

1332 WAIVERS AND HEALTHCARE SUPPLY: LOWERING COSTS, IMPROVING QUALITY, AND EXPANDING ACCESS

ROBERT F. GRABOYES

Senior Research Fellow, Open Health Program, Mercatus Center at George Mason University

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I am grateful for the opportunity to respond to the Centers for Medicare & Medicaid Services' (CMS) request for information on ideas for innovative programs and concepts that states could consider in developing a 1332 waiver plan. I am a senior research fellow at the Mercatus Center at George Mason University, and I taught health economics to midcareer healthcare professionals at five universities between 1999 and 2017. I am the author of "Fortress and Frontier in American Health Care,"¹ and my work focuses on the question of how America can make healthcare as innovative in the next 25 years as information technology was in the past 25 years. Mercatus is dedicated to advancing knowledge relevant to current policy debates. As part of its mission, Mercatus scholars conduct independent, nonpartisan analyses of agencies' rules and proposals.

To simultaneously lower costs, improve quality, and expand access, state and federal governments must reduce barriers on the supply side of healthcare. The demand side (payment systems and coverage) has long been the dominant focus in healthcare reform, but it is only half of the equation—a single blade of a pair of scissors. Concentrating exclusively on insurance reform pushes the country toward greater risk aversion and more redistribution of wealth and care, and it may actually impede technological and institutional innovation.

To understand the possibilities that await this country, it helps to look at success stories beyond its borders. One can do no better than to examine a single exemplar: In India, the Narayana Health System operates 20 for-profit hospitals, with many patients paying cash. A cardiac bypass operation there costs just over \$1,000, versus \$100,000 here. Narayana's success rates and quality of care equal or surpass those of almost any other hospital on earth. Wishing to serve American patients, Narayana partnered with America's Ascension system to open a hospital in the Cayman

¹ Robert F. Graboyes, "Fortress and Frontier in American Health Care" (Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, 2014).

Islands. Narayana’s CEO, Dr. Devi Shetty, said, “The best location to build a hospital on the planet today is a ship that is parked in the U.S. waters just outside its territory. . . . The site at the Cayman Islands is the closest approximation that fits the bill.”² This raises two questions that any healthcare reformer ought to ask and ask again: How does Narayana achieve such economies? And why do Narayana and its American partner feel compelled to serve American patients from beyond the reach of American law and regulation?

The answer to that first question is that Narayana’s institutional model invites myriad innovations, small and large, in ways that more closely resemble a Toyota car factory than a typical American hospital. The answer to the second question is that American laws and regulations impose enormous inertia on the country’s healthcare delivery systems, locking old methods in place and thwarting would-be innovators. States, with encouragement from the federal government, can change those realities, and 1332 waiver plans can be integral to that effort.

Earlier this year, the Senate Health, Education, Labor, and Pension Committee requested ideas to address rising healthcare costs. My submission suggested how technology, entrepreneurship, and innovation can accomplish what ought to be the central goal of healthcare reform: bringing better health to more people at lower cost, year after year.³ My letter and those from other Mercatus scholars listed promising paths by which states can enable entrepreneurs to provide innovative solutions to patients, including the following:

1. *Telemedicine.*⁴ Increased access to telemedicine can yield lower costs and greater access to quality care. Policymakers should consider removing regulatory barriers that hinder the advancement of telemedicine. (Simplifying the task of providing telemedical services across state lines is one example.)
2. *Nonphysician providers.*⁵ Nurse practitioners, physician assistants, physical therapists, pharmacists, and other physician extenders all play important roles in patient treatment. More patients could have access to the care they need if those professionals were given full practice authority.
3. *Hospital competition.*⁶ Certificate-of-need laws require providers to undergo lengthy, costly, erratic, and often politicized approval processes before offering new medical services. These laws have been shown to increase costs and diminish access to quality care while doing little if any good.

² Soma Das, “Devi Shetty Opens Low-Cost Healthcare Venture in Cayman Islands outside US Regulatory Reach,” *Economic Times*, February 24, 2014.

