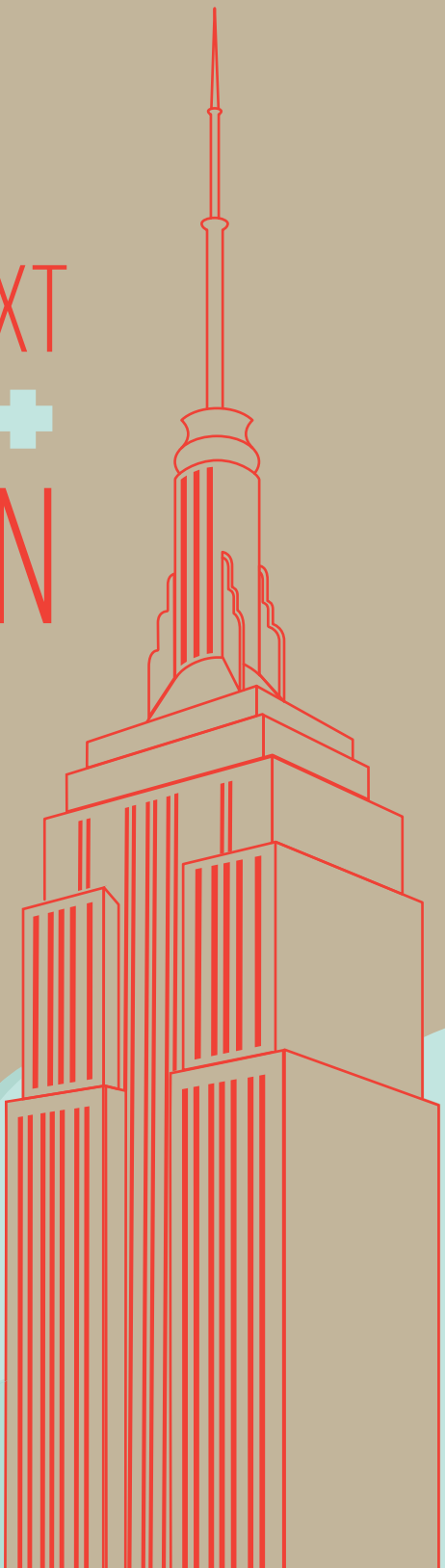
NEW YORK'S NEXT HEALTH CARE REVOLUTION

HOW EMPLOYERS CAN EMPOWER PATIENTS AND CONSUMERS



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CHAPTER 2

Bringing Effective Competition to New York's Health Care System

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Introduction

The New York State health care system has both an opportunity and a pressing need to transform itself into an efficient, high-performing system that offers top value to consumers. The state's providers excel in many ways: Memorial Sloan Kettering is among the best cancer treatment centers in the world, for example, and New York Presbyterian is consistently ranked among the top ten U.S. hospitals.[1] But the cost of health care in the state has long been among the most expensive in the country, and performance has lagged in many other key respects. Fortunately, New York can build on changes that are already under way to bring the state to the forefront of health care in the nation.

This is certainly no time for federal or state policymakers to consider America's health care spending problem "cured." Despite the recent slowdown in health spending growth, rising costs continue to impose an ever-larger burden on employers, consumers, and taxpayers. In 2015, New Yorkers will spend $234 billion on health care—about one of every six dollars produced in the state.[2] Unless action is taken, health spending in New York State is projected to grow to nearly $320 billion by 2020, rising by more than one-third in a mere five years.[3]

Nationally, the cost picture is equally bleak. The actuaries at the Centers for Medicare and Medicaid Services (CMS) project that national health spending will grow from $3.2 trillion in 2015 to $4.3 trillion in 2020, reaching $5.2 trillion by 2023.[4] Health spending will increase from 17.6 percent to 19.3 percent of GDP over that period.

The impact of high and rising costs extends beyond the burden placed on family budgets by insurance premiums and copayments for

health services. Unpredictable health care cost growth has made it difficult for employers to plan for future hiring and business expansion. Employees' wages have stagnated as a growing share of worker compensation is devoted to covering the cost of health insurance.

