



# A CURE FOR WHAT AILS US

STATE-LED HEALTHCARE SOLUTIONS TO FIX WASHINGTON'S BOTCHES

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STATE-LED HEALTHCARE SOLUTIONS TO FIX WASHINGTON'S BOTCHES

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# INTRODUCTION

The United States healthcare system is broken, and politicians in Washington, D.C. have consistently failed to deliver on promises to repair it. Healthcare costs continue to grow while access shrinks. Claims that the most recent round of reforms will buck this trend are presented dubiously with hedging effect, and many expect the reforms to weaken the system further. For many industry leaders, the Patient Protection and Affordable Care Act (PPACA) amounts to reform in name only, effectively treating what are internal medical problems with Band-Aids. While PPACA was largely a partisan battle to which Democrats claim victory, it has not been without critics from its own camp. In describing the healthcare reform law, former Tennessee Governor Phil Bredesen, a Democrat, said, “Congress and the Obama Administration have just added over thirty million more people into an obsolete and broken system and done little to address the underlying problems,” adding further, that “in multiple ways they’ve made them worse.”<sup>1</sup>

While healthcare policy is one dictated largely at the federal level, there nonetheless exists a real opportunity for state lawmakers to affect meaningful change for citizens of their states. Such state-led healthcare reforms have the potential to reduce costs of healthcare services and insurance, thereby expanding access to quality care for more Americans.

This report analyzes the current predicaments facing Tennessee policymakers in the wake of PPACA. It also offers state-led solutions that would move our nation’s healthcare system in the right direction, treating the diseases that weaken our healthcare system rather than the mere symptoms.

First, state lawmakers and Gov. Bill Haslam should outright refuse to expand Medicaid under PPACA. They should equally reject a state health insurance exchange, as well as the well-intentioned distraction that is a healthcare compact.

Policymakers should then embark on an effort to implement a variety of free market healthcare solutions, including measures that help Tennesseans free themselves from dependence on employer-based insurance policies, enable and encourage the purchase of insurance across state lines, reduce insurance coverage mandates, protect mid-level scope of practice, and enact medical licensing reform. Such changes will make great strides toward reducing the costs of both health insurance and healthcare, providing for greater access to both among Tennesseans.



## Peter Demos

Peter Demos started working in his family restaurant as a dishwasher at just 12 years old. Today, he runs the family’s chain of Demos’ Restaurants, which have been around for more than two decades. Peter operates five locations throughout Middle Tennessee and northern Alabama, employing 530 people. At least for now.

The Patient Protection and Affordable Care Act will soon take a tremendous toll on this family business. While Peter is unable to clearly determine the true costs of President Obama’s signature healthcare law, he estimates it will cost his business between \$250,000 and \$600,000 a year. If the law stands as-is, this means Peter will be forced to shut down two of his five locations or force shorter hours on his employees. At best, his workers will lose precious paid hours; at worst, the law will cost them their jobs. If Peter is forced to shut down two restaurants, roughly 200 people will be out of work.

To curb the growth in healthcare costs, Peter believes he should be able to shop for his employees’ health insurance across state lines and that there should be more transparency in pricing for healthcare services. As for PPACA, Peter notes that “this could be the most devastating piece of legislation that our country has ever seen, and it could potentially have a worldwide impact.”

# SAYING “NO” TO THE WASHINGTON WAY

## *Medicaid Expansion*

PPACA envisions states expanding Medicaid, the nation’s system for providing government-run health insurance to the poor. The law demands that states open enrollment in the program to any citizen earning less than 133 percent of the federal poverty level.<sup>2</sup> Tennessee’s Medicaid system, TennCare, has fluctuating eligibility limits based on a number of factors, including different rates for mothers who are pregnant, infants, and other children.<sup>3</sup> Those who are working can enroll in the program if they make 80 percent of the federal poverty level, while non-working adults qualify if their income is 70 percent of the poverty level.<sup>4</sup> Even at these qualification thresholds, TennCare eats up 27 percent of the entire state budget, costing taxpayers nearly \$8.7 billion annually.<sup>5</sup>

If Tennessee adopted the Medicaid expansions required under PPACA, TennCare could balloon to cover an additional 300,000 people almost immediately.<sup>6</sup> A report by Blue Cross Blue Shield of Tennessee estimates an additional 660,000 people could be added to TennCare rolls by 2014, a 65 percent increase from 2009 levels.<sup>7</sup>

Tennessee has a difficult history with its costly Medicaid program. In 2007, then-Gov. Phil Bredesen was forced to remove approximately 170,000 people from the TennCare rolls in order to avoid a budget crisis.<sup>8</sup> Even this proved to be insufficient, and by the end of his second term, Bredesen had removed more than 350,000 Tennesseans from the program.<sup>9</sup>

By expanding Medicaid to cover significantly more Tennesseans, state leaders will assuredly be setting the program on an unsustainable trajectory. While many gawk at the “free federal money” that will cover most of the expansion in the near future, the state

will be required to pick up more and more of the tab each year. Under PPACA, the federal government will cover 100 percent of the new enrollees through 2017, gradually declining to 90 percent in 2020 and beyond.<sup>10</sup> It is unclear as to whether the federal government will maintain this contribution level in future years.

