

HOW TO MAKE OHIO HEALTHCARE MORE AFFORDABLE

A Public Policy Guide



By Rea S. Hederman Jr.



THE BUCKEYE INSTITUTE

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INTRODUCTION

Healthcare and health insurance costs remain significant concerns for businesses and consumers across the country.¹ Health insurance benefits are the second largest line item for employers, and small and large businesses looking to offer affordable health benefits to their employees continue to search for suitable healthcare plans to meet employee needs at prices they can afford.² Various factors contribute to rising healthcare costs and insurance premiums, many of them driven by government rules and misguided federal regulations, but state policymakers can take steps to make healthcare more affordable. States play critical roles in regulating hospitals, doctors, nurses, and insurers, and they can pursue policies that will increase access to care, promote innovative and time-saving technologies, make pricing more transparent, and spur competition among care providers and in insurance markets. As policymakers seek ways to reduce costs and relieve pricing pressure, they should continue enforcing strict Medicaid eligibility requirements and repeal well-intended but counterproductive insurance benefit mandates. Transparent, competitive markets that are sensitive to producer supply and consumer demand still out-perform government edicts in delivering quality services at affordable prices. State policymakers should find ways to improve market conditions for care providers, insurers, and patients by reducing regulatory burdens that restrict supply and create artificial demand—both of which make healthcare and health insurance more expensive.

¹ **New Research about Small Business Offering – and Not Offering – Health Insurance**, National Federation of Independent Business press release, April 5, 2023; and Tina Reed, **Amid tight labor market, employers grapple with coverage of pricey treatments**, Axios.com, August 23, 2023.

² **Employer Costs for Employee Compensation-March 2024**, Bureau of Labor Statistics press release, June 18, 2024.

PUBLIC POLICY REFORMS TO MAKE HEALTHCARE MORE AFFORDABLE

State and federal government regulations, market-distorting mandates, and well-intended policies with unintended consequences significantly contribute to the rising costs of healthcare and health insurance in America. Given the prominent role that state law and agencies play in regulating modern medicine and insurance, state policymakers can pursue significant changes to licensing restrictions, pricing transparency requirements, artificial intelligence utilization, insurance benefit mandates, and health system consolidation to help reduce regulatory burdens and lower prices for healthcare and health insurance.

Reform Medical Licensing Laws

State law regulates healthcare and the practice of medicine through agencies and licensing boards that specify which medical services doctors and nurses may and may not provide. Historically, for example, Ohio all but banned licensed out-of-state doctors and nurses from providing medical care to patients in Ohio. Governor John Kasich signed legislation relaxing that prohibition by allowing out-of-state medical practitioners to treat Ohio patients during emergencies. Ohio later joined a multi-state compact that makes it easier for out-of-state nurses to practice in Ohio. Governor Mike DeWine then signed a law that broadly recognizes occupational licenses, including medical licenses, issued by other states.³ And the COVID health emergency suspended some unnecessary restrictions that have limited the scope of care that doctors, nurses, and even pharmacists may provide. The state can and should remove regulatory obstacles that limit patient access to care. Easing access to care and safely expanding the available pool of medical providers will improve patient outcomes and reduce the cost of healthcare in the long run.

Utilize Advanced Practice Registered Nurses

Advanced practice registered nurses (APRN) have received more formal training and hold at least a master's degree in a specialized nursing field and are certified by a national credentialing board. In Ohio, APRNs may be certified registered nurse anesthetists (CRNA), certified nurse-midwives (CNM), clinical nurse

³ **Governor DeWine Signs Bills Into Law**, Office of Governor Mike DeWine press release, January 2, 2023.

specialists (CNS), and certified nurse practitioners (CNP). These highly trained nurses provide vital medical care and assistance within the U.S. health system as the number of primary care physicians fails to keep pace with the demands of an aging population. As of June 2024, 76 million Americans or 22 percent of the total population, live in a federally designated Health Professional Shortage Area (HPSA) with insufficient primary care resources to meet the region's medical needs.⁴ Rural counties are more likely to have an HPSA as doctors move to cities with larger hospitals,⁵ making APRNs increasingly important care providers in rural communities. CNPs, for example, account for more than a quarter of all providers in rural areas⁶ and are projected to be the fastest growing profession over the next 10 years.