Rising health costs also limit the ability of government—federal, state, and local—to finance education, social services, housing, and other critical policy priorities.[5] Over the next decade, the federal government will spend a total of $14.6 trillion for major health programs (including Medicare, Medicaid, subsidies for insurance through the exchanges, and the Children's Health Insurance Program), making health care the largest single category of spending in the budget.[6] Left unchecked, federal health spending and interest on the debt is expected to consume every dollar of federal revenue by 2089.[7]

The fiscal impact of health care on state and local government budgets is equally serious. In 2012, state and local governments paid $475 billion for health care.[8] The state share of Medicaid alone accounted for $189 billion, and contributions to employee and retiree insurance accounted for $153 billion. The remainder was used to finance state and local health departments and other health programs (including the Children's Health Insurance Program, school health, and maternal and child health programs).

New York has the nation's third-largest public retiree health plan, with $250 billion in unfunded liabilities at the state and municipal levels.[9] Because these expenses are incurred on a pay-as-you-go basis, taxpayers must bear the full cost of past promises made to retirees. Annual costs for current employees are ramping up as well, with about $2 billion in expenditures for state employees in 2013.

Despite the high price tag, it is widely recognized that Americans do not get enough bang for their health care buck. The Institute of Medicine estimates that 30 percent of health spending is wasted or misused.[10] Unnecessary services and inefficiently delivered care account for about half of the unnecessary spending. High administrative costs, fraud, and failure to adopt preventive health measures also contribute to the excess cost.

States that, like New York, spend the most for health care do not obtain substantially better performance than states that spend less. In 2009, New York was the sixth-most expensive U.S. state, measured as

health spending per capita; over the previous two decades, the state was the third- or fourth-most expensive.[11] Yet the Commonwealth Fund's 2014 State Scorecard ranks New York 19th in the nation on the overall quality of its health care system. New York was ranked 36th on potentially avoidable use of hospitals and cost of care, 17th on access and affordability, and 12th on healthy lives.[12]

The mismatch between health spending and value produced by the health care system is stark and long-standing. Health care has largely failed to adopt new, more efficient, user-friendly ways of delivering better services at better prices. In contrast, other industries with consumer-focused business models have been able to improve their products and services while keeping cost in check. The smartphone in your pocket, for instance, is more powerful and costs less than a large desktop computer did a decade ago.

Effective competition is the missing ingredient in American health care, for competition promotes quality improvement and cost-saving efficiencies that benefit consumers. Tight government regulation and misguided payment policies discourage the entry of new health plans and adoption of new ways of delivering services.

Fostering true competition is not a matter of simply counting noses. In well-functioning markets, consumers have a choice of firms supplying the product. They also have the necessary information and control over resources so that their preferences and purchasing decisions drive the market.

Indeed, New York has an abundance of hospitals and insurers but very little effective competition on the basis of cost and quality. Consumers—and even many payers, such as large self-insured corporations—have little or no ability to compare the price and performance of different providers. In the absence of such information, inefficient providers can charge higher prices than otherwise possible, and unsafe practices are likely to continue.

These are conditions that have long been the rule in the health sector because of the failure to foster effective competition. In contrast, household names in the 1970s in the consumer electronics industry—including IBM, Texas Instruments, and Hewlett-Packard—were forced to radically change their business models and eventually lost out to more nimble competitors like Apple, Microsoft, and Google. While the technology

inside hospitals has changed, their structure and business model have remained largely unchanged and unchallenged for most of the last half-century, thanks in part to rigid regulation and perverse financial incentives at the state and federal levels.

Major reforms are needed to promote effective competition among health industry stakeholders and to shift the health sector to a focus on the consumer. To be sure, federal health policy—including the Affordable Care Act (ACA), rules governing Medicare and Medicaid, tax provisions, antitrust activities, and other federal regulatory actions—plays a dominant role in shaping the way much of the health system operates. But within that context, New York's citizens, employers, legislators, and regulators can pursue an important pro-competitive agenda to make the state's health care more efficient and effective and less expensive.

I. Why Competition Matters

Health care in the United States is an amalgam of public and private financing for services that are largely provided by private hospitals, physicians, and other practitioners. At its best, American health care is the best in the world. But much of our care falls short of that ideal, and all of it is expensive.

The rising cost of health benefits has largely absorbed the funds that would otherwise have resulted in higher cash wages for workers, threatening the ability of families to pay for care while meeting other obligations. Federal, state, and local budgets are also feeling pressure from the rising cost of health care, drawing away spending from other priorities. The cost of health care is seen in high insurance premiums, large deductibles and copayments, and high fees. It is also hidden in reduced wages, higher taxes, and restrictions on what consumers may buy.

