MERCATUS CENTER
George Mason University

POLICY BRIEF

Improving Healthcare Access in the States after COVID-19

Jared M. Rhoads, Darcy Nikol Bryan, and Robert F. Graboyes

July 2020

The speed and scope of COVID-19 took the United States by surprise. No state was adequately prepared to handle the pandemic, and no federal agencies had enough knowledge to offer sufficient guidance. As the country continues to cope with the crisis, the extent to which regulatory restrictions on healthcare access have hindered, and continue to hinder, states' ability to respond is increasingly obvious. Both patients with COVID-19 and patients with other health problems have suffered from restrictions on access to medical professionals and services—restrictions imposed long before the crisis hit. Now is the time to review these problematic restrictions and take action so that the states will be better prepared if and when a future crisis occurs. Implementing reforms will benefit patients and providers even in the absence of a crisis.

TOP HEALTHCARE ACCESS PRIORITIES FOR CRISIS PREPAREDNESS

The following initiatives should be priorities for state-level policymakers who wish to increase healthcare access in their states:

- Remove restrictions on telemedicine.
- Remove restrictions on scope of practice for nurse practitioners, pharmacists, behavioral health providers, midwives, and dental hygienists.
- Facilitate interstate licensing for medical professionals.
- Remove certificate-of-need restrictions.
- Ease restrictions on compounding pharmacies.
- Limit liability for charity caregivers.

- Allow insurers in other states to issue health insurance in the state.
- Remove restrictions on short-term insurance plans.
- Ease restrictions on direct primary care.

1. REMOVE RESTRICTIONS ON TELEMEDICINE

Ease Telepharmacy Location Restrictions

Telepharmacy refers to the use of telecommunications technologies such as videoconferencing to deliver pharmaceutical care and pharmacy services at a distance. Telepharmacy can be especially beneficial for rural patients. As the number of independently owned rural pharmacies falls, enabling a pharmacist to support clinical services such as diagnostics and disease management or to provide patient education, medication reconciliation, and other services at a distance can be a safe and efficient way to deliver high-quality care. Some exemplary states in this realm include New Mexico, North Dakota, South Dakota, and Wyoming, each of which has defined *telepharmacy* and clearly described the provisions that pertain to it.

Allow Broad Medicaid Reimbursement by Provider Type

Telemedicine has been shown to be beneficial across a wide variety of specialties and clinical areas, including psychiatry,[1] chronic disease management,[2] and nutrition coaching,[3] to name just a few. Unfortunately, many states restrict the use of telemedicine in their Medicaid programs by allowing only certain types of providers to be reimbursed when they use telemedicine to provide otherwise reimbursable services. Twenty-six states and the District of Columbia allow broad Medicaid reimbursement by provider type. These states, which include California, Colorado, Florida, Massachusetts, Michigan, New Hampshire, and Utah, do not make reimbursement conditional on the type of provider that performs a telemedicine service.

Ease Telepresenter Requirements

A telepresenter is a special assistant who must be physically present with the patient during telemedicine encounters in order to make those encounters eligible for Medicaid reimbursement. States have different rules regarding the need for, and use of, telepresenters. While telepresenters might be desirable in some cases, requiring their presence can be an obstacle to care. Thus, the decision about whether to use a telepresenter should be left to the physician and the patient. Three examples of states that have recently lifted their telepresenter laws are Illinois and Missouri (in 2018) and Texas (in 2017). In each of these cases, the repeal of the telepresenter provision was part of a more comprehensive bill aimed at simplifying and removing barriers to telehealth.

Allow Online Prescribing

Online prescribing occurs when a physician prescribes a drug to a patient on the basis of an online visit, encounter, or interaction. To protect against the misuse or abuse of this ability, all states require that physicians and patients establish a relationship before the physician may write a prescription. However, states vary in what they require and whether they allow the relationship to be established using telemedicine. Having fewer limitations on online prescribing is best for maximizing convenience and patient autonomy. Two examples of states that have recently passed legislation allowing greater leeway for online prescribing are New York and West Virginia. Both states in 2019 refined their online prescribing rules to allow providers to support medication-assisted treatment through telehealth.

