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A HEALTHIER FUTURE

POLICY IDEAS FOR IMPROVING HEALTHCARE IN WISCONSIN

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Introduction

Across the country, concerns about the rising costs and access to healthcare have been rising—and these feelings were only exacerbated by the COVID-19 pandemic. More than ever, many people are feeling the effects of staffing shortages, longer waiting times, rising prices, and more. Healthcare spending continues to grow each year and is consistently a top concern among US adults.

The conversation on healthcare has been centered around insurance coverage for years, but this alone does not make healthcare more affordable or accessible. About 33% of insured US adults are concerned about affording their monthly premiums, and 44% are worried about affording healthcare before their deductible is met.[1] Insurance coverage on its own is simply not enough to fix problems of worker shortages, unfree market supplies, or lack of access. We must implement policies that address the root causes.

In this report, we propose multiple policy ideas that can be implemented to address the issues we face in our healthcare system in Wisconsin. They comprise three general categories: Freedom to Practice, Rising Healthcare Costs, and Lack of Access.

Freedom to Practice

Even before the pandemic, Wisconsin had been facing an increase in demand for healthcare workers as our population ages. Many healthcare workers are getting burnt out from providers being short-staffed and overworked, so they're retiring sooner or leaving the profession.[2] This results in high turnover and lower productivity. This cycle has only been made worse due to the pandemic. In Wisconsin, we are facing one of the worst healthcare worker shortages after the pandemic: 29% of our hospitals face critical staff shortages.[3] But as it turns out, there are a lot of things that the government can do to "get out of the way" and liberate health care professionals to meet this need on their own.

Rising Healthcare Costs

The cost of health insurance has been increasing since the passage of the Affordable Care Act (ACA).[4] The average national premium, for instance, rose by 129% between 2013 and 2019.[5] Although premiums for ACA marketplace participants have recently been given American Rescue Plan Act subsidies to help with costs,[6] those subsidies will not continue forever.[7] Note also that Wisconsin has the 4th-highest healthcare costs across the country.[8]

Lack of Access

Although Wisconsin has one of the lowest uninsured rates in the country,[9] there are still 312,000 Wisconsinites, about 5.5%, who do not have health insurance.[10] Even for insured patients, the above-noted shortage of healthcare workers means that patients have less access to healthcare, the care that's available costs more, and the care ultimately received may not be of the highest quality.

Freedom to Practice:
Universal Licensure Recognition

Problem:

For at least four years, Wisconsin has been facing a backlog of state worker license applications.[11] This affects many professions, but especially healthcare professionals from other states who are left unable to work here.[12] For example, it can take 10-16 weeks for a physician to acquire a license to practice.[13]

Background:

Some healthcare professions already have licensure reciprocity in Wisconsin. For example, Wisconsin is a member of three interstate compacts for physicians, nurses, and psychologists that allow for those professions to easily practice in another compact state, whether permanently or temporarily.[14] This is a step in the right direction but is limited to only those professions and workers who are from the states within those compacts.

Solution: Universal licensure recognition.

The state of Wisconsin should recognize healthcare professional licenses obtained in other states with a substantially equivalent scope of practice.

20 states have already enacted universal licensure, such as:

- Arizona
- Iowa
- Ohio
- Missouri

This policy would still need some stipulations, e.g. the license must be in good standing, but it would create a much more streamlined process to free healthcare professionals to practice here.[15]

Next Steps:

In 2020, Governor Evers signed an emergency order[16] that temporarily granted licensure reciprocity to any healthcare provider as defined in Wis. Stat. § 146.8 1(1)(a) through (hg.)[17] This helped get qualified healthcare professionals into the field during the COVID-19 pandemic with few problems. This same thinking should be made permanent and applied to all licensed professions to help ensure that we have the workforce the state needs to move forward.

Freedom to Practice:
APRN Full Practice Authority

Background:

One of the medical professions that Wisconsin's government overly restricts is nursing. There are four advanced practice registered nurse ("APRN") professions that offer important and timely care for patients.[18] These are:

- Nurse Practitioners
- Nurse Anesthetists
- Clinical Nurse Specialists
- Certified Nurse-Midwives

APRNs are educated and capable. To become an APRN, candidates must have a Bachelor of Science in Nursing (BSN) and some work experience before earning a Master of Science in Nursing (MSN). Then, they must pass a national exam for their nursing specialty.[19] They are a critical part of a healthcare team with the ability to assess and diagnose patients, order tests, and prescribe medications.[20]

Problem:

There are 1.6 million Wisconsinites living in a primary care shortage area where less than 60% of primary care needs are met.[21] This will only get worse over time as Wisconsin is expected to need 2,263 primary care doctors by 2030. Unfortunately, medical schools and residencies are not creating enough doctors to meet this demand, especially in rural areas.[22] APRNs can help provide primary care to people who may otherwise have no care at all.

