HEALTH CARE

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THE ISSUE: FEDERAL AND STATE HEALTH CARE POLICIES INCREASE PRICES AND DECREASE SUPPLY AND INNOVATION

The health sector serves American workers poorly. Prices are sky-high. While the quality of care is often exceptional, in many areas quality is so low as to be dangerous to patients' health. The cause of these problems is a dense thicket of state and federal laws that deny workers the right to make their own decisions about their health care, including the right to control whether, to what extent, and where to spend their earnings on health care.

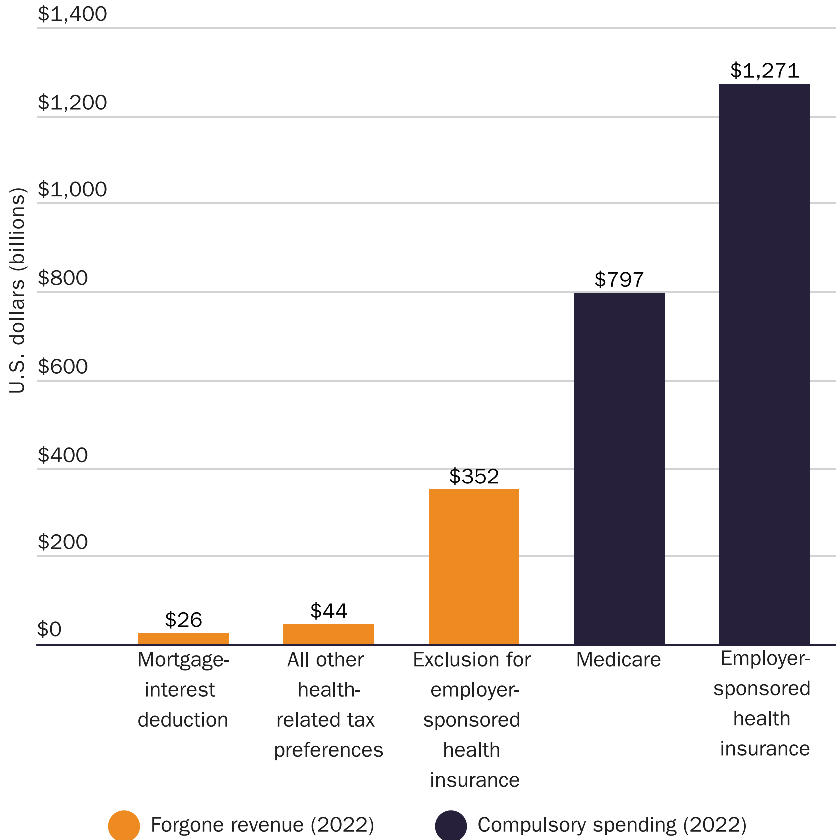
The tax code is the greatest obstacle to workers controlling their health care decisions. For nearly as long as there has been a federal income tax—and for longer than modern health insurance has existed—the federal tax code has effectively penalized workers unless they surrender a sizeable share of earnings to their employer; enroll in a health insurance plan the employer chooses, purchases, controls, and revokes upon separation; and pay any remaining portion of the insurance premium directly.

This system's implicit penalties are large. Suppose two jobs offer the same total compensation but one offers $22,221 in health benefits (the cost of the average employer-sponsored family plan in 2021), while the other instead offers $22,221 in cash wages. The federal tax code penalizes a worker who chooses the latter job: at a marginal tax rate of 33 percent, the tax code effectively creates a $7,333 per year penalty if the worker wants to take that $22,221 as cash in order to choose her own health plan. To avoid that implicit penalty, most (though not all) workers obtain health insurance through an employer.

Since employers finance health benefits by reducing cash wages and other compensation, this feature of the tax code denies workers control of a sizeable share of their income.[1] In the above hypothetical, the worker loses control over $22,221 of earnings, as well as her choice of health plan, to the employer. In 2022, workers, in the aggregate, lost control of nearly $1.3 trillion of their earnings—$944 billion that their employers paid toward employee health benefits, plus another $327 billion that workers paid directly. If workers declined their employers' health benefits and instead took that $1.3 trillion as cash wages, they would have had to pay a total of $352 billion in implicit penalties.