Allow Online Eye Exams

It is possible to conduct certain types of eye examinations online with the help of innovative mobile apps. For some individuals, the convenience and cost savings make an online refractive eye exam an attractive proposition. During a pandemic, online eye exams reduce in-person contact. To date, the FDA has been the primary intervener in this space, preventing online eye exam providers from advertising any app-based service as a diagnosis-making medical device, but states have started to become involved too: multiple states either prohibit or restrict online eye exams. The majority of states do not have a law against online eye exams and therefore allow maximum innovation in this area by default. The states that are of most interest in this regard, therefore, are the states that have specifically acted to restrict online eye exams: Georgia, Indiana, and South Carolina. To date, these bans generally have been advanced under the banner of "consumer protection." In 2016 in South Carolina, the then governor opposed the piece of legislation instituting the ban and vetoed it, but the legislature overrode her veto.

Reimburse Medicaid Providers at Parity for Store-and-Forward Telemedicine

Store-and-forward telemedicine refers to a form of telemedicine in which images, video, or data are captured on the patient side and then uploaded to a server for later evaluation by a healthcare provider. Whereas in private insurance the policy of whether store-and-forward telemedicine is reimbursed should be left to insurers and physicians to decide, in public programs such as Medicaid, there is a public interest in ensuring that care can be delivered as efficiently as possible. Progress in this area often comes by way of a state redefining telemedicine to specifically include store-and-forward technologies, allowing them to be reimbursable in Medicaid. New Mexico is an example of a state that recently redefined telemedicine in this way. It changed its law on this issue in 2019.

Reimburse Medicaid Providers at Parity for Remote Patient Monitoring

Remote patient monitoring is a type of telemedicine in which devices collect patient information such as vital signs, blood oxygen levels, heart rate, and blood sugar levels and relay this information to monitoring centers. Clinicians working at monitoring centers can intervene or call for help if the data indicate that a patient is in distress. Three exemplary states in this regard are Louisiana, Maryland, and Virginia, all of which recently passed legislation allowing Medicaid providers to be reimbursed at parity for remote patient monitoring.

2. REMOVE RESTRICTIONS ON SCOPE OF PRACTICE FOR NURSE PRACTITIONERS, PHARMACISTS, BEHAVIORAL HEALTH PROVIDERS, MIDWIVES, AND DENTAL HYGIENISTS

Grant Nurse Practitioners Broad Scope of Practice

Growing evidence indicates that nurse practitioners, who are advanced-practice registered nurses trained at the graduate level, can perform some primary care services as safely and effectively as physicians perform them.[4] The same logic applies to other advanced-practice nurses, such as clinical specialists and nurse anesthetists. Washington State is generally considered one of the best states in terms of allowing nurse practitioners a broad scope of practice. One of the states that most recently improved in this area is Florida—it broadened the scope of practice for nurse practitioners in 2020.

Grant Pharmacists Broad Scope of Practice

Pharmacists play a critical role in providing care to patients, but states impose a variety of barriers to their practice. States decide whether pharmacists are allowed to initiate or update drug therapy pursuant to a written collaborative practice agreement with a licensed provider; manage medication therapy outside a pharmacy setting; administer drugs, immunizations, and tests; interpret and prescribe on the basis of test results; order lab tests; and prescribe naloxone. California, Iowa, and New Jersey are exemplary states on this issue. Two states that have acted very recently on this issue are Florida and West Virginia, both of which passed legislation to broaden pharmacist scope of practice in 2020.

Grant Behavioral Health Providers Broad Scope of Practice

Addiction counselors provide addiction recovery support and other services in a variety of community settings. State credentialing requirements determine what treatments addiction counselors may provide and to whom, so the requirements can make these services either easier or more difficult for patients to obtain. Many states grant behavioral health providers broad scope of practice, including Oregon, Pennsylvania, and Wisconsin.