In addition, this does not leave the state without direct immediate costs. PPACA does not authorize the federal government to cover additional enrollees who are currently eligible for Medicaid but are not enrolled. Once the law requires individuals to obtain health insurance starting in 2014, many of those eligible will contribute to a “woodwork effect,” enrolling in TennCare rather than paying the individual mandate penalty or obtaining private insurance. A conservative estimate pegs this number at 60,625 people who are presently eligible but not enrolled in TennCare, costing Tennessee an additional \$913 million between 2014 and 2019 alone.<sup>11</sup>

This number will likely grow as many businesses drop health insurance coverage for their lower-income employees. Faced with penalties for failing to maintain health insurance, a large portion of those who qualify for TennCare will then likely turn to the government program for coverage. Even though most of the costs associated with PPACA have yet to become a reality, nine percent of employers already plan to drop health insurance coverage for their workers within one to three years, according to a Deloitte survey.<sup>12</sup> In the same survey, one-third of employers stated they would consider eliminating health coverage “if they find that the law requires them to provide more generous benefits than they do at the moment; if a tax on high-cost plans takes effect in 2018 as scheduled; or if they conclude that the cost of penalties for not providing insurance could be less expensive than paying for benefits.”<sup>13</sup> If employers make good on their promises, TennCare rolls could vastly increase over the next few years.

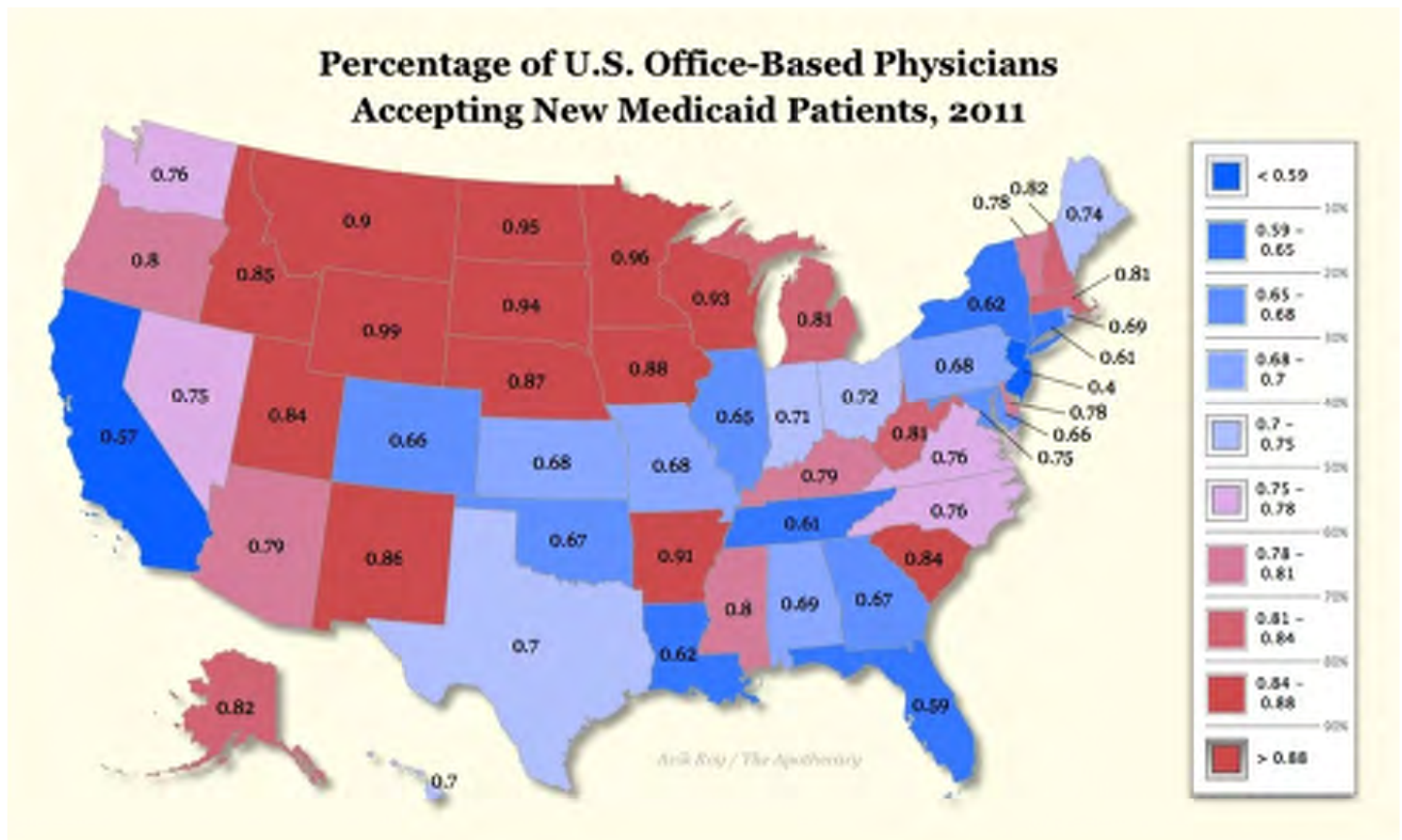
And those new TennCare enrollees will find themselves with coverage that is less than desirable. Tennessee



doctors are becoming less likely to accept new Medicaid patients, further limiting the options of those who move onto the TennCare rolls. According to a new study by *Health Affairs*, as of 2011, just 61 percent of Tennessee physicians accepted new Medicaid patients. Only three other states—New Jersey, California, and

Florida—had a lower acceptance rate than Tennessee.<sup>14</sup> As Figure 1 shows, expanding Medicaid in Tennessee will result in more limited opportunities for those new enrollees, further compounding the problems with those Tennesseans’ access to quality care.