For these providers to practice they must partner with a physician who is willing to supervise and collaborate with them. This creates a barrier for APRNs who might not be able to find a physician willing to take on that role.[23] This limits the availability of healthcare services for patients: healthcare worker shortages create longer wait times and rising costs.

Solution: Grant full practice authority to APRNs.

There are 27 states that grant APRNs full practice authority. This expanded scope of practice allows them to evaluate and diagnose patients, order and interpret diagnostic tests, and prescribe medications without supervision or collaboration.[24] During the pandemic, Governor Evers suspended nursing management and collaboration with other healthcare professionals.[25] While the pandemic has subsided, the problems with healthcare access persist and this change should be made permanent. Expanding APRN practice authority can increase healthcare access and lower costs while delivering similar health outcomes.[26] Crucially, APRNs have been growing in rural communities, making up 25% of providers in those areas.[27]

Next Steps:

Senate Bill 394, introduced in 2021, would have made this change permanent, allowing APRNs full practice authority after 3,840 practice hours with supervision. This bill passed both chambers of the legislature but was vetoed by Governor Evers.[28] Similar legislation, SB 145, has been introduced again in 2023. It still requires APRNs to practice in collaboration with a physician but removes the supervision requirement once they have completed 3,840 practice hours.[29]

Freedom to Practice:
International Physicians

Problem:

Wisconsin is facing a shortage of doctors. It is estimated that by 2030 there will be physician shortages in at least 23 states, Wisconsin being one of them.[30] Even at the present, about 20% of the US population has limited or no access to a primary care physician.[31]

This is an even larger problem when it comes to specialty doctors in rural areas: there are only 30 specialists per 100,000 people, compared to 263 per 100,000 in urban areas.[32] This physician shortage leads to higher healthcare costs and health disparities, especially between urban and rural areas where rural patients are less likely to get quality care or be part of adequate insurance networks.[33]

Background:

It is expected that US-trained doctors will receive an undergraduate, pre-med degree before going to medical school. However, many other countries begin training immediately with what they need to know in practice. Because of this, current US licensing requirements require international doctors to, essentially, start over. Many foreign-trained doctors, depending on their training, may have to go back to school for general classes such as calculus, physics, and general biology. All international doctors also have to pass three certifying exams and redo a residency program which can take three to seven years—despite their years of prior experience.[34] These barriers often cause international medical professionals to take jobs in the US that are not in the healthcare field.[35]

Solution:

The United States Department of Health and Human Services have recommended an approach to reform: that state legislatures deem foreign doctors and residency programs as acceptable for practice in their state.[36] The criteria would still require graduation from medical school and passing the United States Medical Licensing Examination, in addition to other criteria set by the Accreditation Council for Graduate Medical Education.[37]

Individual doctors or residency programs can apply; it is also recommended that any doctor or residency program that is deemed acceptable by other states should be automatically accepted. Such doctors who practice in the state should be required to work in a rural area for at least five years before being able to practice elsewhere.

Freedom to Practice:
Dental Therapy License

Problem:

In Wisconsin, another cause for concern is dental care access. According to the Kaiser Family Foundation,[38] over 1.2 million people in Wisconsin lack access to dental care. Insufficient dental care can lead to a higher risk for many different bad outcomes, e.g.:[39]

- Tooth Loss
- Gum Disease
- Oral Cancer
- Heart Disease
- Dementia

This is especially problematic in rural areas. These are more likely to be designated as a Healthcare Provider Shortage Area ("HPSA"),[40] i.e. a geographic area, population, or facility with a shortage in primary, dental, or mental healthcare providers.[41] Low-income and elderly patients are significantly impacted as well, given that only a third of Wisconsin dentists accept Medicaid patients.[42]

Background:

There are 173 HPSA designations in our state in need of about 275 dentists.[43] Marquette University is the only dental school in the state and graduates about 100 dentists a year—but they don't tend to work in areas that need them the most.[44]

Solution:

Some states have recognized the profession of dental therapist. A dental therapist is a mid-level practitioner, comparable to a Nurse Practitioner or a Physician Assistant, that has a limited scope of dental practice. They can provide up to 30 dental services including placing temporary crowns, fabrication of athletic mouth guards, or extracting primary teeth.[45]