Allow Midwives to Practice

There exist several paths to becoming a midwife. Certified nurse-midwives have earned a bachelor's degree in nursing, have completed training in a nurse-midwifery program, and have passed a national exam. Certified midwives have earned a bachelor's degree in a health-related field other than nursing and have also participated in a nurse-midwifery program and passed a national exam. Certified professional midwives have gained experience in midwifery through self-study, apprenticeship, or some other form of training and have passed a national exam. While certified nurse-midwives are allowed to practice in all 50 states and the District of Columbia, certified midwives and certified professional midwives may practice in only a few states, which limits access to maternity care. Examples of states that allow midwives to practice relatively unencumbered by regulation include Kansas, Mississippi, and Nevada.

Grant Dental Hygienists Broad Scope of Practice

Dental hygienists assist dentists in meeting patients' oral healthcare needs by providing routine care such as teeth cleaning and dental X-rays. Depending on the state, dental hygienists can be allowed to work independently or required to work under the authority of a dentist as a primary oral health professional. There are no states that currently grant dental hygienists broad scope of practice. Some states restrict dental hygienists to a greater extent than other states do, but all restrict these professionals in some way. This is an area in which a state legislature could take innovative steps.

3. FACILITATE INTERSTATE LICENSING FOR MEDICAL PROFESSIONALS

The Interstate Medical Licensure Compact is an agreement by certain states according to which licensed physicians can qualify to practice medicine across state lines within participating states if they meet eligibility requirements. States that have joined the compact enjoy enhanced access to medical professionals by removing barriers to these individuals' mobility. More than half of the states, plus the District of Columbia, now allow some form of interstate licensing by belonging to the Interstate Medical Licensure Compact. Kentucky, Michigan, and North Dakota are the three states that most recently joined the compact, all in 2019.

4. REMOVE CERTIFICATE-OF-NEED RESTRICTIONS

Certificate-of-need (CON) laws are laws that require healthcare providers to seek approval from their state government before making new investments in facilities, equipment, or services. While the stated purpose of CON laws is to limit healthcare cost growth by avoiding the duplication of services, research shows that the laws lead to greater expenditures,[5] lower quality of care,[6] and diminished access to needed services.[7] By removing CON requirements, states can enable more competition to flourish, which helps patients by improving healthcare access and driving down costs.[8]

The last state to fully repeal its CON laws was New Hampshire in 2016, but other states have made modifications to their CON laws since then. Notably, during the COVID-19 pandemic, many states (including Connecticut, Michigan, and South Carolina) temporarily suspended their CON laws so as not to stand in the way of institutions trying to add much-needed healthcare system capacity.

5. EASE RESTRICTIONS ON COMPOUNDING PHARMACIES

Compounding pharmacies have played a role in the provision of pharmaceutical products for decades. They are laboratories in which pharmacists mix drugs to create custom medications for patients. The FDA defines a sterile drug compounding pharmacy as a facility in which a pharmacist combines, mixes, or alters ingredients of a drug to tailor medications to the needs of specific patients. Some states prohibit compounding pharmacies from making extra quantities of drugs (called "office stock"). To increase pharmacy responsiveness to patient needs, these restrictions should be eased. Eleven states allow traditional pharmacies to compound sterile office stock; these states include Arizona, New Hampshire, Oregon, and Tennessee.

6. LIMIT LIABILITY FOR CHARITY CAREGIVERS

Many retired and practicing physicians want to volunteer their time and expertise to care for underserved populations. However, the cost of malpractice insurance is prohibitive, acting as a barrier to the growth of a volunteer physician workforce that would expand healthcare access for impoverished patients. Some states have sought to mitigate this risk by enacting legislation that limits the liability of physician volunteers. Relatively few states offer charity caregivers immunity from liability. An exemplary state on this issue is Idaho, which provides qualified immunity to volunteer healthcare providers when they provide care in free medical clinics and community health screening events. In 2020, Idaho extended its law to include medical students.

7. ALLOW INSURERS IN OTHER STATES TO ISSUE HEALTH INSURANCE IN THE STATE

The market for private health insurance in the United States is largely compartmentalized by state. Each state regulates health insurance differently, and most states do not allow health insurance companies from other states to sell policies in the areas under their jurisdiction. Proponents of the sale of health insurance across state borders point to the potential for improved consumer choice and lower prices. The most recent state to enact a law allowing this was Oklahoma, in 2017.

