that brings together public and private data on hospital pricing and quality to finally enable a transparent hospital marketplace. It uses data from the RAND 4.0 Hospital Price Transparency Study.[59] The data represents what employers and insurers paid in 2018-2020.

Figures 5A-C show pricing data from select Wisconsin hospitals using the Sage tool. In this sampling of data, for example, employers can see that Froedtert Hospital in Milwaukee has — relatively speaking — reasonable prices (Figure 5A), and there is little room for negotiating a lower price because the price charged is close to their break-even level. Likewise, for imaging work (Figure 5B), HSHS St. Joseph's Hospital in Chippewa Falls is quite expensive, whereas ThedaCare at multiple locations (Neenah, Waupaca, Shawano, New London) is more affordable, by more than tenfold. For childbirth (Figure 5C), Aurora West Allis Medical Center charges 267% of the Medicare reimbursement rate (the benchmark that is used), while multiple nearby Ascension hospitals are in the 150% to 160% range — this is a 1.7-fold difference in price.

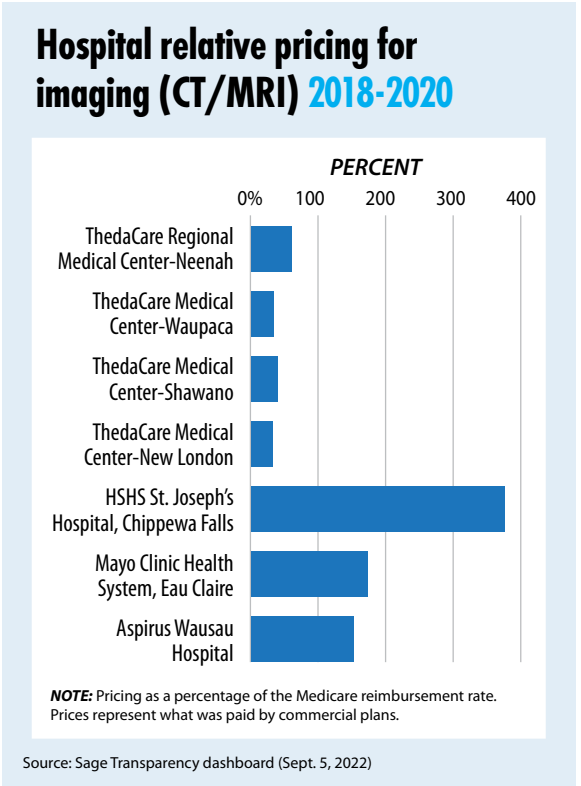
Figure 5A



Source: Sage Transparency dashboard (Sept. 5, 2022)

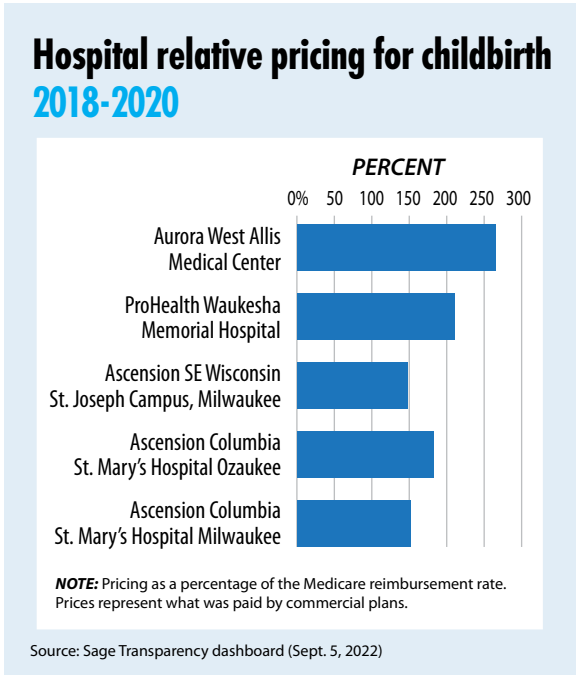
Would you be willing to pay 70% more for a car being sold on one side of town than an-

Figure 5B



Source: Sage Transparency dashboard (Sept. 5, 2022)

Figure 5C



Source: Sage Transparency dashboard (Sept. 5, 2022)

other? Only if, when you made the purchase, you didn't know the price because it was an opaque market. Price transparency is crucial for a functioning market, and now that it is mandated, employers, who are the primary payers for health insurance, can shop for value to get the most and best care for their dollars. But that's only if hospitals comply with price transparency mandates. Given that Wisconsin ranks fourth highest in the U.S. for hospital commercial prices (inpatient and outpatient plus professional services) relative to Medicare (Figure 6), we stand to gain from price transparency-led market forces that can rein in these high costs.