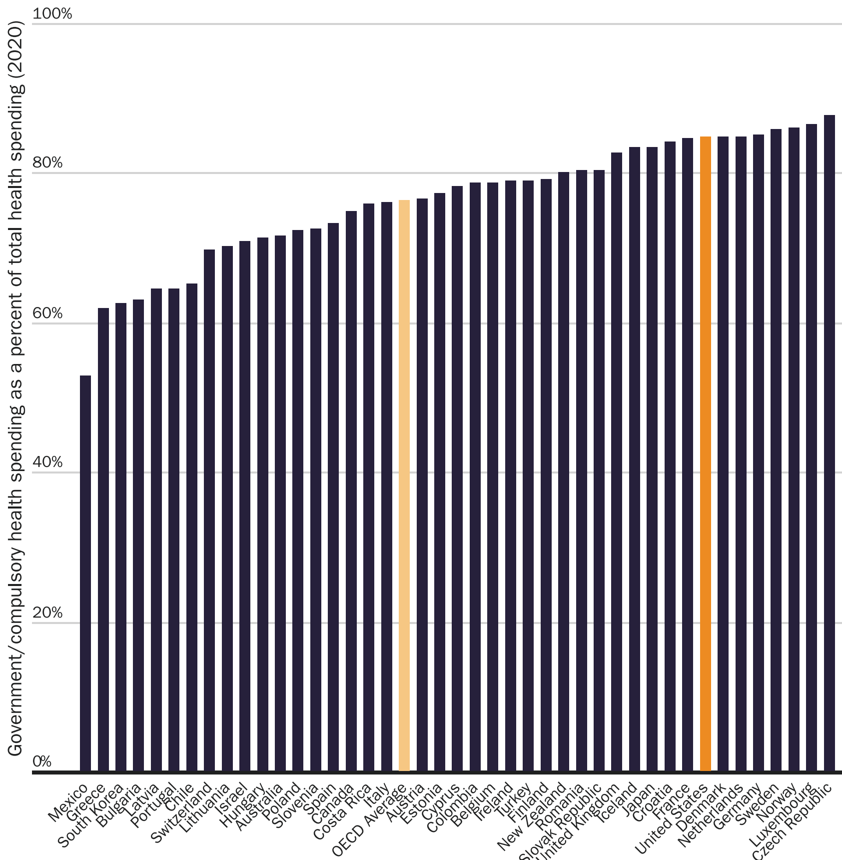
Employer-sponsored health insurance is therefore a compulsory system in which workers must participate on pain of higher taxes or criminal penalties if they fail to pay those higher taxes. Figure 1 shows that the $1.3 trillion that employers and workers spend on health benefits is the largest source of compulsory health spending in the United States. As Figures 2 and 3 show, the United States ranks ninth among advanced nations in terms of compulsory health spending as a share of overall health spending and first in terms of compulsory health spending as a share of gross domestic product (GDP), and the federal tax code is the principal reason why.

FIGURE 1 Employee health benefits are the largest source of compulsory health spending in the United States



Sources: U.S. Office of Management and Budget, "Tax Expenditures," in *Analytical Perspectives: Budget of the U.S. Government, Fiscal Year 2022* (Washington: Government Publishing Office, 2021), pp. 111, 113; "The Budget and Economic Outlook: 2021 to 2031," Congressional Budget Office, February 2021, p. 5; Boards of Trustees, "2021 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds," Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, August 31, 2021, p. 111; National Health Statistics Group, "Table 5-6—Private Health Insurance by Sponsor: Calendar Years 1987–2020," Office of the Actuary, Centers for Medicare & Medicaid Services, Department of Health and Human Services; National Health Statistics Group, "Table 16—National Health Expenditures (NHE), Amounts and Average Growth Annual Growth from Previous Year Shown, by Type or Sponsor, Selected Calendar Years 2011–2028," Office of the Actuary, Centers for Medicare & Medicaid Services, Department of Health and Human Services; and author's calculations.

FIGURE 2 Compulsory spending comprises a larger share of health spending in the United States than most OECD nations