Research during the pandemic demonstrated that APRNs could spend more time with patients, see more patients, and see patients in different jurisdictions without sacrificing the quality of care.⁷ Regrettably, state regulations limit the extent to which APRNs may utilize their medical training and serve the underserved populations that need them. Ohio has slowly removed some regulatory barriers, but state policymakers should accelerate the deregulatory process. Recently introduced legislation would grant APRNs, particularly CNSs, CNMs, and CNPs more signature authority,⁸ which, as experts have explained, can reduce administrative costs and patient wait times, and free physicians to treat more patients.⁹ Another beneficial reform would eliminate required collaborative agreements between APRNs and supervising physicians. Such agreements hinder CRNAs and other APRNs from fully utilizing their skills and training, which reduces available health services and increases costs to patients without adding value.

A 2014 Federal Trade Commission (FTC) study raised concerns about the negative effects of collaborative agreements on access to providers and affordable care,¹⁰

⁴ **Health Workforce Shortage Areas**, HRSA.gov (Last visited October 25, 2024).

⁵ **How family nurse practitioners can help ease the primary care physician shortage**, Creighton University, April 19, 2023.

⁶ Hilary Barnes, Michael R. Richards, Matthew D. McHugh and Grant Martsolf, "**Rural and Nonrural Primary Care Physician Practices Increasing Rely on Nurse Practitioners**," *Health Affairs*, Volume 37, Issue 6 (June 2018) p. 908-914.

⁷ Brendan Martin, Michelle Buck, and Elizabeth Zhong, "**Evaluating the Impact of Executive Orders Lifting Restrictions on Advanced Practice Registered Nurses During the COVID-19 Pandemic**," *Journal of Nursing Regulation*, Volume 14, Issue 1 (April 2023) p. 50-58.

⁸ Ohio Legislative Services Commission, **S.B. 196 Bill Analysis**, February 23, 2024.

⁹ Alicia Plemmons, **Testimony to the Senate Health Committee on Senate Bill 196**, Kneer Regulatory Research Center at West Virginia University May 8, 2024

¹⁰ **Competition and the Regulation of Advanced Practice Nurses**, Federal Trade Commission, March 2014.

observing that “[i]mposing great restrictions on APRNs will only exacerbate existing and projected healthcare workforce shortages”¹¹ by keeping the supply of qualified health professionals low, which will increase prices. The FTC advised against restrictions on APRNs, noting that “expert bodies have concluded that APRNs are safe and effective as independent providers of many healthcare services within the scope of their training, licensure, certification, and current practice.”¹² The COVID-19 pandemic confirmed the experts’ opinion as the U.S. Department of Veterans Affairs suspended the collaborative supervision requirement for its CRNAs in states without collaborative mandates¹³ and almost a dozen states temporarily suspended their collaboration mandate on CRNAs. These temporary suspensions ended with the public health emergency, but several states permanently lifted the requirement after realizing that CRNAs could deliver quality, safe, effective care, and fill important gaps in the provider network. Survey data show that more CRNAs practice independently as anesthesiologists retire and states remove their collaborative agreement mandate. Twenty-three states and the District of Columbia already do not require such agreements between CRNAs and supervising physicians.¹⁴ Ohio should become the 24th.

Safeguard Against Facility Fees

States can take legislative steps to prevent hospitals and health systems from assessing patients and insurers excessive fees for the use of facilities or equipment. Hospitals assess facility fees to cover overhead for equipment at central locations and have become more common as they acquire physician groups and outpatient clinics. Unfortunately, hospitals sometimes assess facility fees even when their equipment or facility are not used, and often add them to outpatient visits and well after the original bill. *The Wall Street Journal* reported that a bill for a patient in Avon, Ohio, for example, almost tripled due to a late-arriving facility fee well after the original medical visit.¹⁵ The *Journal* also reported that 80 percent of heart disease tests sent to an insurer have a facility fee added.¹⁶ Such fees are not cheap and have increased costs to Medicare alone by more than \$6 billion.