*Figure 1: State-by-State Comparison of Medicaid Acceptance*

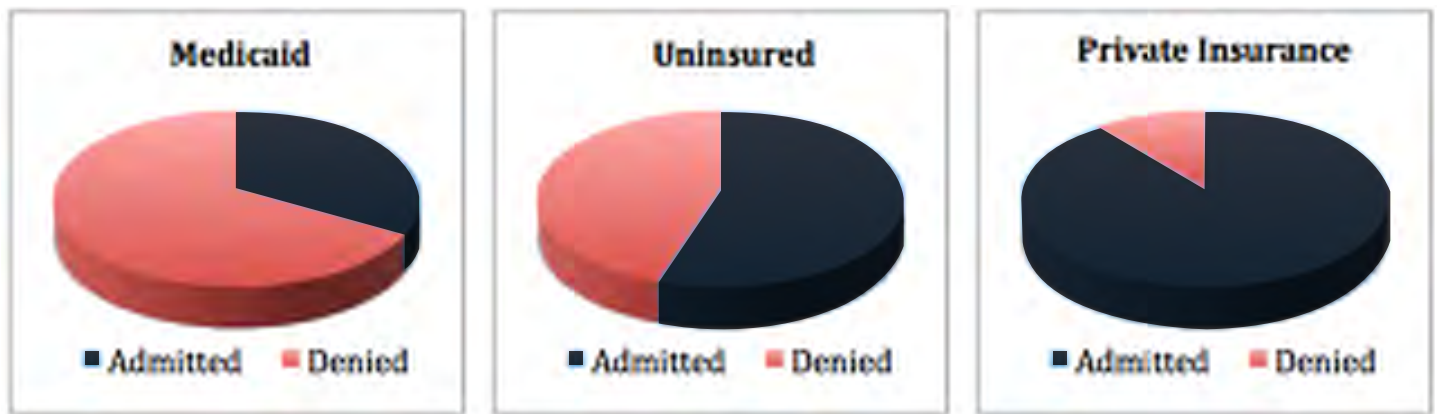


*Source: Forbes*

Children fare even worse when it comes to physician access than adults on Medicaid. A 2011 study by the New England Journal of Medicine found that two-thirds of children enrolled in Medicaid were denied an appointment with a specialist when seeking treatment for an urgent medical condition. Comparatively, just 11 percent of similarly situated children on private insurance were denied an appointment.<sup>15</sup> The U.S. Government

Accountability Office more recently determined that Medicaid-enrolled children “have worse physician access than those with no insurance at all.”<sup>16</sup> In a survey, the GAO found that 53 percent of physicians were admitting either “none” or only “some” new patients under age 18. Comparatively, just 45 percent of physicians refused uninsured children.<sup>17</sup>

Figure 2: Percentage of Children Seeking Appointment with Specialists



Fortunately, there is a way to avoid these problems associated with Medicaid expansion that not only harm taxpayers' wallets, but indeed the very patients the program is designed to help. While the state cannot avoid the expenses that will result from the "woodwork effect," it can shield itself from the future consequences of a Medicaid expansion. The recent U.S. Supreme Court ruling on PPACA's constitutionality gives states this option. Under the law, states that refuse to expand Medicaid would be faced with losing existing Medicaid funding, putting tremendous pressure on states to comply. However, the Supreme Court ruled that this penalty is unconstitutional. Writing for the majority, Chief Justice John Roberts ruled that:

*"Nothing in our opinion precludes Congress from offering funds under the [PPACA] to expand the availability of health care and requiring that states accepting such funds comply with the conditions on their use. What Congress is not free to do is to penalize states that choose not to participate in that new program by taking away their existing Medicaid funding."<sup>18</sup>*

Thus, states are now free to reject the Medicaid expansion without facing the prospect of losing existing Medicaid funding.

Inevitably, Tennessee will be unable to provide the essential services under TennCare as its share of the costs

grow over time. By expanding Medicaid, state officials are setting Tennessee up for another round of massive cuts similar to those experienced during Gov. Bredesen's tenure. Not only is this fiscally imprudent, it is immoral to enroll low-income Tennesseans in an unsustainable program, only to remove their coverage at a time when they can least afford it. It is imperative, therefore, that state policymakers follow the lead of their colleagues in other states who are refusing to expand Medicaid. This refusal is the best solution to protect taxpayers and those who would get swallowed up by the unaffordable program.

#### *State Health Insurance Exchange*

*"Let me make a prediction here: subsidized, Individual Exchange-based health insurance is an open-ended entitlement that will ultimately, and perhaps quite quickly, create extremely large and unbudgeted costs for our federal government."<sup>19</sup>*

-Gov. Phil Bredesen

Another component of PPACA encourages states to set up their own health insurance exchanges. These exchanges are envisioned to serve as "marketplaces" for various government-approved health insurance plans, where consumers can compare coverage and prices. In reality, a state exchange is the vehicle through which

PPACA's costly mandates will be enforced. Under the law, if states do not set up their own exchanges by an evolving deadline, the federal government has the authority to establish an exchange in those states.

While it may be enticing to establish a state-run exchange to have more control and autonomy over its components, the practical result is that a state exchange *is* a federal exchange. The federal government will impose a litany of rules and regulations on states operating their own exchanges, thereby eroding the autonomy of any state exchange. Even worse, these rules themselves are already changing regularly and will undoubtedly evolve in the future, leaving state leaders with a moving target for compliance with federal regulations.

According to Michael Cannon, director of health policy studies at the Cato Institute, there are a number of reasons states should refuse to set up an exchange. The first is jobs. PPACA imposes a tax as high as \$3,000 per employee for employers that fail to provide “essential” (i.e., government-approved) health insurance coverage. However, this tax can only be enforced via state-run exchanges. PPACA does not permit the tax to be levied if the federal government creates the exchange in lieu of state action. Thus, states that refuse to set up an exchange will spare their employers significant taxes. Further, they could potentially lure employers from states that do establish exchanges, protecting those employers against the costly tax as well.<sup>20</sup>

The structure of PPACA means that if a state refuses to establish an exchange, it can prevent many of its residents from the individual mandate to purchase health insurance, possibly the least popular provision in the law. If the lowest-cost plan in a state exchange is greater than eight percent of an individual or family's income, that individual or family is exempt from the mandate to purchase health insurance. However, the subsidies administered through state exchanges offset this, meaning that if a person or family receives a subsidy via the exchange, what they pay out of pocket for the lowest-cost plan may no longer be more than eight percent of their income. Thus, they will then be

required to purchase insurance due to the mandate.