Recommendation: Wisconsin hospitals need to comply with price transparency regulations to create a transparent market that consumers — especially employers buying healthcare — can shop. This can be facilitated by price transparency legislation, such as SB 1137 passed in Texas. We also need more in-depth data on Wisconsin pricing, maintained by an objective party. Patients and payers need transparent and accurate information about prices and costs. In Wisconsin (besides Sage), one source of such data is the Wisconsin Health Information Organization (WHIO),[60] the state's statutory all-payer claims database. It is a neutral party in the middle of the healthcare systems' competing interests. Although hospitals may resist disclosure, supporting investment in objective public-private data like WHIO is a key to achieving an open, transparent and well-functioning healthcare marketplace.

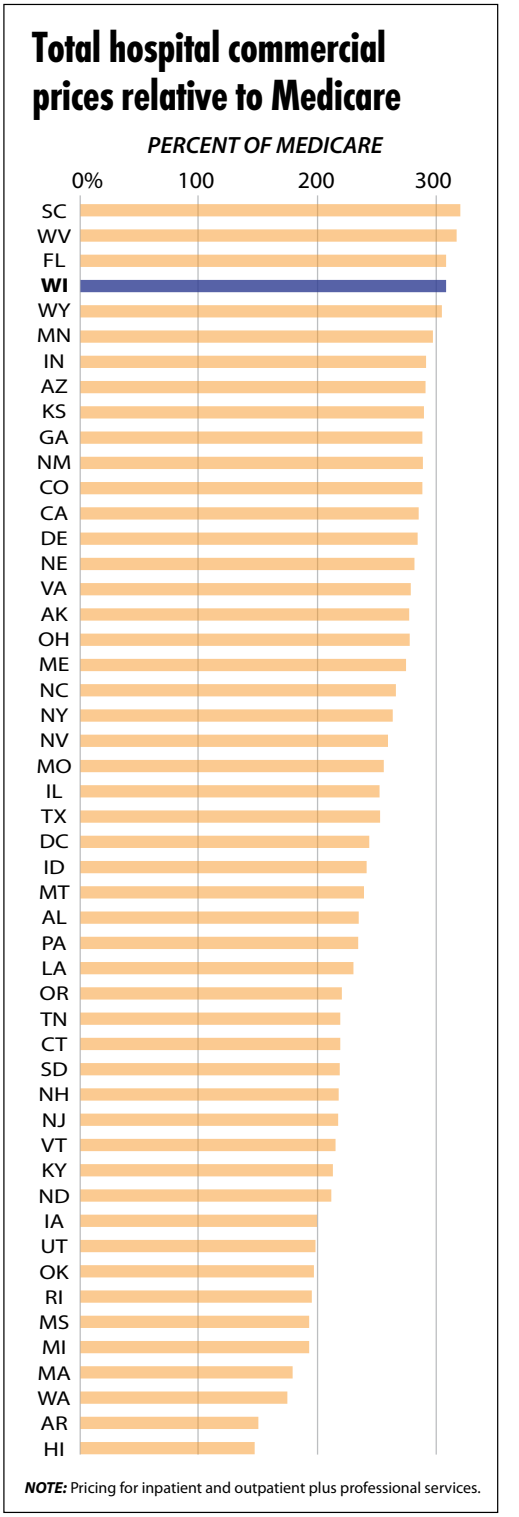
HSAs, Medicare and Medicaid

Price transparency of drugs, hospital expenses and health plans, as just discussed, would allow patients to shop, provided they have mobile medical records that permit them to get their care where they want. Still, patients need a pool of money to draw from for these shoppable healthcare expenses, especially those not fully reimbursed by insurance. Federal legislation (HR 6271[61]) is being considered to address this problem by permitting more flexibility in spending from health savings accounts (HSAs). Permitting HSA spending for direct primary care would empower patients; under current rules, DPC is not an allowable medical expense.

Likewise, allowing spending of Medicare or Medicaid dollars via HSA vouchers also would empower patients to obtain better care more flexibly through a free and open market. This would require a federal waiver. Such legislation would give patients more freedom in purchasing healthcare. Early attempts have not been encouraging, with one effort failing in Texas. This is legislation worth developing at the state and federal level.