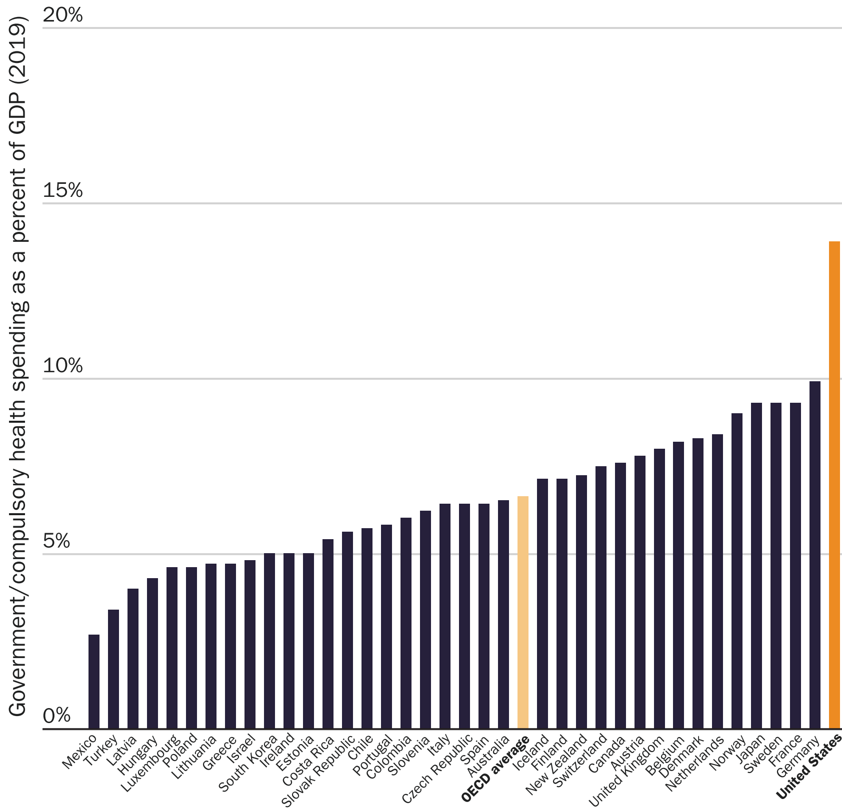


Source: "Health Spending: Government/Compulsory, % of Health Spending, 2020," Organisation for Economic Co-operation and Development, https://data.oecd.org/chart/6LrL.
Note: OECD = Organisation for Economic Co-operation and Development.

This feature of the federal tax code—the "tax exclusion" for employer-sponsored health insurance—has done enormous harm to workers. As Feldstein and Friedman (1977) wrote, "It can with justice be said that the tax [exclusion] has been responsible for much of the health care crisis."[2] The exclusion reduces access to quality, affordable health insurance and medical care in three ways.

First, it increases prices for health insurance and medical care. Since the tax code penalizes every dollar workers do not devote to health benefits, it encourages workers to demand excessive levels of health insurance coverage. Excessive coverage, in turn, leads to greater medical consumption and higher prices—because patients care less about both price and quantity when someone else is paying—

FIGURE 3 As a share of GDP, compulsory health spending is higher in the United States than any other OECD nation



Source: "Health Spending: Government/Compulsory, % of GDP, 2020 or Latest Available," Organisation for Economic Co-operation and Development, https://data.oecd.org/chart/6CTC.
Note: OECD = Organisation for Economic Co-operation and Development; GDP = gross domestic product.

which, in turn, push health insurance premiums higher. Finkelstein (2007) estimated that the growth in health insurance in the latter part of the 20th century, of which the exclusion was a major driver, is responsible for half the growth in per capita health spending over that time.[3] Tilipman (2022) found that employers offer overly broad provider networks that leave the average worker $620 worse off per year.[4] By encouraging workers to consume excessive levels of health insurance and medical care, the exclusion creates a deadweight economic loss on the order of 1 percent of GDP (i.e., $230 billion in 2021).[5]

Second, the exclusion reduces choice, competition, and innovation in health care. Employers offer workers fewer health plan options than workers would

have on the open market. Eighty percent of covered workers have only one or two health plan types from which to choose.[6] The exclusion also tilts the playing field in favor of particular ways of financing and delivering medical care (i.e., fee-for-service payment and fragmented delivery) at the expense of other payment arrangements (e.g., prepayment or capitation) and delivery systems (e.g., integrated health systems and coordinated care). The exclusion thus inhibits entry and competition by innovative health plans that reduce premiums and improve quality on dimensions where the health sector is weak.