¹¹ *Ibid.*

¹² *Ibid.*

¹³ Sidath Panangala and Jared Sussman, **Full Practice Authority for VA Registered Nurse Anesthetists (CRNAs) During the Covid-19 Pandemic**, Congressional Research Service, May 27, 2020.

¹⁴ Paige Haefele, **Where CRNA policy changed in the last 5 years**, Becker’s ASC Review, January 11, 2024.

¹⁵ Melanie Evans, **Hospitals Are Adding Billions in ‘Facility’ Fees for Routine Care**, *The Wall Street Journal*, March 25, 2024.

¹⁶ *Ibid.*

Ohio has largely prevented abusive facility fees and is one of the few states that does not allow such fees for telehealth consultations unless equipment is used during the consultation. This restriction helps keep telehealth more affordable for patients and hospitals, limiting fees to equipment that care providers actually used. Indiana recently barred facility fees at nonprofit hospitals and other states have prohibited facility fees entirely for some services. Ohio and other states should study these legislative efforts and assess how they might fit within their own healthcare regimes. Similarly, states should enact stronger transparency requirements so that hospitals must disclose facility fees to patients upfront to limit surprise billing. At minimum, Ohio should abandon any legislation that would proactively authorize implementing facility fees.

Promote Transparent Pricing

Markets need transparent pricing to function. Prices help buyers decide how to value goods and services. If the price is too high, buyers can reject the service and seek other options, which in turn helps sellers set their prices consistent with demand. Buyers and sellers receiving and acting on pricing information provide the best value and exchange for both parties in competitive markets. In healthcare markets, however, consumers often do not have the necessary information to make informed purchasing decisions. Consumers receive larger bills than expected *after* unanticipated tests and undisclosed facility fees are added. These surprise bills are so unpopular that state and federal lawmakers from both parties have proposed legislation to restrict them. In 2019, President Donald Trump issued an executive order requiring new federal regulations to improve price transparency by requiring healthcare providers and hospitals to disclose the out-of-pocket costs of services and goods to patients *before* patients receive the service.¹⁷

Progress on pricing transparency has been uneven. Lawsuits challenging the regulations slowed their implementation, but as those cases have been dismissed or dropped more healthcare providers have complied with the transparency requirements and more employers are using price transparency to find better value for employees.¹⁸ That success should encourage states to continue promoting transparent pricing and working with the federal government to enforce transparency rules.¹⁹ Indiana and Virginia have already enacted laws that require

¹⁷ The Federal Register, **Executive Order 13877**, Volume 84, Number 124, June 24, 2019.

¹⁸ Theo Merkel, **Healthcare Price Transparency: Achievements, Challenges and Next Steps**, Paragon Institute, August 2023.

¹⁹ The Federal Register, **Transparency in Coverage Final Rule**, Volume 85, Issue 219 (November 2020) p. 72158-72310.

more transparency from healthcare providers.²⁰ Draft legislation in Ohio would strengthen consumer protections by requiring hospitals to conspicuously post prices for their services so that consumers can make better informed treatment decisions.²¹ Hospitals that fail to comply would be fined and have limited capacity to pursue payments from uninformed consumers. Ohio rules should require hospitals and healthcare providers to post all prices, including costs for each available treatment, equipment use, facility fees, and other costs.

In a competitive, value-driven market, consumers need transparent pricing information to make important, informed decisions to help them save money, choose wisely among available providers and treatments, and signal to hospitals and health insurers which products and services they genuinely need and want. This does not mean that companies are forced to disclose pricing strategies or trade secrets, which could serve to increase costs due to collusion,²² but that pricing to the end consumer is transparent. Without that information, markets fail.