Recommendation: Wisconsin should lead nationally by implementing a pilot program to provide flexible healthcare options to disadvantaged populations served by Medicaid, using HSA vouchers to purchase care wherever they want, rather than being restricted as they are now. This would require a federal waiver. Or, if federal waivers are not granted, perhaps there could be philanthropic or industry-funded sources of funds, to be placed in flexible HSAs, that could be spent on DPC memberships for the poor to complement Medicaid. State legislation is also needed to introduce more flexibility in terms of how HSA dollars can be spent to include purchasing of DPC. For the $1,200 per year

Figure 6



Source: Employers' Forum of Indiana using RAND 4.0 data, Sage Transparency dashboard (August 2022)

typically charged for a DPC membership, patients would have less need to use emergency rooms for primary care, which would save the system money and provide better care, and chronic conditions such as diabetes and heart disease could be better managed.

Scope of Practice

There is a tremendous workforce problem in healthcare in Wisconsin and nationally. Rural areas have an especially acute shortage of nurses, medical assistants, physicians, physician assistants and dentists. In response to that provider shortage, legislation was introduced to increase what is known as scope of practice.

With a broader scope of practice, non-physician providers such as nurses, pharmacists, dentists and physician assistants would be able to practice with more autonomy. Two recent Wisconsin bills were aimed at broadening scope of practice. The first, 2021 SB 394,[62] would have allowed for advanced practice registered nurses (APRNs) to practice without a written collaborative agreement with a physician. It passed the Legislature but was vetoed by Gov. Evers. The second, 2021 AB 125,[63] became law. It allows physician assistants (PAs) to practice under a written collaborative agreement rather than under direct supervision of a physician. The trend nationally is for advanced practice providers (APPs) to be given a broader scope of practice. Professional societies such as the American Medical Association (AMA) have opposed some expansions of scope of practice, citing dangers associated with the trend.[64] It is not clear whether the data supports this concern, but clearly scope of practice expansion must be done with caution, not creating unwarranted risk to patients by expanding too far.

Other useful licensure legislation would facilitate telehealth by allowing physicians and therapists in one state to offer care online to patients in another state. Interstate agreements such as licensure compacts that simplify cross-state telehealth in participating states are highly worthwhile.

Recommendation: Scope of practice expansion for healthcare professionals such a APRNs, PAs and pharmacists is a positive development but cannot be done carte blanche. There need to be reasonable limits to the expanded scope that ensure patient safety. Licensure compacts that permit delivery of healthcare across state lines should be pursued.

Workforce

Wisconsin is seeking to increase the supply of practitioners by attracting more teachers and students to medical, nursing and pharmacy schools. The state provided $5 million in the last biennial budget to support grants and loan forgiveness for nurse educators who agree to teach for three years in a Wisconsin school of nursing. A similar program is advancing to encourage pharmacists to move to rural practice areas (2021 SB 872).[65] While financial incentives are one strategy to increase the pool of practitioners, a simpler approach may be to remove artificial bottlenecks. A significant bottleneck for the physician pool is the limited number of residency slots for doctors. Those slots are funded in part

by Medicare,[66] which pays hospitals to run graduate medical education for a set group of residents. There are similar bottlenecks for training nurses.

Recommendation: State-based incentives to encourage training of nurses, pharmacists and even doctors to pursue practice in rural areas may make sense, if that is what voters want. Better yet would be for communities to provide the incentives themselves, and to remove artificial roadblocks to healthcare provider training such as limits to residency slots.

Conclusion

Policy action is needed at the state and federal levels to remove the current market dysfunctions in healthcare delivery. The most promising ideas will further empower decision-making and spending at the patient-provider interface. They will reduce the role and influence of third parties such as insurers and governments.

For this to happen, there needs to be more price transparency for drugs, hospital services and healthcare plans. Patients and payers need meaningful choices to go where they want for their care, using options such as telehealth and flexible HSA plans. HSA plans should empower patients to purchase with or without the use of insurance, including via the increasingly popular direct primary care options that provide extensive electronic and in-person access to a provider for an entire year at less than the cost of a single emergency room visit.

Flexible HSA spending and DPC options also should be made available to patients on Medicare and Medicaid via vouchers enabled by federal waivers. Legislation and regulations are pending in Wisconsin and at the federal level to enable this new and better world of healthcare delivery. Wisconsin, already a leader in delivering quality healthcare, has an opportunity to show the rest of the nation how to provide more affordable and accessible care as well. On, Wisconsin!