Third, the exclusion has, for decades, stripped workers of their health insurance coverage after they get sick. The average worker changes jobs a dozen times by age 52.[7] Absent the exclusion, workers could purchase health insurance that remained with them between jobs—coverage that neither disappears nor charges higher premiums because an enrollee falls ill. As Professor Sherry Glied, an economic adviser to presidents Clinton and Obama, noted, "Before the passage of Medicare, many Americans over sixty-five were covered by health insurance policies that were guaranteed renewable for life" because more than 70 insurance companies offered such guaranteed-renewable health insurance.[8]

Instead, the exclusion penalizes workers unless they enroll in health insurance that automatically disappears when they change jobs, or when the employer drops coverage, or when enrollees lose a spouse to divorce or death, or when they age off a parent's plan, or when they retire, or when they become too sick to work. Workers in poor health are roughly twice as likely to end up with no insurance if they obtained coverage from a small employer versus purchasing it directly from an insurer.[9] Indeed, Congress created Medicare in 1965 in part because "many [workers] who had insurance coverage before retirement were unable to retain the coverage after retirement […] because the policy was available to employed persons only."[10] Decade after decade, the tax code has penalized workers who choose secure health insurance and forced them into less-secure health insurance.

As the Employee Benefits chapter discusses further, these implicit penalties—and the insecure coverage on which they make workers dependent—lead to "job lock" and "entrepreneurship lock," where workers forgo better professional opportunities for fear of losing access to health insurance.[11] The exclusion reduces voluntary job turnover by 20 to 25 percent per year, which prevents workers "from making their preferred labor mobility choice, such as to change jobs, start a business, reduce work hours, or exit the labor force to stay home with children or retire."[12] Workers who have health insurance through their own employer are less likely to start or own their own businesses than workers who have health insurance through a spouse or Medicare.[13] Reducing worker mobility also increases employers' bargaining power and, given the linkage between job-to-job transitions and wage growth, may reduce workers' lifetime earnings.[14]

Yet, even after workers gain control of their health care dollars, numerous state and federal laws would still block them from using those dollars to obtain health care services that best suit their needs.

First, state clinician-licensing laws impede the widespread use of telehealth and erect barriers to the free flow of health care services across state lines. Patients are free to travel to another state to receive medical treatment from any doctor in that state. In most cases, however, patients cannot receive services from those same doctors at home via telemedicine. Most states allow clinicians to provide telehealth services to in-state patients only if the provider has a license from that state.[15] The ostensible purpose of clinician-licensing laws is to improve quality, but licensing actually inhibits quality by preventing patients from consulting with top specialists around the country.

The barriers that clinician-licensing laws create to interstate telehealth stem from the fact that states currently define the locus of the practice of medicine as the location of the patient. This arbitrary legal definition prevents patients from receiving services from a clinician who does not hold a license from the state where the patient is. Even if the clinician held licenses in all 49 other states, this rule would still strip the patient of the right to purchase services from that clinician.

Government licensing of clinicians leaves workers with fewer choices, higher prices, less convenient access to care, and fewer innovative services.

Second, clinician-licensing laws further decrease the available local supply of health care services and thus further increase prices. The effects of licensing restrictions became clear during the early days of the COVID-19 pandemic, when the governors of several of the hardest-hit states suspended licensing requirements to allow out-of-state practitioners to come to the aid of their states' residents.[16] These emergency actions tacitly recognized that clinician-licensing laws block access to care. As the Occupational Licensing chapter discusses, licensing restrictions discourage interstate mobility and employment in the relevant professions, while increasing the cost of related services.

Clinician-licensing laws also dictate what categories of clinicians may practice in the state and the specific services that each type of clinician may offer (i.e., the clinician's scope of practice). Questions about scope of practice typically descend into special-interest turf wars. When lobbyists for nurse practitioners and physician assistants seek to change laws so that their clients may practice independently of physicians or expand their scope of practice to meet their expertise—allowing them to compete with physicians to provide more services—lobbyists for physicians resist.[17]

State legislators are not competent to adjudicate such matters, so they side with whichever special-interest group has the most political clout. The American Medical Association boasts that it has blocked more than 100 attempts to expand midlevel clinicians' scopes of practice since 2019.[18] Patients, by contrast, have little say in the matter and end up paying higher prices because scope-of-practice

restrictions prevent midlevel clinicians from providing services they are competent to perform at a lower price than physicians charge.

In response to the COVID-19 public health crisis, many states temporarily broadened many midlevel clinicians' scopes of practice. In rare cases, states have relaxed scope-of-practice restrictions for other reasons. To address the demand for health care professionals, for example, a growing number of states have abandoned the federal guideline that Certified Registered Nurse Anesthetists practice under the supervision of physicians.[19] In many states, certified registered nurse anesthetists can practice independently, providing broader access to anesthesia services, particularly in rural areas. In these cases, states are again implicitly admitting that clinician-licensing laws restrict access to care.