For example, if the lowest-cost plan in the state exchange has a premium of \$225 per month, or \$2,700 per year, a person making \$30,000 annually would be exempt from the mandate to purchase health insurance. This is due to the fact that the lowest-cost plan in the state exchange is greater than eight percent of his income (in this case it amounts to nine percent of his income). However, if that person receives a subsidy of just \$400 to purchase insurance that lowers his out-of-pocket cost to obtain that plan to \$2,300 a year, or less than eight percent of his income, the individual loses the exemption, and he must now purchase health insurance or face a penalty.

Because PPACA itself does not allow subsidies to flow through federally instated exchanges, states that refuse to establish a state-run exchange could preserve this exemption for many of its residents.<sup>21</sup> The Cato Institute estimates that 17.8 million people nationwide would be exempt from the individual mandate if every state refused to establish an exchange. Tennessee alone could protect 346,310 residents, who without the existence of a state exchange would be exempted from the individual mandate.

It should be noted that, despite the plain language and overwhelming legislative intent to pass the subsidies—and penalties—through state exchanges and not federal exchanges, the Internal Revenue Service (IRS) has sought to change this. Recently, the IRS passed a rule that would allow the subsidies and penalties to flow through federal exchanges in the event states refused to establish their own exchanges. The practical effect could be that states could no longer shield their citizens and employers from the individual and employer mandates in PPACA.

However, many legal scholars posit that the IRS rule is unconstitutional and could not survive a court challenge. States refusing to set up an exchange should understand the implication of subjecting their residents and businesses to PPACA's penalties, as well as the legal considerations surrounding the constitutionality of the IRS rule that seeks to negate this protection. In a recent

policy paper, the Cato Institute's Michael Cannon and Case Western Reserve law professor Jonathan Adler outline numerous reasons why the IRS rule is illegal and how it could be overturned, thus preserving the states' authority to protect their residents from the individual and employer mandates by refusing to establish their own exchanges.<sup>22</sup> Vanderbilt Law Professor James Blumstein reiterated many of these same points in testimony before the Health Subcommittee of the U.S. House of Representatives' Ways and Means Committee, arguing that if this change were to be made, it would have to be done by Congress, not an IRS rule.<sup>23</sup>

Second, because the subsidies provided to individuals and small employers operate exclusively through state exchanges, any state that does not establish an exchange will contribute to the fiscal health of the nation by preventing these costly subsidies from taking place within its borders if the IRS rule is struck down by the courts.<sup>24</sup>

Third, states that create an exchange will be forced to cover much of the costs. It is estimated that an exchange will cost a given state anywhere from \$10 to \$100 million per year to operate.<sup>25</sup> This adds an additional burden to state taxpayers, above and beyond the existing costs of implementing other provisions of PPACA.

It is precisely for these reasons that a number of states, including Florida, Louisiana, Oklahoma, Kansas, and Wisconsin have already refused to establish an exchange, while several other states are moving in that same direction.<sup>26</sup> In order to protect its own fiscal well being and that of the nation, to shield employers and individuals from costly taxes, and to prevent the tentacles of PPACA from reaching further into the lives of Tennesseans, policymakers should flatly reject a state-run health insurance exchange.

### *Healthcare Compact*

One solution that purports to provide states with greater autonomy is that of a healthcare compact. This idea surfaced during the 107th Tennessee General Assembly, and while it passed the state Senate, it failed to garner a

majority of votes in the House of Representatives on the last day of session.<sup>27</sup> Under the bill as proposed, states could band together to form a compact that could then be approved by Congress. Once in place, the states would establish an interstate advisory commission to compile healthcare related information and to "study the issues of health care regulation of particular concern to the member states."<sup>28</sup> Those states could then demand that Congress remit the portion spent within each state's borders on Medicaid and Medicare back to that state. The states would then in theory run their own Medicaid and Medicare programs.

It is highly unlikely that Congress would ever adopt such a compact, making it a futile effort. It is for this reason that, while admirable in theory, a healthcare compact represents a distraction from meaningful free market reforms.