Despite unparalleled levels of health spending, tens of millions of Americans lack insurance coverage for lengthy periods of time.[13] Even with expanded access to insurance through the ACA, there are likely to be some 30 million uninsured people once the reform takes full effect;[14] 1.7 million New Yorkers are expected to remain uninsured even after full implementation.[15] Moreover, the care that people receive too often fails to yield improvements in their health and well-being commensurate with the trillions we pay.

Increased competition is the key to resolving these problems. Competing manufacturers and suppliers aggressively seek ways to trim unnecessary costs and improve their products to attract a larger share of the market; in some cases, they create entirely new markets. Online retailers such as Amazon created a more convenient way to shop for many consumers that would not have been identified if we were limited to sales in brick-and-mortar shops. Competition is vigorous in many industries, resulting in lower prices, a wider variety of products, and greater innovation.

Competition is the exception, not the rule, in American health care, although that may be changing. After a failed attempt in the 1990s to control health benefit costs by shifting to restrictive managed care plans, many employers now offer a choice of high-deductible insurance in addition to more traditional types of health plans. The rapid adoption of high-deductible insurance plans is a significant factor driving the slowdown in health spending over the past decade.[16] More realistic choices, with out-of-pocket prices reflecting the true cost of health services, caused workers to reevaluate what they wish to purchase and how much they wish to pay.

Medicare's Part D prescription drug benefit offers a rare glimpse of competition in U.S. health care. Seniors have a wide range of coverage choices from competing plans, allowing them to select better coverage at lower cost. In 2012, actual program costs were 57 percent lower than CBO projections, partly because of the impact of competition and consumer choice.[17] Aggressive negotiation between Part D plans, pharmaceutical manufacturers, and pharmacies have created incentives to promote greater use of generic drugs, keeping costs down.

Perhaps more important, consumer satisfaction with the Medicare Part D program is consistently very high. A 2007 AARP survey—shortly after the program launched—found that 85 percent of Part D beneficiaries were satisfied with their drug plans, and 78 percent felt that they had made a good decision.[18] Satisfaction remains (as of 2013) at, or above, 90 percent, including for low-income seniors eligible for additional federal subsidies.[19]

In 2014, more than 37 million Medicare beneficiaries enrolled in Medicare drug plans, an increase of 2 million since 2013 and 15 million since 2006.[20] Although Congress specified a standard-benefit

package when it enacted Part D, it gave the plans flexibility to innovate. In 2015, no plans use the standard benefit design, but all plans offer benefits valued at least as much, with 55 percent of the plans offering extra benefits.[21] The base premium in 2015 is $33.13 per month, a 2 percent increase over the previous year. The program's costs (measured per enrollee) have risen, on average, by 2.3 percent annually between 2006 and 2013, well below other health care costs.

The Part D experience demonstrates that a well-organized competitive market in health care will work. Plans found enough customers to make the coverage affordable and attractive while remaining sufficiently profitable to operate over the long term. This was accomplished without going back to the taxpayer for ever-increasing subsidies and without needing a government-run plan to fill in if private plans chose not to compete.

II. Why Competition Remains the Exception

Health care consumers are ready for a change. A PricewaterhouseCoopers survey found that consumers want a better experience with their providers: better access to information (including online and mobile applications), more convenient access to services, and better communication during the visit.[22] They also want better information from insurers and faster claims processing. Consumers want the health system to better respond to their needs at an affordable price.

Encouragingly, change *is* occurring in the U.S. health system, and more is to come. Rising costs have led employers and insurers to develop health plans that give consumers greater say in what they buy and how much they pay. The ACA's "Cadillac tax," a 40 percent excise tax on the value of employer-sponsored plans that exceed a threshold amount, has added to the pressure to adopt lower-cost health plans; that pressure will persist regardless of how the courts may rule or how Congress may seek to change provisions in the law. These forces are reshaping how consumers and patients interact with the health system. Indeed, employers have already begun to respond by trimming back the generosity of their health coverage.[23]

Government insurance exchanges also bring more health plan choices to consumers who do not have access to insurance through work.

Narrow provider networks and higher out-of-pocket costs, including high deductibles, are becoming adopted widely on state exchanges, including New York's. They require consumers to shop carefully for the plans that best fit their families' needs. Whether they have employer-sponsored insurance or purchase coverage on the ACA exchanges, consumers will increasingly need to assume more responsibility for the plans they choose and health care received. The question is thus: Will we create a competitive environment where innovative providers and insurers are driven to provide the tools and information that consumers require to make the best decisions for themselves and their families?