8. REMOVE RESTRICTIONS ON SHORT-TERM INSURANCE PLANS

Short-term renewable health insurance is insurance sold to individuals for up to one year and is sometimes renewable for multiple years. It exists as an alternative to the traditional employer-

sponsored insurance system for individuals who find that they want or need coverage on a more temporary basis. Short-term renewable health insurance is a special category of insurance because these policies are exempt from federal health insurance regulations. Policies in this category can be significantly less expensive than traditional health insurance and offer better access to medical care.[9] State-level actions are going in opposite directions on this issue. For instance, Maine, Maryland, and Vermont have all recently passed legislation to add further restrictions to short-term plans. They are not good examples to follow. By contrast, Arizona, Indiana, and Oklahoma have enacted legislation that removes restrictions, allowing policies that satisfy the federal maximum on duration and renewability.

9. EASE RESTRICTIONS ON DIRECT PRIMARY CARE

Direct primary care (DPC) is a model of healthcare provision in which a primary care doctor charges patients a retainer fee covering all or most primary care services, including clinical, laboratory, and consulting services. This model enables physicians to move away from fee-for-service insurance billing. DPC practices claim to reduce administrative overhead by approximately 40 percent.[10] Additionally, DPC practitioners have the flexibility to use email and telemedicine to interact with patients, which is a benefit of the model because these methods of providing care are not typically compensated by insurance companies.

Do Not Treat DPC as an Insurance Product

Despite the clear benefits of DPC, opponents of DPC charge that the model constitutes a form of managed care and thus violates insurance regulations. These accusations drive physicians away from opening DPC practices, reducing patient choice. To get the benefits of DPC, states can clarify that DPC does not represent insurance and will not be subject to insurance regulations. Exemplary states on this issue include Colorado, Kansas, and Texas. The states that most recently enacted legislation clarifying that DPC is not insurance (all in 2019) are Arizona, Georgia, Hawaii, Maryland, Minnesota, New Hampshire, South Carolina, and Wisconsin.

Allow DPC Wholesale Lab Pricing

DPC wholesale lab pricing is the ability of a DPC practice to negotiate low rates with national laboratories and pass the savings on to their patients. As a supposed anti-markup consumer protection measure, some states require that laboratories bill patients or insurers directly, meaning that a DPC practice cannot be the entity that purchases the laboratory work. This has the unintended effect of preventing DPC practices from getting a wholesale price on labs, even though a wholesale price could result in savings for patients. The vast majority of states allow DPC wholesale lab pricing. In fact, there are only two states that prohibit DPC practices from offering this service to their patients: New Jersey and New York.

Allow DPC Drug Dispensing

DPC drug dispensing is the ability of a DPC provider to dispense medications on site at his or her clinic. This is a key benefit of the DPC model. By the time a drug is sold at a retail pharmacy, its cost may have increased by up to 200 percent.[11] DPC providers can provide the medication at near-wholesale prices, passing on the cost savings to their patients. The best states on this issue are the states that permit DPC drug dispensing and have no registration requirement. Exemplary states include Connecticut, Delaware, Michigan, South Dakota, and Vermont.

CONCLUSION

The COVID-19 pandemic offers a rare opportunity and imperative to rethink thousands of restrictions on the provision of healthcare. This includes restrictions on which professionals can provide which types of healthcare, the types of care specific institutions can provide, the extent to which patients can determine the course of their treatments, which means of delivering care are allowable, and how care should be paid for. With the advent of the pandemic, states rushed to effect many of the reforms suggested here—often out of a sense of desperation. The pandemic laid bare the dangers inherent in these restrictions. But these laws and regulations degraded the provision of healthcare and raised costs long before the word "coronavirus" entered the public lexicon. While COVID-19 has been an unparalleled disaster in many dimensions, perhaps a silver lining will be to make clear the negatives imposed by layers upon layers of healthcare restrictions laid down over a century or more.