Third, state and federal laws also block physicians in foreign jurisdictions from providing medical care to willing U.S. patients. State licensing boards require international medical school graduates who have completed postgraduate specialty training and hold licenses to practice in other countries to repeat their entire postgraduate training in an accredited U.S. institution before receiving a state medical license. As a result, many foreign-trained doctors take positions in ancillary medical fields such as nursing, lab technician, or radiology technician instead of starting all over again. Government regulation deprives U.S. patients of the benefit of these physicians' human capital and the lower prices that would come with greater competition.

Finally, state "certificate of need" (CON) laws require providers to obtain government authorization before offering new services or opening or expanding health care facilities. These laws are not about ensuring new services or facilities meet minimum standards. Rather, they are about allowing the government to decide whether local health care markets need more competitors. Since incumbent providers heavily influence CON authorities, all too often the answer is "no." As of January 2022, 35 states and the District of Columbia had some form of CON law on the books, with the scope of restrictions varying widely.[20]

By restricting entry into health care markets, CON laws increase prices and negatively impact quality. A 2022 Palmetto Promise Institute review of dozens of academic studies found that CON laws correlate with higher per unit costs, higher expenditures, less access to care, and lower quality care.[21] They also render state health care systems sclerotic and unable to meet changes in demand, such as during public health emergencies. CON laws nevertheless persist because incumbent providers fiercely resist reform or repeal.

THE POLICY SOLUTIONS: EXPAND HEALTH SAVINGS ACCOUNTS; REMOVE BARRIERS TO INTERSTATE TELEHEALTH; ADOPT UNIVERSAL LICENSE RECOGNITION; EXPAND SCOPE OF PRACTICE LIMITATIONS; ALLOW FOREIGN DOCTORS TO PRACTICE HERE; AND REPEAL CERTIFICATE OF NEED LAWS

The most effective way to bring health insurance and health care within the reach of more workers is to drive down health care prices, and the most effective way to reduce health care prices is to make patients more cost-conscious. Figure 4, for example, summarizes a series of experiments that found cost-conscious patients forced providers to reduce prices by up to 32 percent over two years for services including hip and knee replacements, knee and shoulder arthroscopy, cataract removal, colonoscopy, CT and MRI scans, and laboratory tests.

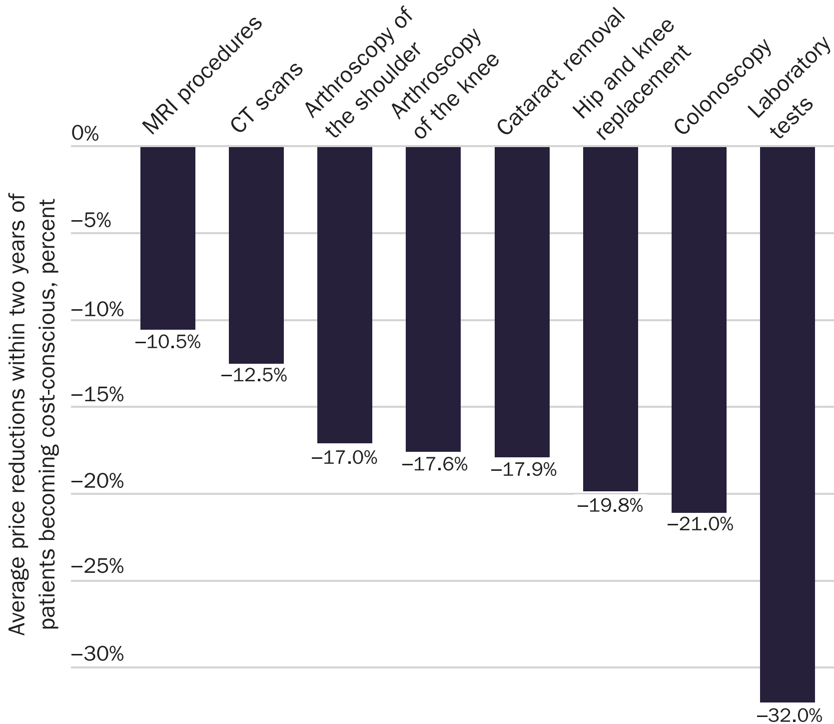
The most important thing policymakers can do to make patients more cost-conscious is to return to workers the $1.3 trillion of earnings that the federal tax code puts under their employers' control. Returning those funds to workers would lead them to demand lower prices because they would reap the savings. It would also constitute an effective tax cut larger than the Reagan tax cuts of 1981, as Figure 5 shows.