We have made real progress but are not yet headed toward a fully competitive, consumer-friendly health system. Formidable roadblocks remain to reforming a system that is neither highly competitive nor highly responsive to consumer demands. Numerous factors that prevent competition from taking hold more broadly in the American health care sector are, nevertheless, amenable to reform from policymakers in New York.

How we finance health care discourages competition

Because of substantial tax benefits, the majority of Americans in the health insurance market have long preferred to purchase coverage through employers rather than on the open market. Premium payments made by workers for their employer-sponsored health insurance are excluded from their income for tax purposes. In 2014, this exclusion is estimated to save families more than $300 billion in federal income and payroll taxes.[24]

The tax exclusion is available only through one's employer, discouraging workers from considering other sources of coverage. This reduces the size of the individual insurance market and reduces the scope of competition among insurers. The subsidy also encourages workers to buy more generous health insurance with low deductibles and other cost-sharing requirements, masking the true cost of health services and encouraging greater utilization than otherwise.

Traditional health insurers pay physicians, hospitals, and other providers on a fee-for service basis. This means that the provider receives additional payments for delivering additional services, regardless of whether the service is an essential part of the patient's treatment. Providers under

this system have strong incentives to provide more services; generous coverage, with low out-of-pocket costs, reduces consumer concerns about unnecessary costs. These financial incentives have played a major role in the rapid rise of U.S. health care spending.

Because of growing concerns about cost and performance, alternative financing arrangements have become increasingly popular. To create more cost awareness among consumers, employers are increasingly offering high-deductible health plans linked to a health savings account (HSA) for medical expenses. Account-based plans give consumers more direct control over, and more responsibility for, their health spending.

America's Health Insurance Plans (AHIP) reports that enrollment in HSA-qualified high-deductible plans has grown from 3.2 million people in 2006 to 17.4 million in 2014.[25] Across the nation, about 10 percent of people enrolled in commercial health insurance participated in such plans. New York is well below that level, with 5.4 percent of the state's commercial insurance enrollment in HSA-qualified high-deductible plans.

This is, however, likely to change because many of the plans offered on the ACA's insurance exchanges are also high-deductible, although the law does not authorize a savings account to help enrollees cover their out-of-pocket costs. An analysis of health plans offered in 2014 on the 34 federally facilitated insurance exchanges shows that average deductible amounts for bronze-, silver-, and gold-level health plans are all above the Treasury's definition of "high deductible."[26]

Employers are trying other approaches to slow rising health costs and improve outcomes. There is increasing interest in shifting from fee-for-service to payment for an episode of care ("bundled payment") and other performance-based payment methods. The Pacific Business Group on Health has developed a "centers of excellence" program that negotiates bundled payments with high-quality health centers, focusing first on hip and knee replacements.[27]

Less progress has been made tying payment for services to measures of quality or outcomes. Typical pay-for-performance systems provide a bonus to providers that meet or exceed agreed-upon quality or process measures. There are more than 40 private-sector pay-for-performance programs and numerous other federal initiatives.[28] However, the technical challenges are substantial, and only a small percentage of health services have payments tied to performance measures.

Private insurance exchanges—which could give workers more health plan choices than the typical employer plan—are attracting interest, though their impact on cost remains uncertain.[29] Employers are also adopting a defined contribution approach, with increasing interest in shifting to a private exchange rather than continuing to offer only one or two insurance options. Rather than paying for more expensive health plans, a fixed employer premium contribution gives workers a strong incentive to select lower-cost, higher-value plans while allowing them to purchase more expensive plans if they wish.

Nonetheless, the push to base contracts on outcomes—and not just process metrics—should remain a critical focus for New York's employers, public and private. Process metrics can be easily manipulated and can encourage the very type of overutilization that has long defined fee-for-service health care. By using analytics to map relationships between conditions, treatment pathways, and outcomes, policymakers can focus their efforts on creating bundled payments for complex services, which can promote care coordination. By focusing on outcomes and total costs, purchasers can remain agnostic about exactly how to achieve those outcomes, or who is most capable of delivering them.