ABOUT THE AUTHORS

Jared M. Rhoads earned his MPH in public health and health policy at Dartmouth College. He is a research project manager at the Dartmouth Institute for Health Policy and Clinical Practice. His previous education includes a BS in management of information systems from Worcester Polytechnic Institute in 2002 and an MS in information technology from Bentley University in 2005. He was a Mercatus Center Frédéric Bastiat fellow. He has previously worked in the healthcare industry as a researcher and consultant. Rhoads's research interests include health policy and healthcare innovation.

Darcy Nikol Bryan is an obstetrics and gynecology physician with an active practice at Women's Care Florida in Tampa. She earned an MD from Yale University's School of Medicine and a master's in public administration from the University of Texas at Arlington. She is a certified remote pilot and student private pilot. Her research encompasses public policy and the impact of technology on healthcare provision. She coauthored the book *Women Warriors: A History of Courage in the Battle against Cancer*.

Robert F. Graboyes is a senior research fellow and healthcare scholar at the Mercatus Center at George Mason University. Previously, he was a healthcare adviser for the National Federation of Independent Business, an economics professor at the University of Richmond, a regional economist and director of education at the Federal Reserve Bank of Richmond, and a sub-Saharan Africa economist for Chase Manhattan Bank. His degrees include a PhD in economics from Columbia University; master's degrees from Columbia University, Virginia Commonwealth University, and the College of William and Mary; and a bachelor's degree from the University of Virginia.

NOTES

1. Rashid L. Bashshur et al., "The Empirical Evidence for Telemedicine Interventions in Mental Disorders," *Telemedicine and e-Health* 22, no. 2 (2016): 87–113.
2. Adam Darkins et al., "Care Coordination/Home Telehealth: The Systematic Implementation of Health Informatics, Home Telehealth, and Disease Management to Support the Care of Veteran Patients with Chronic Conditions," *Telemedicine and e-Health* 14, no. 10 (2008): 1118–26.
3. James H. Rimmer et al., "Telehealth Weight Management Intervention for Adults with Physical Disabilities: A Randomized Controlled Trial," *American Journal of Physical Medicine & Rehabilitation* 92, no. 12 (2013): 1084–94.
4. S. A. Brown and D. E. Grimes, "A Meta-Analysis of Nurse Practitioners and Nurse Midwives in Primary Care," *Nursing Research* 44, no. 6 (1995): 332–39.
5. Matthew D. Mitchell, "Do Certificate-of-Need Laws Limit Spending?" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2016); David M. Cutler, Robert S. Huckman, and Jonathan T. Kolstad, "Input Constraints and the Efficiency of Entry: Lessons from Cardiac Surgery," *American Economic Journal: Economic Policy* 2, no. 1 (2010): 51–76.
6. Thomas Stratmann and David Wille, "Certificate-of-Need Laws and Hospital Quality" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2016).
7. Melissa D. A. Carlson et al., "Geographic Access to Hospice in the United States," *Journal of Palliative Medicine* 13, no. 11 (2010): 1331–38; Thomas Stratmann and Matthew C. Baker, "Winners and Losers from Barriers to Entry in the Healthcare Markets: Evidence from Certificate-of-Need Laws" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2017).
8. Thomas Stratmann et al., "Certificate-of-Need Laws: Frequently Asked Questions," Mercatus Center at George Mason University, August 29, 2017, https://www.mercatus.org/publications/corporate-welfare/certificate-need-laws-frequently-asked-questions.
9. Chris Pope, *Renewable Term Health Insurance: Better Coverage Than Obamacare* (New York: Manhattan Institute, May 16, 2019).
10. Phillip Eskew and Kathleen Klink, "Direct Primary Care: Practice Distribution and Cost across the Nation," *Journal of the American Board of Family Medicine* 28, no. 6 (2015): 793–801.
11. Stacie B. Dusetzina et al., "Association of Prescription Drug Price Rebates in Medicare Part D with Patient Out-of-Pocket and Federal Spending," *JAMA Internal Medicine* 177, no. 8 (2017): 1185–88.