Badger Institute takeaways

Wisconsin lawmakers should:

- **Pass legislation to enable emerging direct primary care options by stating that DPC is not insurance.**
- **Reevaluate legislation on "white bagging," taking better account of the valid interests both of patients and doctors to choose a drug supplier and of small self-insured employers to control extraordinary costs.**
- **Consider modifying existing statutes on drug pricing to retain price transparency elements while eliminating price controls.**
- **Pass Right to Try 2.0 legislation to enable faster adoption of personalized medicine, sometimes called "N=1" medicine.**
- **Pass legislation to require coverage parity for telehealth but not payment parity. Reform licensing to permit telehealth to be provided across state lines.**
- **Pass stronger price transparency legislation, such as Texas has done, and ensure hospital compliance. Examine ways to use the Wisconsin Health Information Organization's all-payer claims database to widely disclose accurate information about costs.**
- **Implement a pilot program to provide Medicaid patients with HSA vouchers to purchase care wherever they want. This would require a federal waiver.**
- **Expand the scope of practice for healthcare professionals such as advanced practice registered nurses, physician assistants and pharmacists. Pursue licensure compacts that permit delivery of care across state lines.**

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Endnotes

[1] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet

[2] https://www.badgerinstitute.org/News/2022-2023/A-Roadmap-for-Healthcare-Reform-in-Wisconsin1.htm

[3] https://goforward.com/blog/healthcare-is-backwards/healthcare-vs-sickcare

[4] https://www.rand.org/blog/2021/11/does-vertical-integration-improve-or-imperil-us-health.html

[5] Sem, DS. 2020. Purple Solutions: A Bipartisan Roadmap to Better Healthcare in America.

[6] https://www.verywellhealth.com/what-is-direct-primary-care-4777328#citation-16

[7] McAneny, Barbara L., "Consolidation in Healthcare: A Case Report on the U.S. Medical-Industrial Complex," chapter in Sem, Daniel (ed.), "Purple Solutions: A Bipartisan Roadmap to Better Healthcare in America," 2020.

[8] https://moqc.org/wp-content/uploads/2017/06/Physician-Burnout.pdf

[9] https://www.elationhealth.com/blog/direct-primary-care-blog/patient-load/

[10] https://www.talktomira.com/post/how-much-does-an-er-visit-cost

[11] https://www.medicaleconomics.com/view/high-cost-of-health-care-may-be-boosting-direct-primary-care-membership

[12] https://www.healthmarkets.com/resources/health-insurance/bronze-plans-all-you-need-to-know/

[13] Communication at the 2021 Healthcare Economics Summit: http://rxthinktank.org/the-2021-healthcare-economics-summit-in-review/#1562940987261-57c055ea-d345; also: Goldhill, D. Catastrophic Care: Why Everything We Think We Know About Health Care is Wrong. 2013. https://www.amazon.com/Catastrophic-Care-Everything-Think-Health/dp/034580273X

[14] https://www.fiercehealthcare.com/tech/sesame-raises-24m-to-expand-cash-pay-marketplace-for-healthcare-services; https://sesamecare.com/

[15] Communication at the 2021 Healthcare Economics Summit: http://rxthinktank.org/the-2021-healthcare-economics-summit-in-review/#1562940987261-57c055ea-d345; also: https://www.familydpc.com/

[16] https://mapper.dpcfrontier.com/; https://www.dpcare.org/dpc-practice-locations

[17] https://www.cnbc.com/2022/07/21/amazon-to-buy-primary-health-care-provider-one-medical-for-roughly-3point9-billion.html

[18] https://www.prnewswire.com/news-releases/everside-health-announces-164-million-in-growth-equity-funding-from-nea-and-new-investors-301591812.html

[19] https://www.aafp.org/dam/AAFP/documents/advocacy/payment/dpc/BKG-DPC.pdf

[20] https://docs.legis.wisconsin.gov/2021/related/proposals/sb889

[21] https://www.dpcare.org/dpcc-model-legislation

[22] https://www.goodrx.com/healthcare-access/drug-cost-and-savings/most-expensive-drugs-period

[23] https://revcycleintelligence.com/news/hospital-markups-drive-prescription-drug-spending-phrma-says

[24] https://www.ashp.org/news/2021/03/22/white-bagging-a-growing-concern-for-health-systems?loginreturnUrl=SSOCheckOnly; https://www.priorauthtraining.org/what-is-white-bagging/

[25] https://www.wmc.org/issues/health-care/wmc-testifies-against-legislation-that-would-eliminate-white-bagging-and-result-in-higher-health-care-costs-for-employers-employees/