Payment reform can discourage the fragmentation and overutilization that has defined fee-for-service contracts to date, while encouraging innovation and competition in the delivery of care to consumers. Liberating the market for new competitors to challenge incumbents around these types of contracts is the next critical step—thereby generating synergy for other reforms like reference pricing, direct contracting, value-based insurance design, and health savings accounts or consumer-directed health plans.

Health care cost and quality information is typically unavailable to consumers

For competition to be effective, consumers need to know what they are buying and what it costs. Those conditions are difficult to satisfy in health care.

At present, consumers rarely know what they will pay in advance of medical treatment. The cost they pay out of their own pockets depends on the nature of the service, the terms of their insurance coverage, and who provides the care. For many routine services, such as a physician office visit,

insurance typically charges a standard copayment, such as $20. But if the consumer has not yet met the insurance deductible, which must be paid before the insurer pays its share of a medical bill, the routine visit might require a much larger payment. If the health care provider is not in the preferred network, the out-of-pocket cost paid by the consumer could be substantially higher.

The situation is even more complicated if the consumer receives more complex services, such as surgery performed in a hospital. A few health systems, including Geisinger Health System, based in central Pennsylvania, and Baptist Health South Florida, help consumers estimate their out-of-pocket cost.[30] They are the exceptions.

In most cases, a consumer knows what the charge is only after the hospitalization, and that figure can be shockingly high. It is increasingly common for high-cost medical consultants and other hospital employees to look in on a patient and generate a hefty fee, a practice sometimes called drive-by doctoring.[31] Typically, the consumer has no idea what went into a complex treatment without looking at a detailed bill.

Cost information is not the only thing missing. Information on provider quality is largely inaccessible to a typical patient. Many public and private organizations report quality metrics for physicians, hospitals, and other providers. While such reports can offer a great deal of technical data, the information is difficult to interpret and means little to most consumers.

The Medicare program offers comparative information on physicians, hospitals, nursing homes, home health agencies, and dialysis facilities.[32] The most comprehensive information on provider performance is available from Hospital Compare, which reports quality measures related to the treatment of Medicare patients for heart attack, heart failure, pneumonia, and surgery for all U.S. acute care hospitals.[33]

The ACA requires additional public reporting of provider performance on cost, quality, and other measures, and many states have their own reporting programs. Other groups—including the National Committee for Quality Assurance, National Quality Forum, Leapfrog Group for Patient Safety (created by employers), and Informed Patient Institute—produce report cards on plan and provider performance.

This explosion of complex technical data has not had much impact on consumer choice of health care providers. It remains very difficult to

make meaningful comparisons of performance across different providers. How well providers follow clinical protocols and the degree of patient satisfaction are certainly relevant considerations. But we also care about the improvement in patient well-being resulting from the services rendered, and that rarely can be attributed solely to the efforts of a single provider.

Consumers are interested in whether the health care provider will do a good job, the effect of care on their health, and cost. Yet consumers often cannot find even the most basic information to help make potentially life-changing decisions about their health care.

Current health care regulation discourages competition

Government regulation is a fact of life in health care. Regulation is often characterized as promoting orderly markets and protecting consumers, but excessive regulation can protect vested interests, limit market innovation, and reduce value to consumers. Regulation can provide benefits to society, but at a cost.

Health care regulation imposes a substantial burden on the economy, both in the direct cost of implementing and complying with the regulation and in the restrictions on business activity that result. One study estimated that the total cost of health services regulation exceeded $339 billion in 2004.[34] This figure takes into account regulation of health facilities, health professionals, health insurance, drugs and medical devices, and the medical tort system, including the costs of defensive medicine. Allowing for some $170 billion in benefits gained from the regulations, the net burden amounted to $169 billion *annually*.

State actions are responsible for a substantial share of the economic burden of health regulation. More than a century of legislation and court cases have affirmed that states, not the federal government, have the power to regulate insurance.[35] The ACA gives the federal government new authority over the health insurance market (including mandates requiring individuals to purchase insurance and employers to offer it), but states continue to dominate the field. In addition, states actively regulate other major aspects of health care, including who may provide health services, where they may practice, and what services they may provide.