Improve Use of Artificial Intelligence

Artificial Intelligence (AI) holds promise for healthcare. It is no replacement for doctors and nurses, but AI can perform some data-related and diagnostic functions more efficiently than humans, which means it can reduce some administrative costs and improve care. AI can analyze vast sums of data much faster than humans or standard computer programs, for example. And it can diagnose some diseases like Sepsis and read X-rays more accurately than physicians.²³ These capabilities augment healthcare staff and create time for doctors and nurses to treat patients as only human care providers can.²⁴

Overblown concerns about the developing technology, however, have spurred misguided regulatory actions that have already hampered AI progress and its incumbent benefits. The federal government has proposed hundreds of pages of

²⁰ Kevin Davenport and Jack Pitsor, **State Actions to Control Commercial Health Insurance Costs**, National Conference of State Legislatures, July 21, 2023.

²¹ Ohio Legislative Services Commission, **H.B. 48 Analysis**, July 12, 2023.

²² Margot Sanger-Katz, **Why Transparency of Medical Prices Could Actually Make them go Higher**, *The New York Times*, June 24, 2019.

²³ Roy Adams, et. al., **“Prospective, multi-site study of patient outcomes after implementation of the TREWS machine learning-based early warning system for sepsis,”** *Nature Medicine*, July 21, 2022.

²⁴ Rea S. Hederman Jr. and Logan Kolas, **A Healthcare World Reimagined: How Big Government Threatens Healthcare AI and What to Do About It**, The Buckeye Institute, April 1, 2024.

AI-restrictive rules,²⁵ 40 states have proposed or are considering their own,²⁶ and even some cities have explored anti-AI regulations that will slow innovation. Hasty assumptions about AI's feared risks have clouded a more proper view of AI's potential benefits.

A better approach would allow AI developers to partner with and work under state oversight. Ohio can expand its financial regulatory “sandbox”—which allows businesses to develop and test products under agency oversight, temporarily free from many regulatory restrictions—to include healthcare-related AI innovation. Policymakers should extend the sandbox testing period well beyond twenty-four months and improve cooperation with other states and federal agencies.²⁷ Cultivating an AI-friendly regulatory environment will attract more developers, improve the nascent technology's healthcare applications, and offer Ohio's premier hospital systems more cutting-edge technology that can save physicians and patients time and money.

Prevent Medicaid Abuse

Medicaid abuse contributes to healthcare's rising cost. Ohio's Medicaid enrollment has grown since Medicaid eligibility expanded and federal rules during the COVID-19 pandemic prevented states from removing ineligible enrollees from the program. Medicaid enrollees peaked at 3.6 million in the spring of 2023, even as near record-low unemployment hovered between 3.3 and 3.5 percent. Care provider shortages cap available healthcare appointments and doctor visits, and ineligible enrollees make it harder and more expensive for eligible patients to be treated. And Medicaid fraud has cost Ohio more than \$1 billion on enrollees who receive Medicaid from other states.²⁸ A recent audit of Ohio Medicaid found and removed hundreds of thousands of ineligible enrollees, many of whom were temporarily eligible during the pandemic but have since returned to work or found alternative health insurance.²⁹ Consequently, Ohio Medicaid enrollment has fallen by 500,000 enrollees (14 percent) as unemployment has climbed to slightly more than four percent. Ohio has saved hundreds of millions of dollars by removing

²⁵ Adam Thierer, **The Battle over AI Regulation Will End in a Big Fight over Transparency & Audits**, medium.com, April 6, 2024.

²⁶ **Artificial Intelligence 2024 Legislation**, National Conference of State Legislatures, June 3, 2024.

²⁷ Logan Kolas, **A Sandbox for Everything: A Universal Approach to Help Innovators**, The Buckeye Institute, January 10, 2024.

²⁸ **Ohio Department of Medicaid: The Cost of Concurrent Enrollment, Auditor of State Report**, Ohio Auditor of State's Office, March 2024.