Congress can deliver that $1.3 trillion tax cut by expanding tax-free health savings accounts (HSAs) and making the tax exclusion available only for HSA contributions. These accounts currently allow about 30 million workers to shield about $42 billion of their earnings per year from the exclusion's implicit penalties. This means HSAs currently reclaim for workers only about 4 percent of the $1 trillion of their earnings that the exclusion puts under their employers' control, as Figure 6 depicts.

Dramatically expanding HSAs would allow workers to take that $1 trillion as cash income that they control. The vast majority of workers could then deposit those funds in an HSA without any tax consequences. Returning control over that $1 trillion to the workers who earned it would put workers at the center of the health sector, create greater cost-consciousness, force providers and insurers to lower prices, and improve employment opportunities and independence by letting workers purchase secure health insurance that does not tie them to one employer. As the Independent Work chapter explains, freelancers, gig workers, and other independent workers should also be allowed to open and contribute tax-free funds to these expanded HSAs.

State and federal policymakers should also take steps to reduce or eliminate restrictions on the supply of health care services.

FIGURE 4 Cost-consciousness lowers prices

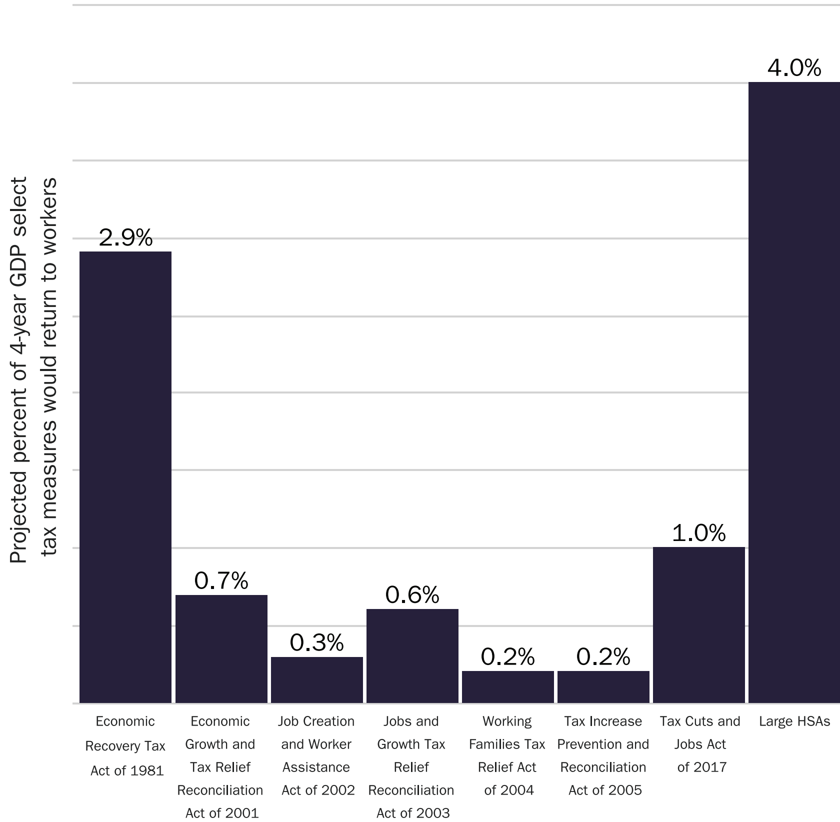


Source: James Robinson, Timothy Brown, and Christopher Whaley, "Reference Pricing Changes the 'Choice Architecture' of Health Care for Consumers," *Health Affairs* 36, no. 3 (March 2017), https://doi.org/10.1377/hlthaff.2016.1256.

First, states should eliminate obstacles to telehealth delivery across state lines. Doing so would increase access to care, enable patients to take advantage of expertise in areas of the country that may be otherwise beyond their reach, and increase competition among health care providers, thus lowering prices and improving quality of care. Early in the COVID-19 pandemic, many states temporarily removed barriers to the delivery of telehealth across state lines, but some of those measures have since lapsed.[22]

In 2021, however, Arizona learned from its pandemic experiences and became the first state to allow patients to receive telehealth services from clinicians in any state.[23] Out-of-state telehealth providers must obey Arizona's laws governing standards of care and scopes of practice. Arizona's professional licensing boards may review, discipline, and even ban out-of-state providers if they violate Arizona standards of care. They must show proof of malpractice insurance coverage. Patients may bring malpractice claims against out-of-state telehealth providers in Arizona courts. Other states and territories should follow Arizona's example.

