

RESEARCH SUMMARY

Healthcare Openness and Access Project 2020: Prerelease Summary

The Mercatus Center at George Mason University is prereleasing a working-paper version of its long-planned 2020 edition of the Healthcare Openness and Access Project (HOAP). It does so in hopes of giving policymakers ideas on how to stretch their healthcare resources as COVID-19 (novel coronavirus) sweeps the country. The full, peer-reviewed version of HOAP 2020 should be available for release this summer.

There is broad agreement in the United States that it would be desirable to lower the cost and improve the quality of healthcare and to broaden health insurance coverage. There is much disagreement, however, about how this trio of goals is to be accomplished. Proposals from various political perspectives have one thing in common: they assume the key to lower costs and better care is to reconfigure the insurance system.

However, health insurance reform should not be the sole or even principal focus of reform efforts. States have (and should have) substantial control over the delivery of healthcare—and not solely or principally in the area of insurance reform. To make the best use of state powers in improving care, it is vital to compare how healthcare institutions work across the states. In [HOAP 2020](#), Jared M. Rhoads, Darcy N. Bryan, and Robert F. Graboyes present state-by-state measures of the flexibility and discretion that patients and providers have in managing health and healthcare.

HOAP seeks to raise important questions, such as how open each state’s laws and regulations are to institutional variation in the delivery of care and how much access to varying modes of care this openness confers on the state’s patients and providers. The goal of HOAP is to encourage these types of questions rather than to provide definitive answers.

RELEVANCE TO COVID-19

HOAP focuses on healthcare laws and regulations at the state level, and many of the questions it addresses are central to the battle with COVID-19. Using emergency powers, governors across the country have at breathtaking speed effectively implemented nationwide medical licensure, reduced restrictions on telemedicine, eased licensure requirements for healthcare professionals, expanded scope of practice for nonphysician providers, eliminated certificate-of-need requirements faced by hospitals, and opened the way for pharmacists to produce hand sanitizer.

In a few short weeks, COVID-19 extended outside China, swept across more than 100 countries (hitting Western Europe especially hard), and began spreading across the United States. To slow the contagion and prevent it from overwhelming healthcare systems (as it has in Italy), large swaths of the world economy have begun shutting down. People are staying home, as social distancing and self-isolation become the key to “flattening the curve.”

HOAP suggests a complementary strategy that might be called “raising the ceiling”—increasing healthcare system capacity to lessen the need to flatten the curve. HOAP stresses policies that maximize the capacity of patients and

providers to improvise and innovate. And, as states experiment with the lessons of HOAP in time of emergency, perhaps they will find these ideas more appealing for the calmer times that will follow this pandemic.

BACKGROUND AND STUDY DESIGN

HOAP's overall index averages five equally weighted categories of indicators (variables) that measure the discretion that patients, providers, and institutions have over broad areas of healthcare, such as public health and telemedicine. The equal weighting of indicators within each category is an explicit recognition of the fact that no single set of weights should be considered "correct." HOAP is constructed so that readers and researchers can alter the weights assigned to different variables to reflect their own preferences.

The first iteration of HOAP (HOAP 2016) was issued in December 2016. HOAP 2018, issued in June of that year, revised the data to reflect changes in state laws in the interim and to reflect modest changes in sources of data. HOAP 2020 incorporates new indicators that may better represent the discretion states allow in the provision of healthcare goods and services. HOAP 2020's five categories replace the previous editions' ten subindexes. Changes in state rankings between 2018 and 2020 reflect both changes in methodology and changes in states' laws and regulations, so one should be cautious about reading too much into the numeric differences between HOAP 2018 and HOAP 2020.

KEY POINTS

- *Insurance isn't the only issue.* To be sure, insurance is a very important part of the healthcare system, and HOAP does include some insurance-related indicators. However, simultaneous progress on the three goals of healthcare reform—lower costs, higher quality, and broader coverage—will require fundamental changes in the technologies and structures of care and in how, where, when, and why care is delivered. HOAP highlights institutional features that help determine the degree to which experimentation is possible.
- *States matter in healthcare policy.* States possess great power to determine which providers may perform what services, the means by which they may do so, their legal responsibilities in the event that patients suffer harm, and so forth. The HOAP index suggests how the states differ in encouraging delivery-system innovation.
- *Perception of state policies does not always match reality.* For example, a leftward tilt in the ACA debate does not necessarily correlate with tight centralized control of healthcare at the state level. Nor does a rightward tilt in the debate always comport with extensive patient-provider discretion. For example, HOAP data suggest that "blue" states Oregon and Hawaii offer broad leeway to patients and providers, while "red" states Arkansas and Kentucky have some of the most restrictive healthcare laws and regulations in the nation.
- *Comparisons among states are important.* HOAP as a whole provides a great deal of comparative data on healthcare policy in the states. It is a one-stop source of information on policy differences around the country. As an example, 41 states require a physician's signature to prescribe oral contraceptives. So, to many, that requirement may seem to be the natural order of things, a universal. But 10 jurisdictions (including the District of Columbia) allow pharmacists to autonomously prescribe oral contraceptives. Perhaps this anomaly will persuade policymakers in other states to at least ask how that market functions in those 10 jurisdictions.
- *Discussion is valuable to determine how to move forward.* HOAP should become a catalyst for discussion, but it is not the definitive measure of openness, access, flexibility, or discretion in healthcare for any particular state. If observers question aspects of the index and offer alternative measures, then the project will have done its job.