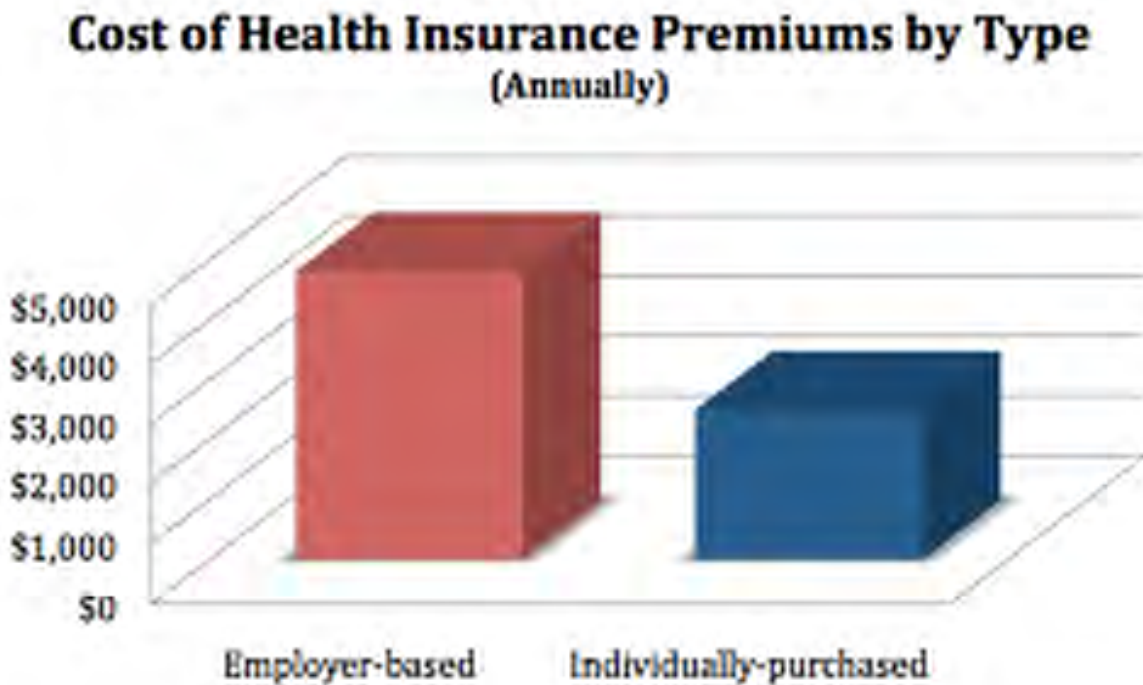
## **DELIVERING STATE-LED, FREE MARKET REFORMS**

### *Moving Away from Employer-based Insurance*

Employer-based health insurance plans are the most common type of health insurance coverage in the state, and such plans have increasingly contributed to overall higher health insurance costs. The idea of employer-based plans was relatively uncommon until World War II, when a labor shortage—the direct result of National War Labor Board wage freezes—forced employers to create alternative compensation mechanisms in order to attract workers.<sup>29</sup> By 2010, 54 percent of Tennesseans had employer-based health insurance.<sup>30</sup> Over time, people have come to expect that they will obtain health benefits through their jobs, and because of additional tax incentives created for employers that provide these benefits, employer-based health insurance has been the norm since 1942.<sup>31</sup> As a result, Tennesseans are shielded from realizing the true costs of their health care policies and decisions, as well as cost-effective alternatives to their employer-based coverage.



Figure 3: Employer and Individual Insurance Costs



Costs for employer-based policies generally are higher because of regulations, as well as underwriting and benefits management. These higher costs, as well as excessive coverage features, are realized in the form of increased premiums. In 2011, the average individual premium for a Tennessean with employer-based coverage was \$4,799 per year.<sup>32</sup> Compare that to Tennesseans who purchased their own insurance, who spent an average of just \$2,488 per year.<sup>33</sup>

What employers currently contribute to health benefits could be provided to the employee directly through increased wages. Employer-based individual premiums rose by eight percent between 2010 and 2011,<sup>34</sup> while wages only increased 2.9 percent in that same year.<sup>35</sup> Because of the preferential tax treatment of employer-based plans, employers offer increasingly rich Cadillac plans to attract and retain employees, instead of the wage increases that would benefit their employees more directly.

Individuals continue to expect employer-based insurance even though every other form of insurance, such as car or home insurance, is not tethered to their jobs. Like with these other forms of insurance, employees who purchase their own health insurance would have the opportunity to

shop around to find a plan that meets their needs at a price that works for them.

Moving away from employer-based insurance would provide employees with a chance to choose plans that cost less than their current plans, giving them more disposable income. Employers would benefit as well, saving money that would allow them not only to increase wages, but also to hire more employees and provide goods and services at more competitive prices.

Tennesseans who move away from employer-based plans would also find that their policies are portable and not dependent on their jobs. Individuals could keep their plans even if they leave their jobs. The lack of portability of employer-based insurance has left many Americans uninsured. In fact, one in six Americans with employer-based coverage in 2006 lost that coverage by 2008.<sup>36</sup> Many of those who lost their coverage were only uninsured temporarily as a result of switching jobs. Excluding those who are eligible for Medicaid, 70 percent of those considered uninsured lack insurance for less than four months,<sup>37</sup> and less than 2.5 percent of the uninsured remain so for longer than three years.<sup>38</sup>

Though the Consolidated Omnibus Budget Reconciliation Act (COBRA) is aimed at covering discharged employees, the high cost keeps many unemployed Tennesseans uninsured. In Tennessee and 40 other states, COBRA family premiums eat up more than 75 percent of average unemployment insurance benefits.<sup>39</sup> In addition, not everyone qualifies for COBRA. For example, COBRA is not available those who leave a job at a company with less than 20 full-time employees.<sup>40</sup>

Further, employer-based insurance itself is simply not available to everyone, and the lack of a viable individual insurance market leaves many without coverage. Of the uninsured in the United States, 61 percent have a job yet do not have access to employer-based insurance.<sup>41</sup> In addition, 53 percent of unemployed Tennesseans are uninsured.<sup>42</sup> Moving more Tennesseans away from employer-based insurance would make finding affordable individual insurance easier. A stronger market for individual-based plans would reduce administrative costs and allow individuals to choose tailored plans without wasteful, excessive features present in many employer-based policies.

Individual-based policies would also benefit those with pre-existing conditions, many of whom are not covered under current employer-based insurance regulations. For example, those with pre-existing conditions who lack medical coverage for over 63 days are not guaranteed coverage.<sup>43</sup> With more choice given to consumers, many of those who might be denied traditional employer-based plans would have access to high risk pools and plans that meet their individual needs.