FIGURE 5 Expanding health savings accounts would return a larger share of GDP to workers than past tax cuts



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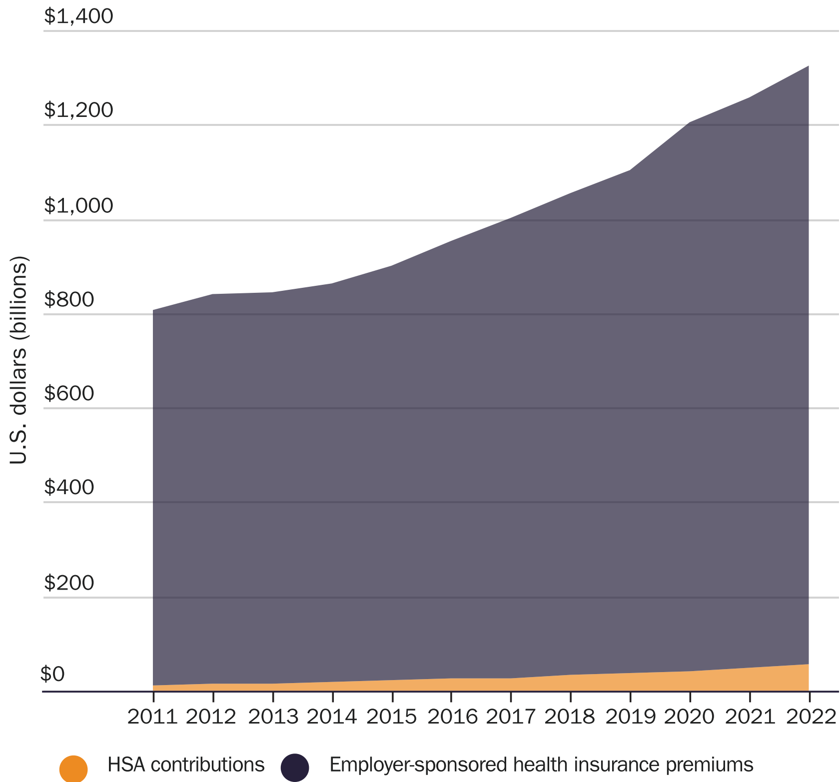
Note: GDP = gross domestic product; HSA = health savings account.

FIGURE 6 Employer-sponsored health insurance premiums dwarf HSA contributions



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Notes: * = author's calculations 2022 estimated; HSA = health savings account.

Federal policymakers can also remove barriers to interstate telehealth services.[24] While states have constitutional authority to regulate the practice of medicine for residents within their borders, telehealth services that cross state lines are interstate commerce that Congress has the authority to liberalize under Article 1, Section 8 of the Constitution. Congress should use that authority to define the locus of the practice of medicine as the location of the *clinician*, not—as states currently do—the location of the patient. Doing so would free patients to consult with top specialists via telehealth in any part of the country.

Second, states should reform burdensome clinician-licensing restrictions. They should recognize out-of-state licenses for clinicians who establish a business presence within the state. In early 2019, Arizona became the first state

to enact universal license recognition.[25] Since then, 16 states have enacted variations of Arizona's universal license-recognition law.[26] This reform makes it easier for health care practitioners to provide services to patients in various parts of the country. However, five states, including Arizona, require clinicians to establish a residence. Eleven other states, including New Jersey, Pennsylvania, and Missouri, don't. State lawmakers in all 50 states and the District of Columbia should enact universal license recognition without a residency requirement.

States should go even further by recognizing the out-of-state licenses of clinicians who provide short-term in-person care in another state. Examples include clinicians who provide care during temporary stints in medically underserved areas, clinicians who practice very close to the border of a neighboring state, and out-of-state clinicians who specialize in rare conditions or who help manage fragile patients too unstable for transfer. Truly universal license recognition would also make it easier for locum tenens (i.e., "fill in") providers and out-of-state specialists to provide itinerant temporary health services to remote and underserved communities by removing the barriers that unnecessary licensing applications and fees create.