²⁹ Rea S. Hederman Jr., **Medicaid: How and Why States Must Review Eligibility**, The Buckeye Institute, September 11, 2023.

ineligible enrollees and keeping Ohio’s 2024 budget balanced.³⁰ Audit and removal efforts must continue in order to protect taxpayers, maintain a balanced budget, incentivize work, and reduce wait-times and expense for eligible Medicaid patients.³¹

Repeal Health Insurance Benefit Mandates

Healthcare, like other goods and services, is provided and purchased within a nominally competitive market. Supply and demand, actuarial risk, innovation, research and development, and various public policies affect how that market functions and the costs associated with providing healthcare services. Health insurance, for example, helps reduce healthcare costs by spreading risk across a broader clientele. But insurance benefit mandates required by law or regulation decrease flexibility for insurers, increase covered benefits, and ultimately raise the prices for health insurance premiums.

Health insurance benefit mandates require health insurers to include certain benefits in insurance plans regardless of consumer demand. The Affordable Care Act (ACA) issued federal benefit mandates, but states can and do issue their own benefit requirements, too. These regulatory mandates reduce flexibility for insurance providers, require unwanted services and benefits, and ultimately discourage employers from offering affordable insurance plans to employees.³² Nationally, according to a 2013 economic study, insurance mandates increase insurance premiums by .05 to one percent per year.³³ But soon after the ACA up-ended the U.S. healthcare system, its federal mandates raised the average Ohio insurance premium by 11 percent.³⁴ Well-intended preventative healthcare requirements raise consumer premiums,³⁵ and even specialized care for autism patients costs more after state-level insurance benefit mandates set the care and coverage requirements.³⁶

³⁰ Ohio Legislative Budget Office, **Legislative Budget Footnotes, July 2024**, July 2024.

³¹ Rea S. Hederman Jr., **Medicaid: How and Why States Must Review Eligibility**, The Buckeye Institute, September 11, 2023.

³² Peter Nelson, **Bills adding health benefit mandates undermine access to affordable premiums**, Center of the American Experiment, March 19, 2024.

³³ James Bailey, **“The Effect of Health Insurance Benefit Mandates on Premiums,”** *Eastern Economic Journal*, Volume 40, Issue 1 (March 2013) p. 119-127.

³⁴ Drew Gonshorowski, **2015 ACA-Exchange-Premiums Update: Premiums Still Rising**, The Heritage Foundation, March 20, 2015.

³⁵ Louise Russel, **“Preventing Chronic Disease: An Important Investment, But Don’t Count on Cost Savings,”** *Health Affairs*, Volume 28, Issue 1 (January 2009), p. 42-45.

³⁶ Colleen L. Barry, Andrew J. Epstein, Steven C. Marcus, Alene Kennedy-Hendricks, Molly K. Candon, Ming Xie, and David S. Mandell, **“Effects Of State Insurance Mandates On**

Special interest groups lobby federal and state policymakers to mandate benefits and coverage that reduces flexibility and increases costs. And those restrictions and higher premiums tend to discourage consumers from selecting insurance plans they might otherwise prefer and even discourage employers from offering health plans to employees. Legislators must appreciate these unintended but foreseeable consequences of regulatory meddling and recognize that new insurance coverage mandates raise prices and premiums. Even worse, as employer-offered insurance plans become artificially more expensive, employers off-set those higher costs by reducing employee wages,³⁷ with the additional unintended consequence of reducing taxable incomes for state and local governments. Not surprisingly, given the higher prices that health insurance mandates impose on employer insurance plans and employee premiums, Ohio's two largest employer trade associations, the Ohio Chamber of Commerce and National Federation of Independent Business (NFIB), oppose them.³⁸

Trade associations oppose insurance mandates for good reason: paradoxically, studies show that although policymakers intend insurance mandates to cover more health services, they result in fewer employees buying employer provided health insurance. By raising insurance premiums on employer-based plans, the mandates make the insurance plans less affordable and therefore less desirable to employees. Research has demonstrated that each state mandate reduces the likelihood of insurance coverage among employees by .2 percent.³⁹

End “Any Willing Provider” Requirements and Prevent Government Price-Setting

Any Willing Provider (AWP) provisions require insurers and middlemen like pharmaceutical benefit managers (PBM) to contract with any provider that is willing to accept the terms of a health insurance plan's network contract. AWP provisions prevent healthcare providers from entering contracts that would

Healthcare Use And Spending For Autism Spectrum Disorder, *Health Affairs*, Volume 36, Issue 10 (October 2017), p. 1754-1761.