The General Assembly should pass legislation creating purchasing pools to be managed by private insurance companies. This would help individuals who wish to purchase insurance on their own and add some structure to the individual health insurance market. Individuals could pool together to purchase group plans, an added incentive for insurers to move away from employer-based insurance.

Because of administrative costs, small businesses pay 18 percent more for the same coverage as groups with 1,000 or more participants.<sup>44</sup> A purchasing pool could offer the same administrative advantages of large companies, giving employees at smaller businesses and self-employed individuals policies that cost less. This would save five to 10 percent of the total cost of private non-group insurance, while giving participants the choice and portability they currently lack with employer-based plans.<sup>45</sup>



## Dr. Manish Sethi

Dr. Manish Sethi is an Orthopaedic trauma surgeon and Assistant Professor at Vanderbilt University. Manish is

currently Director of the Vanderbilt Orthopaedic Institute Center for Health Policy and is the lead author of the book *Orthopaedic Traumatology: An Evidence Based Approach*. Manish also takes an active role in teaching health policy at Vanderbilt University, serving as course director for The Evolution of American Healthcare, an introductory course for undergraduates.

When asked how he would treat the ailing American healthcare industry, Manish noted the importance of separating employment from health insurance. “By uncoupling employment and health insurance,” he stated, “we could create so much more market competition and drive down costs.” By doing so consumers, now directly in charge of their healthcare dollars, could demand and incentivize more pricing transparency by physicians, resulting in more informed healthcare decisions.

Manish points to areas in healthcare already benefitting from market forces, such as LASIK procedures. “The private sector and consumer driven care could fundamentally change and reshape American healthcare and get it moving in a positive direction,” he added. Unfortunately, he feels PPACA only presents more obstacles and instability for the industry.

Manish fears the effects of government disrupting the doctor-patient relationship and the long-term effects that will have on the profession. “I think fewer people will pursue a life in medicine,” he said. As for the prognosis, Manish asserts, “PPACA will increase the cost of healthcare, and quality of care will only improve when we introduce healthcare to market forces.”

“Unfortunately, PPACA does quite the opposite,” he concluded.

Further, Congress should give individuals the same tax benefits afforded to employers for purchasing insurance, a move the General Assembly could encourage through a formal resolution and active lobbying of members of Congress. This would level the playing field rather than favor the more costly employer-based market at the expense of the individual insurance market. Moving away from employer-based insurance would drive the health insurance market to be more consumer-driven. Subsequently, it would reduce the costs of health insurance and allow for portability of plans, both of which will expand access to health insurance for more Tennesseans.

### *Permitting the Purchase of Insurance Across State Lines*

Currently, Tennesseans are prohibited by law from purchasing a health insurance plan from a company outside Tennessee. This severely restricts market supply, driving up health insurance costs. Allowing Tennesseans to choose from policies in other states—and increasing competition between insurance companies—could reduce costs for individuals and families. Additionally, consumers could tap insurance markets in states with more consumer-oriented policies, such as one with fewer mandates than their home state, allowing them to get the same or better coverage for less than their current options provide.

On aggregate, Tennessee's nearly four-dozen coverage mandates exceed the individual needs of many Tennesseans.<sup>46</sup> The true costs of these mandates on insurance companies are simply passed on to consumers through increased premiums. Opening up the insurance market and permitting individuals to purchase insurance policies in other states would allow them to bypass plans with unnecessary coverage mandates and higher rates. For instance, three of the states bordering Tennessee have lower average individual premiums, and 15 states nationally beat Tennessee's individual premiums, on average.<sup>47</sup> While the average Tennessean pays a premium of \$4,753 per year, they could go to Mississippi and only pay \$4,603.<sup>48</sup> Additionally, this would foster competition among states, discouraging the imposition of costly mandates and potentially leading to a reduction in existing mandates.

Furthermore, breaking down state line barriers in the health

insurance market could lead to one-third of the uninsured finding the coverage they need.<sup>49</sup> Insurance companies could also decrease prices due to a more heterogeneous risk pool. Additionally, as other states open their insurance markets as well, Tennessee insurance companies would have the opportunity to provide quality coverage to a larger market, no longer restricted by the state line.

Though state government has the power to regulate insurance, it currently maintains a monopoly over insurance regulations and prohibits individuals from customizing coverage plans. The American Medical Association found that in 83 percent of U.S. cities, there is a significant lack of competition in the health insurance market.<sup>50</sup> Tennessee legislators should open the market to put more control back in the hands of consumers. Allowing interstate competition would lead to lower premiums in all states with insurance companies across the country competing to provide the best price to their customers.

### *Reducing Coverage Mandates*

State law is riddled with coverage mandates, whereby insurance companies are required to provide coverage for specific treatments. As of 2011, Tennessee state law imposed 41 different health insurance mandates on its citizens.<sup>51</sup> Among the treatments that Tennesseans must pay for, regardless of their lifestyle or risk factors, include alcohol/substance abuse, autism, breast reconstruction, cervical cancer, Chlamydia, and prostate cancer screening.<sup>52</sup> Mandates also require insurers to cover—and individuals to pay for—certain providers, such as chiropractors, nurse midwives, psychologists, social workers, and speech therapists, even if the individual will never use the services of these providers.<sup>53</sup>

These mandates force individuals to obtain coverage for treatment that they might not want or need. As a result, they pay higher premiums. Research shows that every single mandate “adds roughly one half to one percent to the costs of a health insurance plan.”<sup>54</sup> Certain mandates, however, can tack on as much as 10 percent to an insurance plan.<sup>55</sup> While single health benefit mandates “have not been shown to result in significant increases in the

monthly or annual cost of health insurance premiums,” the “accumulation of several health benefits...can result in significant increases to the actual cost of health insurance premiums.”<sup>56</sup> This cost is specifically challenging for small business employers and employees. Even at the lowest annual increase caused by a single mandate, a total of 20 mandates will result in an average premium increase of \$1,000 a year.<sup>57</sup> Because certain mandates add more cost to health insurance premiums than others, it is likely that the impact of coverage mandates is far greater.