New York State's attempt during the 1990s to expand access to affordable coverage demonstrates the consequences of insurance regulation

gone wrong.[36] By imposing guaranteed issue (which requires insurers to offer coverage to all applicants) and community rating (which prevents insurers from charging people more based on their age or health), insurers were caught in a "death spiral." Healthier applicants dropped out of coverage because of high premiums; as healthier people dropped out, those premiums rose higher still. By 1996, the individual insurance market in New York State was essentially wiped out.[37]

That has since changed. The ACA's restrictions on insurance premiums sold on the exchange are less restrictive than New York's pure community rating (still in effect today). Under the ACA, insurers may charge somewhat higher premiums to older people and to smokers, which confers pricing flexibility not allowed under state regulation. The individual mandate also provides an incentive for healthy people to purchase insurance. In effect, the ACA opens the door for New York's policymakers to enact additional reforms that can make health insurance more affordable for the young and healthy, better spreading actuarial risk across the entire insured population.

The ACA's framework could give New York policymakers greater willingness to experiment with deregulatory efforts that allow for greater innovation in health insurance design and health care delivery, further enhancing the long-term viability of the individual insurance market.

Other forms of regulation favored by states impose serious costs on their citizens, too. The focus of much regulation is to limit who may provide health care in the state and under what circumstances.

Many states, including New York, use certificate of need (CON) laws to prevent hospitals and other medical facilities from entering new markets or expanding their capacity without regulatory approval. Regulators argue that CON is needed to prevent overbuilding that can increase health care costs, but there is little evidence that excessive investment in plant and equipment is reduced.[38] Instead of benefiting consumers, CON laws protect incumbent hospitals and health organizations and restrict competition. Political clout, rather than community need, may be the determining factor in CON rulings.[39]

Bans on the corporate practice of medicine similarly prevent the adoption of smarter business arrangements, limit physicians' ability to coordinate their services with other medical and nonmedical professionals, and discourage entrepreneurs from entering the health care market.

New York does not allow for-profit hospitals to operate in the state. Such regulations claim to protect physicians' ability to make independent medical judgments without conflicting business interests.[40] They also inhibit provider experimentation with different, and potentially more efficient, forms of care delivery.

However, health care has changed greatly since the early 1900s, when these regulations became popular.[41] Instead of independent physicians working alone, health care is delivered in teams bolstered by expensive technologies requiring major investments. State regulation of the business of health care remains locked in the mind-set of the past century, retarding further changes that can lower cost and improve the way care is delivered.

Medical licensing and scope-of-practice laws limit who can practice medicine and what they are permitted to provide patients. Both types of regulation are intended to protect the public from unqualified providers, but they also slow the adoption of more efficient ways of delivering care made possible by improvements in medical technology and medical education. Obtaining a medical license can be costly and time-consuming.[42] That creates a barrier to entering the medical profession but does not guarantee the competence of individual providers or guard against the loss of skills over time.

Scope-of-practice laws define the services that doctors, nurses, and other medical professionals may provide and where those services may be rendered.[43] Regulations have not kept pace with improvements in education and training or changes in medical technology that would enable professionals with less advanced degrees to provide care safely and effectively.[44] The oft-noted shortage of primary care providers is due, in part, to regulations preventing nurse practitioners, physician's assistants, and others from practicing at the top of their licenses.[45]

III. How New York Can Promote Better Care and Better Value Through Competition

If consumers knew what health care they were really paying for, they probably would not want to buy all of it. The current financing system in the U.S. hides that cost in lower wages for workers who get their coverage on the job and higher taxes for everyone to cover the rising cost

of government health programs and subsidies for health insurance. The incentives of fee-for-service payment combined with generous insurance benefits promote greater use of services, though not necessarily better care for patients. Regulations further reinforce the status quo, reducing opportunity for upstart competitors to bring innovative approaches to market. Consumers do not know what they are paying, do not know what they are getting, and cannot know what they are missing.

New York State is a leader in the health care industry. The state hosts world-class hospital systems and renowned medical research centers that save lives daily and find new ways to diagnose and treat disease. The state is also plagued by the same problems found in health care throughout the country. The health system is expensive, hard for consumers to navigate, and resistant to new competitors that can bring fresh ideas to a major industry that has not adjusted quickly to changes in the market. New York is at a critical juncture and has the opportunity to take a number of important steps to encourage more competition in the health sector.

Employers can start by joining the growing movement toward smarter health insurance for their workers. More employers—including the state government and local municipalities, which, combined, employ about 15 percent of the 9 million workers in New York State—could offer an HSA-eligible high-deductible plan as an alternative to their current options.[46] Such a health plan gives workers more responsibility for the routine costs of care and provides tax-free savings to help pay those costs.