³ Robert F. Graboyes, contribution to “Better Health for More People at Lower Cost, Year after Year” (Letter to Chairman Alexander) (Mercatus Center at George Mason University, Arlington, VA, February 28, 2019).

⁴ Jared Rhoads, contribution to “Better Health for More People at Lower Cost, Year after Year” (Letter to Chairman Alexander) (Mercatus Center at George Mason University, Arlington, VA, February 28, 2019).

⁵ Edward J. Timmons, contribution to “Better Health for More People at Lower Cost, Year after Year” (Letter to Chairman Alexander) (Mercatus Center at George Mason University, Arlington, VA, February 28, 2019).

⁶ Matthew D. Mitchell and Anne Philpot, contribution to “Better Health for More People at Lower Cost, Year after Year” (Letter to Chairman Alexander) (Mercatus Center at George Mason University, Arlington, VA, February 28, 2019); Thomas Stratmann, contribution to “Better Health for More People at Lower Cost, Year after Year” (Letter to Chairman Alexander) (Mercatus Center at George Mason University, Arlington, VA, February 28, 2019).

4. *Innovative primary care models.*⁷ Under the direct primary care (DPC) model, for example, physicians offer primary care services for a flat monthly fee. DPC has been shown to result in lower costs and better service. However, in some states, insurance regulation makes it difficult for physicians to adopt novel institutional models.
5. *Unmanned aerial systems.*⁸ Drones can improve the speed at which drugs, blood, and other medical goods are delivered to the patients that need them. This capacity can save lives in time-critical situations when patients are in remote areas, traffic-clogged urban areas, or regions hit by weather conditions that make standard modes of delivery slow or impossible. Several countries have instituted large-scale medical drone programs. The United States is only beginning to explore this capability. (The bipartisan Drone Backlog Reduction Act proposed in the House of Representatives, along with the Department of Transportation’s Unmanned Aircraft Systems Integration Pilot Program, offers interesting possibilities for advancing this technology.)

Other areas for consideration include reforms involving occupational licensing and corporate practice of medicine. States have jurisdiction over these and other areas of healthcare policy, and the federal government can encourage states to take advantage of these advances. Thanks to the principles laid out in the October 2018 guidance on section 1332 waivers, states that implement reforms will receive increased flexibility to innovate. This focus on the supply side has attracted bipartisan support in a number of states—welcome opportunities to set aside partisan differences and accomplish meaningful healthcare reforms. Such flexibility enables states to give providers the incentive to offer better care to more people at a price those people can afford, year after year.

Finally, it is essential to note that unleashing innovation will ultimately require reform of two gigantic sources of inertia in American healthcare: the FDA and Medicare. While these are primarily federal programs, it is worth considering whether states might be allowed to innovate with respect to these two institutions. In recent years, for example, numerous states enacted right-to-try laws to achieve greater flexibility than standard FDA regulations permitted.⁹ (These state-initiated efforts led to a change in federal law.) Medicare’s highly regimented reimbursement system presents serious impediments to innovation, and it might well be advantageous to allow states to experiment with variations. I imagine such experiments fitting into Medicare in a way analogous to charter schools within public education—different models, more decentralized management, and yet part of the larger system. Section 1332 waivers may well be vehicles for such experimentation.

I am pleased to highlight these ideas and research papers from the Mercatus Center to inform your efforts in improving access to quality care.

⁷ Darcy Nikol Bryan, contribution to “Better Health for More People at Lower Cost, Year after Year” (Letter to Chairman Alexander) (Mercatus Center at George Mason University, Arlington, VA, February 28, 2019).

⁸ Robert F. Graboyes and Darcy Nikol Bryan, “Drones Delivering Medical Supplies and More Can Help Save American Lives,” *STAT*, January 18, 2019.

⁹ Richard Williams, Adam Thierer, and Robert F. Graboyes, “US Medical Devices: Choices and Consequences” (Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, 2015).