UNDERSTANDING ALTERNATIVE HEALTHCARE REFORMS:

Re-evaluating the Current Regulatory Structure of the Healthcare System in the U.S.

By Stefan Antohi (10/1/10)

Dispelling Some Common Myths

-In the US, Health care facilities are largely owned and operated by the private sector and health insurance is also provided primarily by the private sector

-This **does not** mean it currently operates under a free market

-State by state medical boards, separate licensing requirements, regulatory restrictions on insurance

-Doctors face continuing medical education requirements, mandatory reporting laws, and differing medical practice acts…this complicates the process of obtaining and maintaining more than 1 license (American Medical Association 2010)

Dispelling Some Common Myths

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-This **does not** mean it currently operates under a free market

-Direct regulatory barriers to entry in the medical industry in each state

-"Certificate of Need Programs"

-Market incumbents can too easily use [certificate of need] procedures to forestall competitors from entering an incumbent's market.

Dispelling Some Common Myths

-Government programs such as Medicare and Medicaid compete with private insurance, so their expansion can only make the system more efficient and affordable for all healthcare consumers.

-In a purely competitive market, increased competition would indeed imply lower prices for consumers, but in the current US healthcare system, the competition between government insurance and private insurance results in a completely different phenomenon; “cost-shifting”

Why current reforms are **not** the panacea…

- Current reforms focus disproportionately on the demand side:
  - According to the Whitehouse website, the law will fill the gap in coverage for 32 million Americans
  - end discrimination against those with pre-existing conditions

increasing **demand** for care **does not** necessarily imply increasing **access** to care.

- Demand-Supply mismatch in Texas
  - less than one-third of the 49,000 doctors treat the three million Texans who depend on Medicaid for healthcare (*FierceHealthcare*, July 15, 2010)."
  - Doctor patient ratio is 1 doctor for every 188 Medicaid patients** and that is if each doctor has a patient mix comprised only of Medicaid patients.
  - Government threatening to cut Medicaid reimbursement rates for doctors is a **disincentive** for them to take on any more Medicaid patients

increasing **demand** for care **does not** necessarily imply increasing **affordability** of care.

- If supply is fixed or rigid, increased demand can only lead to higher prices for medical services

- Current features of the recent healthcare law that deal with supply side seem inadequate
  - Current law will help create 16,000 new primary care physicians by 2015
    - This number would perhaps cut the Medicaid doctor/ patient ratio in Texas by half if all the new physicians were deployed **only** to Texas

Some ideas for better addressing the supply side…

- Reform "Certificate of Need" programs

- Allow doctors to practice more easily across state lines

  -Remove the patchwork of inefficient licensing requirements that exists right now.

  -Consider the use of new technologies that can increase access and reduce cost, specifically "virtual clinics."

Some ideas for better addressing the supply side…

- Allow private insurers to operate across state lines
  - Under present system, healthcare providers in one state are insulated from competition from healthcare providers in another state--→**no price transparency, no price sensitivity→medical costs increase at an alarming rate--** medical costs increasing at an estimated rate about six times that of average yearly inflation

    -Insurances operating across state lines could increase overall awareness on pricing and enforce price sensitivity among providers operating in different states.