Employer-sponsored health insurance should also be partnered with the information tools needed to help workers get the best value from their coverage. One option is to contract with a company like Castlight Health, which provides cost information customized to each employee's health plan.[47] Large insurers—including Aetna, Cigna, and UnitedHealthcare—offer tools that allow enrollees to determine how much a specific health service is likely to cost.

As the market shifts to consumer-based coverage, information on cost and provider performance will increasingly be made available through web-based portals or smartphone apps. Basic cost calculator tools (modeled after Part D) should be built in to the state's health insurance exchange, too, along with measures of customer satisfaction.

To widen the range of health plan choices available to workers, employers can move to a private health insurance exchange, which are

run by benefits consultants like Aon Hewitt or Mercer.[48] By 2018, as many as 40 million people will be covered through private exchanges, according to estimates of industry leaders.

By bringing together a much larger group of enrollees than many employers could do on their own, a private exchange can offer new ways of reducing cost and improving value. Insurers will price their plans competitively and will offer plan options that avoid the "one size fits all" coverage that is the only option in many small firms.

Many private exchanges offer consumer support tools that may include plain-language questionnaires to help employees decide which plan best meets their needs, cost calculators, and physician finders.[49] Private exchanges may also offer supplementary insurance coverage, such as dental or vision insurance, and health savings accounts. Smaller employers can find private exchanges that reduce administrative hassle by integrating payroll, benefits, and other related functions.

The success of that approach depends on the patient's willingness to travel for treatment, and some may not be willing to go long distances. That opens the door to negotiating discounts with local providers. According to Fitch Ratings, direct contracting between hospitals and employers will become more popular as health costs continue to rise.[50]

Regulatory changes are necessary to create a health system capable of meeting the demands of consumers for high-quality care at reasonable prices. In January 2015, New York State took an important step in enacting a law that requires insurers to cover telehealth visits, paying for them at the same rate as in-person visits to a provider.[51] The law covers a wide variety of communications between patient and provider, including telephones, remote patient monitoring devices, and video conferencing. Under the law, patients are responsible for the same out-of-pocket costs for an in-office visit as they are for a telehealth visit.

The new law has the potential to spur the adoption of more convenient, less expensive ways to provide health care. A recent study suggests that a telehealth visit saves about $100, compared with the cost of an in-person visit to a doctor's office, clinic, or emergency room.[52] One report suggests that the global telemedicine market could nearly double in five years.[53]

A barrier to the adoption of innovations in health care finance and delivery are requirements that prevent physicians and other providers from practicing unless they are licensed in New York State—even if they

are fully licensed in another state. Model legislation has been drafted by the Federation of State Medical Boards for an interstate compact to speed the licensing of doctors seeking to practice medicine in multiple states.[54] The compact would ease requirements for practicing across state lines, particularly for physicians relying on telemedicine.[55]

New York's legislators should consider this "low-hanging fruit." The state would enter into an agreement only with another state that meets New York's high standards for medical training. Moreover, such agreements would not change the regulations for practicing medicine in brick-and-mortar locations.

Other regulations limit the adoption of more efficient methods of delivering health care. Scope-of-practice laws restrict the services that may be provided by nurse practitioners, physician assistants, and other skilled medical professionals. Such laws prevent health systems from employing nonphysician practitioners to provide care that they can provide safely and effectively, which raises costs and can delay the patient's treatment.

New York has recently expanded its scope-of-practice rules to allow nurse practitioners to practice independently, rather than under physician supervision.[56] The state should expand its review of such rules to identify additional opportunities to safely add flexibility in the way care is delivered.

CON laws limit whether hospitals and other medical facilities can enter new markets or expand their capacity. New York's Public Health and Health Planning Council recently recommended modest changes in the CON process.[57] The state should go further and repeal this anticompetitive law.

New York's legislature should resist the urge to impose tighter regulations on the health system under the guise of consumer protection. The Assembly may consider new rules that prevent major retail chains from offering primary care services through in-store clinics.[58] The state already bars publicly traded companies from owning medical facilities or employing physicians. Additional restrictions will limit access to convenient health services for millions of New Yorkers.

New York State can usher in a new era of creativity and competition in the health care market. Smarter regulation combined with smarter insurance will bring consumers better value, greater convenience, and more certainty that they will get the care they need when they need it.

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