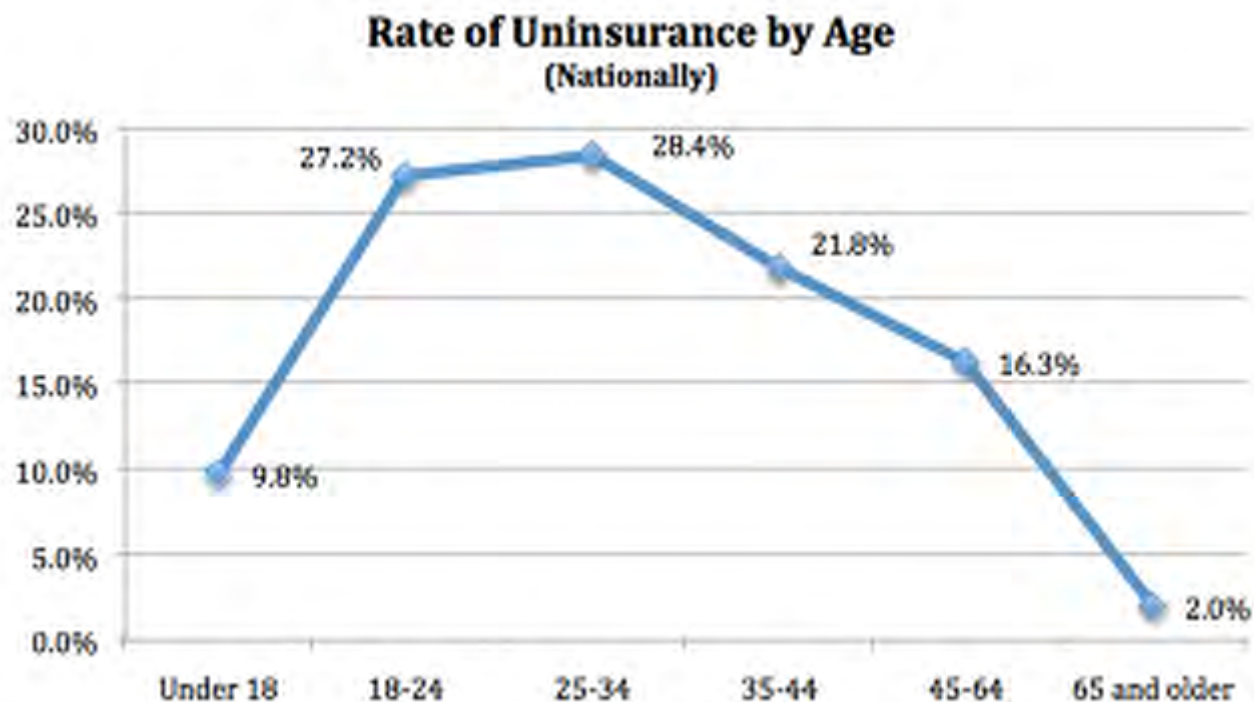
Not only do mandates raise costs, they lead to reductions in quality of care. As insurance companies attempt to keep down costs and shift the risks of providing the litany of mandated treatment, fewer resources are directed at truly necessary treatment.

At least 30 states have passed legislation requiring that a mandate’s cost be determined before implementation.<sup>58</sup> This is a positive first step at preventing the continued growth of coverage mandates, which grew in number by

nearly five percent nationwide from 2010 to 2011 alone.<sup>59</sup> The Tennessee General Assembly should take it a step further and eliminate the myriad of mandates imposed upon Tennesseans. At the very least, legislators should permit insurance companies to offer a “mandate-free” or “mandate-lite” plan for young adults that are less likely to need or want the mandated coverage. Ten states provide for such policies, “offering individuals the chance to purchase a policy with fewer mandates, more tailored to their needs and financial situation.”<sup>60</sup>

Young adults between the ages of 18 and 34 are the least likely to be insured, with nearly 30 percent of the age group living without insurance as of 2010.<sup>61</sup> There are several explanations for this. Most young people are not in stable long-term jobs, and since insurance is employer-based, they are less likely to have continuous coverage. Similarly, young people’s earnings are lower, making them more likely to opt against purchasing costly health insurance, especially since they are the healthiest members of society and often do not view health insurance as a necessity.

*Figure 4: Percentage of Uninsured Americans by Age Range*





While the uninsured rate for young adults under age 26 may decline due to the Affordable Care Act's requirement that these adults be permitted to remain on their parents' insurance, such policy does not effectively reduce the unnecessary costs associated with their coverage due to the continued imposition of state mandates. A mandate-free or mandate-lite plan would take the extra step toward reducing these individuals' health insurance costs.

People of all ages, but especially young adults, should be free to purchase insurance plans that do not contain the coverage mandates imposed by state law. Because young people are far less likely to utilize the numerous treatments that are mandatory, this would significantly reduce their insurance costs. These mandate-free or -lite plans would "entice 19 to 34-year-olds to purchase low priced, basic health insurance, rather than go with no coverage at all."<sup>62</sup> This simple solution would provide more cost-effective insurance options for thousands of currently uninsured young adults.