³⁷ Jonathan Gruber, **The Efficiency of a Group-Specific Mandated Benefit: Evidence From Health Insurance Benefits for Maternity**, NBER working paper 4157, September 1992.

³⁸ **Cost of Health Insurance Mandates to Get Overdue Review**, Ohio Chamber of Commerce press release, December 19, 2016; and **Why Ohio Should Resist Expanding Mandated Health Insurance**, National Federation of Independent Business press release, March 4, 2015.

³⁹ David N. van der Goes, Justin Wang and Katherine C. Wolchik, **“Effect of State Health Insurance Mandates on Employer-provided Health Insurance,”** *Eastern Economic Journal*, Volume 37, Issue 4 (Fall 2011) p. 437-449.

guarantee exclusive access to their network in exchange for lower prices and higher volumes of patients and drugs.

Well-intentioned advocates for AWP laws mistakenly believe that allowing exclusive contract arrangements restricts supply and raises healthcare prices. Economic theory and practice undermine that concern. As several recent cabinet secretaries explained, “Basic economic theory suggests that a buyer can obtain a negotiating advantage by contracting selectively with a subset of providers, or at least having a credible option to do so, because providers will compete aggressively to be included.”⁴⁰ Care providers that want exclusive access to patient groups have a strong incentive to offer their services at a lower price. Without the exclusive access, however, the care provider’s willingness to reduce the price diminishes. In practice, one study estimates that AWP laws increase drug costs by at least five percent.⁴¹ Other studies show that AWP provisions aimed at pharmacies make pharmaceuticals more expensive⁴² and states with more restrictive AWP laws pay more for healthcare overall.⁴³

State policymakers should avoid government price-setting policies such as minimum fee requirements that establish a price “floor” for healthcare services.⁴⁴ Government-mandated prices disrupt markets and increase the costs. With a price floor tied to an average price, care providers have less incentive to innovate on cost-effective treatments because the government-set minimums mandate a higher price even if the providers can offer less expensive service. By not rewarding innovation, prices will rise over time as the government mandate erodes competition incentives. Some states have considered legislation mandating fees and setting prices for certain services.⁴⁵ Each of these misguided efforts will raise health insurance premiums as the higher care costs are passed along to consumers.

⁴⁰ **Reforming America’s Healthcare System Through Choice and Competition**, U.S. Departments of Health and Human Services, Labor, and Treasury, December 3, 2018.

⁴¹ Jonathan Klick and Joshua D. Wright, “**The Effect of Any Willing Provider and Freedom of Choice Laws on Prescription Drug Expenditures**,” *American Law and Economics Review*, Volume 17, Issue (Spring, 2015) p. 192-2013.

⁴² Christine Piette Durrance, “**The Impact of Pharmacy -Specific Any-Willing Provider Legislation on Prescription Drug Exenditures**,” *Atlantic Economic Journal*, Volume 37 (December 2009) p. 409-423.

⁴³ MG Vita, “**Regulatory restrictions on selective contracting: an empirical analysis of “any-willing-provider” regulations**,” *Journal of Health Economics*, Volume 20, Issue 6 (November 2001) p. 955-966.

⁴⁴ Ohio Legislative Services Commission, **H.B. 505 Bill Analysis**, May 21, 2024.

⁴⁵ Bill Hammond, **Public Comments on Proposed Pharmacy Benefit Manager Regulations**, The Empire Center, October 16, 2023.

There are better mechanisms available to policymakers looking to reduce healthcare costs than imposing AWP contract restrictions that raise drug and healthcare prices.