States should also take immediate action to make medical care more accessible by relaxing scope-of-practice regulations. States that did so temporarily during the pandemic should make those measures permanent. States should allow pharmacists and pharmacy technicians broader scope to perform vaccinations, prescribe hormonal contraceptives, and prescribe HIV pre-exposure prophylaxis and post-exposure prophylaxis. They should expand pharmacists' scope of practice to include tuberculosis skin testing and interpretation; testing and administering of prescription medications for patients with influenza and other viral illnesses or common bacterial infections, such as strep throat; the ability to prescribe non-sedating or low-sedating antihistamines, corticosteroids, and decongestants; and the ability to extend routine noncontrolled chronic medication prescriptions for an additional 30–60 days.[27] Expanding pharmacists' scope of practice can save workers time and money by avoiding unnecessary visits to a doctor's office.

Scope-of-practice restrictions bar many other health care professionals from practicing to the full extent of their training.[28] States should permit optometrists who have the training to offer simple eye surgical procedures to patients; let appropriately trained doctorate-level psychologists prescribe psychotherapeutics; and let dental therapists (analogous to physician assistants) and dental hygienists practice independently and to the full extent of their training.[29]

Ultimately, state lawmakers should relinquish the tasks of defining clinician categories and scopes of practice, with which they have no expertise. States should instead certify competing private third-party organizations to perform these tasks. Such organizations could include medical malpractice liability insurers, specialty boards, and health systems.[30] Many private organizations already offer

certification in specific skills, such as specialty certificates for physician assistants in cardiovascular and thoracic surgery or emergency medicine, and for registered nurses in AIDS and pediatric care. Competing private certification organizations would experiment with lower-cost ways of ensuring competence, which would broaden access to care and reduce the student-debt load of clinicians.

Third, states and the federal government can further increase the supply of health care services by increasing immigration and recognizing foreign medical licenses. Canadian provinces, Australia, and most European Union countries allow foreign doctors to practice under the supervision of a domestic physician for a designated period. When the supervisory period is complete and the foreign doctors pass those countries' licensing exams, the doctors receive a license. In many cases, these countries require foreign doctors to practice for a certain period in an underserved area.[31] Workers in the United States would benefit from similar licensing programs for foreign physicians. Governor Phil Murphy of New Jersey patterned a public health emergency measure on the provisional-license model.[32] Other states should do the same.

Finally, states should repeal CON laws. Doing so would reduce prices, improve health care quality, and increase access to care. During the pandemic, 20 states suspended their CON laws. Four other states issued emergency certificates of need, bypassing the usually months-long certificate application process. These steps were tacit admissions that CON laws create barriers to care and impede the health sector's ability to respond quickly to shifts in demand, such as public health emergencies.[33] State lawmakers should heed these lessons and repeal CON laws immediately and permanently.

ACTION PLAN

Workers should be free to control their earnings and to choose from an array of competing health insurers, providers, and clinicians the health insurance and medical care that meets their individual needs. Tax laws and numerous restrictions on the supply of health care are standing in the way.

To return $1.3 trillion to the workers who earned it, Congress should

- apply the tax exclusion solely to funds that individuals or employers deposit in the worker's HSA;
- increase HSA contribution limits dramatically to, say, $9,000 for individuals and $18,000 for families;
- remove the requirement that HSA holders enroll in high-deductible health insurance or any health insurance;
- allow HSA holders to purchase health insurance, of any type and from any source, tax free with HSA funds; and
- ensure that these reforms also apply to independent workers.

These changes would deliver to workers the largest effective tax cut of their lifetimes. It would reorient the health sector toward the needs of patients by making health care and insurance better, more affordable, and more secure.

To expand the supply of health care services in the United States, Congress should

- enact legislation defining the "locus of care" when providing telehealth services as where the practitioner is—not where the patient is.

And state governments should

- enact universal licensing recognition, recognizing occupational licenses from all 50 states, the District of Columbia, and U.S. territories;
- enact legislation allowing patients to receive telehealth services from health care practitioners from all 50 states, the District of Columbia, and U.S. territories;
- enact legislation recognizing the licenses of health care practitioners from any of the 50 states, the District of Columbia, and U.S. territories who
- wish to provide short-term in-person care to patients;
- enact legislation that broadens scope-of-practice regulations to allow clinicians to practice to the full extent of their training;
- enact legislation creating provisional licensing programs for trained and experienced foreign health care practitioners;
- certify competing, private, third-party organizations to define clinician categories, define educational requirements and scopes of practice for those categories, and certify individual clinicians' competence to practice;[34] and
- repeal CON laws.

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