### *Physician Supply, Medical Licensing and Scope of Practice*

The physician supply shortage in Tennessee is well documented. According to the Health Resources and Services Administration (HRSA), 55 of 95 Tennessee counties have too few physicians.<sup>63</sup> Typically, the shortages are in areas where TennCare enrollment is already high. The PPACA Medicaid expansion provision will put additional strain on the system, exacerbating the shortage. While market demand for healthcare can be immediately increased through legislative means, such as PPACA's Medicaid expansion and private insurance subsidies, physician supply cannot be increased to meet that demand under the current system.

Physicians must attend a four-year program then an additional four years of residency before practicing freely. The University of Tennessee Health Science Center accounts for 75 percent of Tennessee's healthcare provider workforce in the state.<sup>64</sup> The UT College of Medicine enrolled 165 future doctors in 2012, and those students will not be able to practice freely until 2020. The Blue Cross Blue Shield of Tennessee report indicates that this combination of immediate increased demand and lagging supply could lead to worse access to care

for those already insured and that Tennessee's access problems in the wake of PPCAC "likely will be worse than those of the nation at large."<sup>65</sup> As such, Tennessee's state officials should look to alternative avenues to help ease the effects of the widening gap between physician supply and demand.

While intended to protect patients and consumers, medical licensing laws by their very nature create supply shortages and drive up the cost of services. Whether such licensing laws can be balanced in such a way to maximize quality of care while keeping costs low is a debate unto itself; but basic economic theory holds that controlling supply—i.e., licensing—increases demand, and increasing demand begets an increase in price. Consequently, this pattern disproportionately and adversely affects the poorest members of our society.

In the long-term, state law should be reformed to allow nurse practitioners, physician assistants, midwives, and other non-physician practitioners greater ability to treat patients. This will increase accessibility to treatment and reduce costs by allowing patients to visit less expensive practitioners that are still qualified to treat them. Non-physician practitioners today receive a high degree of education and experience. If patients are comfortable with the quality of care offered, they should be allowed to obtain such lower-cost services rather than foregoing care altogether.

In the short term, states lawmakers should allow physicians and mid-level providers licensed in other states to practice in Tennessee. This could increase the pool of healthcare providers available to Tennesseans overnight. Tennessee should lead the charge by making it easier for nonresident providers to practice in the state. Additionally, such reforms could significantly increase competition, lowering costs and increasing access to care.

In addition to the reforms noted above, lawmakers should be especially wary of legislation that seeks to limit mid-level providers' scope of practice. Like all proposed medical licensing laws, proponents typically frame scope of practice battles in the context of patient safety. As competition increases, specialists and provider groups may be tempted to curb competition through favorable legislation.

# CONCLUSION

Political sparring at the federal level has largely come to define U.S. healthcare policy. Fresh off another round of “reforms” in name only, the battle is shifting venues and moving to state capitols. In the wake of the Supreme Court’s ruling, PPACA, while wholly failing to address the source of our nation’s healthcare problems, nevertheless shifts some responsibility to state officials and lawmakers.

For the reasons outlined above, Tennessee’s leaders should refuse the expansion of Medicaid on both fiscal and moral grounds. Not only will the expansion likely lead to massive cost increases to taxpayers, but TennCare is incapable of adequately serving current enrollees, much less an additional 300,000 to 660,000 people. Before any expansion is to be considered, state leaders should implore Congress to fundamentally reform Medicaid. Likewise, state officials and lawmakers should avoid the temptation to set up a state insurance exchange, the vehicle for enforcing PPACA’s most insidious provisions such as the employer and individual mandates. Additionally, lawmakers should not waste taxpayer time with a healthcare compact that, although noble in intent, is as impractical as it is imprudent.

Instead, state leaders should work to reduce the dependency on employer-based coverage by incentivizing insurance policies that are both personal and portable, while calling on Congress to eliminate its tax policy that discriminates against individually-purchased plans. The General Assembly should also undertake direct efforts toward honest, state-level reforms such as eliminating arbitrary obstructions to the insurance market like state lines, both for Tennessee consumers shopping for insurance and providers licensed outside the state. A reduction in coverage mandates and permitting insurance companies to create mandate-free or mandate-lite insurance plans, especially for young adults, will further reduce costs and expand insurance access to a largely uninsured population.

Tennessee’s current physician shortage dictates that state leaders increase the provider pool for their constituents, and this glaring problem will only be exacerbated by PPACA. Reform in the area of scope of practice rules coupled with medical licensing reform would greatly improve this problem.

Congress and the Obama Administration have bypassed their opportunity at honest reform. Now, Tennessee policymakers should seize this opportunity to show Washington that honest, meaningful reforms are in fact achievable.



## RICHARDS & RICHARDS

Richards & Richards is the oldest and largest, single market, independently owned and operated records management company in the state of Tennessee. The company has been around for more than 25 years and has just fewer than 50 employees. In addition to a quality work environment, the company prides itself on its employees’ health benefits. Unlike most companies, Richards & Richards pays 100 percent of all employee health insurance premiums, while also providing eye and dental coverage, as well as short- and long-term disability insurance.

That may change because of the Patient Protection and Affordable Care Act, however. As president & CEO Steve Richards explains, the federal healthcare reform law puts his company in a difficult situation, even though it is nearly impossible for him to determine the full impact of the legislation due to its overwhelming complexity.

Once the company reaches more than 50 employees, it will be required to offer government-approved health insurance coverage. If the company faces fines for failing to provide adequate insurance, Steve notes that he may be forced to drop the company’s generous benefits and allow its employees to obtain coverage under PPACA. This flies in the face of President Obama’s claim that “if you like your health insurance, you can keep it.” This stark reality frustrates Steve, who points out that President Obama “has never signed the front of a paycheck, and now he’s telling me—a businessman—how to run my own business.”

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