[26] https://www.ajmc.com/view/when-payers-cost-saving-steps-don-t-help-patients

[27] https://legiscan.com/TX/bill/HB1919/2021

[28] https://www.texaspharmacy.org/page/2021Wrapup

[29] https://docs.legis.wisconsin.gov/2021/proposals/sb753

[30] https://www.dispatch.com/story/news/2021/12/02/us-drug-prices-remain-excessive-part-due-failure-rein-pbms-health-care-prescriptions-rebates/8819629002/

[31] https://www.46brooklyn.com/research/2019/4/21/new-pricing-data-reveals-where-pbms-and-pharmacies-make-their-money

[32] https://www.aha.org/topics/drug-price-transparency

[33] https://www.benefitspro.com/2022/05/30/new-bill-would-crack-down-on-pbm-spread-pricing-increase-transparency/?slreturn=20220702193112

[34] https://content.govdelivery.com/accounts/WIGOV/bulletins/2eaff08

[35] https://www.policymed.com/2014/12/a-tough-road-cost-to-develop-one-new-drug-is-26-billion-approval-rate-for-drugs-entering-clinical-de.html

[36] https://www.cms.gov/newsroom/press-releases/cms-takes-action-lower-prescription-drug-prices-and-increase-transparency

[37] https://www.fiercehealthcare.com/payer/cms-pulls-trump-era-most-favored-nation-drug-price-model

[38] https://www.forbes.com/sites/joshuacohen/2022/06/02/possible-resurrection-of-build-back-better-from-the-dead-drug-price-measures-could-be-key-component/?sh=4c507daa2e1a

[39] https://www.forbes.com/sites/joshuacohen/2022/08/02/critics-decry-drug-pricing-provisions-in-inflation-reduction-act-say-they-will-stifle-innovation/?sh=4934fd65222d

[40] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6050876/

[41] https://docs.legis.wisconsin.gov/2017/related/lcactmemo/act165.pdf

[42] https://www.fda.gov/patients/learn-about-expanded-access-and-other-treatment-options/right-try

[43] https://www.goldwaterinstitute.org/new-hope-for-patients-goldwater-expands-right-to-try-in-arizona/

[44] https://www.michiganvotes.org/2021-HB-4356

[45] https://www.dhs.wisconsin.gov/telehealth/index.htm

[46] https://docs.legis.wisconsin.gov/2021/proposals/sb306

[47] https://www.healthaffairs.org/do/10.1377/forefront.20210503.625394/full/

[48] https://www.mercatus.org/publications/healthcare/telehealth-payment-parity-laws-state-level

[49] https://www.healthit.gov/curesrule/; https://www.greenwayhealth.com/knowledge-center/greenway-blog/21st-century-cures-act-summary-how-it-impacts-your-practice

[50] https://www.businessinsider.com/epic-cerner-dominate-electronic-health-record-market-2019-5; https://www.forbes.com/sites/katiejennings/2021/04/08/billionaire-judy-faulkner-epic-systems/?sh=8086650575a0

[51] https://www.ingentaconnect.com/content/mcb/096/2009/00000018/00000002/art00005

[52] https://healthcostinstitute.org/images/easyblog_articles/109/Price-Quality-Parado_20200109-192229_1.pdf; https://www.bcbs.com/the-health-of-america/reports/study-of-cost-variations-knee-and-hip-replacement-surgeries-the-us; https://www.washingtonpost.com/news/wonk/wp/2013/02/12/how-much-does-hip-surgery-cost-somewhere-between-10000-and-125000/

[53] https://www.cms.gov/newsroom/press-releases/trump-administration-announces-historic-price-transparency-requirements-increase-competition-and

[54] https://www.cms.gov/hospital-price-transparency

[55] https://www.fiercehealthcare.com/hospitals/report-143-hospitals-compliant-price-transparency-rules-one-year

[56] https://spn.org/blog/11-ideas-to-improve-healthcare-price-transparency-in-your-state/

[57] https://legiscan.com/TX/bill/SB1137/2021

[58] https://employerptp.org/sage-transparency/

[59] https://www.rand.org/health-care/projects/price-transparency/hospital-pricing/round4.html; https://employerptp.org/rand/4-0/

[60] https://whio.org/

[61] https://www.congress.gov/bill/117th-congress/house-bill/6271?s=1&r=3

[62] https://docs.legis.wisconsin.gov/2021/proposals/sb394

[63] https://docs.legis.wisconsin.gov/2021/proposals/ab125

[64] https://www.ama-assn.org/practice-management/scope-practice/ama-successfully-fights-scope-practice-expansions-threaten

[65] https://docs.legis.wisconsin.gov/2021/proposals/sb872

[66] https://www.aamc.org/news-insights/gme