Deter Anti-Competitive Healthcare Practices

Aggressive hospital system and physician group consolidation over the last two decades has reduced market competition and contributed to healthcare's rising cost.⁴⁶ With fewer competing care providers, the larger consolidated hospital systems have been able to resist health insurance company pressure to lower prices by refusing to provide service to insurers in large metropolitan areas where the hospitals enjoy dominant market share.⁴⁷ The Federal Trade Commission (FTC) has responded by opposing and blocking some hospital mergers likely to result in higher prices and poorer patient health. And the FTC is currently reviewing the PBM industry for similar reasons and consolidation concerns.

State lawmakers lack the FTC's authority to block mergers or break up healthcare companies, but they can still take legislative steps to promote competition and deter anti-competitive behavior in the healthcare market. States have oversight authority to investigate anti-competitive and monopolistic practices that can increase state Medicaid costs and the health insurance plans offered to state employees. Those authorities give state lawmakers regulatory oversight of virtually every aspect of healthcare to encourage and ensure a freer market with competitive plans, pricing, and care.

⁴⁶ Jacob West, Garret Johnson and Ashish K Jha, "**Trends in acquisitions of physician practices and subsequent clinical integration: A mixed methods study,**" *Journal of Evaluation in Clinical Practice*, Volume 23, Issue 6 (December 2017) p. 1444-1450.

⁴⁷ Rea S. Hederman Jr., **Mercy Hospital System Shows Dangers of Healthcare Monopolies,** The Buckeye Institute, July 27, 2023.

CONCLUSION

Healthcare and health insurance remain expensive for businesses and families. Although federal rules and requirements broadly govern aspects of healthcare, states can and should pursue policies that will make care and insurance plans more affordable. State policymakers can reform medical licensing laws, end collaborative agreement requirements for CRNAs, and authorize better use of specialized nurses and nurse practitioners to help bring more care to more people cost-effectively. States can also prevent hospitals and physician groups from charging unnecessary facility fees, and they can promote more transparent pricing at hospitals. Policymakers can encourage better use of artificial intelligence to reduce administrative costs and improve diagnostics. And states should continue to punish Medicaid fraud and enforce eligibility requirements. Well-intended insurance benefit mandates and “any-willing-provider” requirements ultimately raise provider costs and consumer prices, and policymakers should avoid using the fiat powers of government regulations that distort markets and set artificial prices for care and services. Market competition continues to be the best way to spur innovation, improve care, and price goods and services. Policymakers would do well to resist adding regulatory requirements and interfering in market pricing. Transparency, choice, and competition offer better paths forward for reducing costs and improving quality in healthcare.

ABOUT THE AUTHOR



Rea S. Hederman Jr. is executive director of the Economic Research Center and vice president of policy at The Buckeye Institute. In this role, Hederman oversees Buckeye’s research and policy output.

A nationally recognized expert in healthcare policy and tax policy, Hederman has published numerous reports and papers looking at returning healthcare power to the states, the impact of policy changes on a state’s economy, labor markets, and how to reform tax systems to spur economic growth.

Prior to joining Buckeye, Hederman was director, and a founding member of the Center for Data Analysis (CDA) at the Heritage Foundation, where he served as the organization’s top “number cruncher.” Under Hederman’s leadership, the CDA provided state-of-the-art economic modeling, database products, and original studies.

While at Heritage, Hederman also oversaw the organization’s technical research on taxes, healthcare, income and poverty, entitlements, energy, education, and employment, among other policy and economic issues. He was also responsible for managing Heritage’s legislative statistical analysis and econometric modeling.

Hederman’s commentary has been published in *The Washington Post*, *The Washington Times*, *National Affairs*, *The Hill*, National Review Online, and FoxNews.com, among others. He is regularly quoted by major newspapers and wire services, and has appeared on Fox News Channel, CNN, CNBC, and MSNBC.

Hederman graduated from Georgetown Public Policy Institute with a Master of Public Policy degree and holds a Bachelor of Arts from the University of Virginia.

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