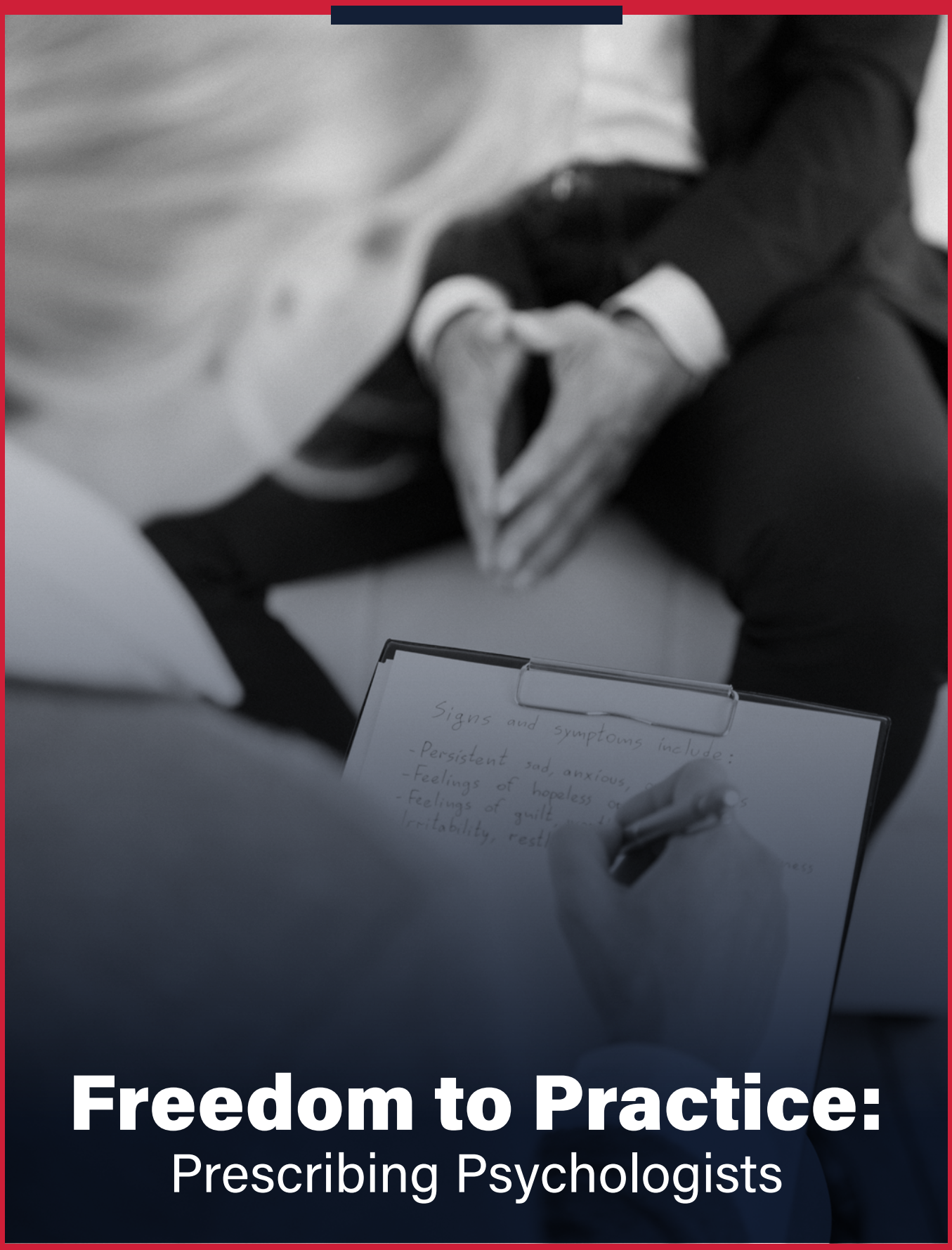
By allowing this profession in the state of Wisconsin, we can offer more dental providers to care for patients at a lower cost, while reducing wait times and benefiting dental practices.

Example:

This has been successfully implemented in Minnesota, which created a dental therapy license in 2009.[46] A study by the Center for Health Workforce Studies found that practices utilizing dental therapists increased their patient caseload and gross revenue.[47]

Next Steps:

This reform has some bipartisan groundwork, since Legislative Republicans introduced a bill for dental therapy in 2017 [48] and Gov. Evers proposed allowing dental therapists in his 2019 budget proposal.[49]



Freedom to Practice:
Prescribing Psychologists

Background:

We have a growing mental health epidemic, especially among young people. This was only made worse by the pandemic. In Wisconsin, rates of depression among high schoolers between 2019 and 2021 increased from 28.5% to 33.7%.[50] According to the Kaiser Family Foundation, only 38.5% of Wisconsin's mental healthcare needs are being met. A 2022 survey found that nationwide, 43% of adults who needed mental healthcare in the previous 12 months did not receive it. [51]

Problem:

Getting medication to treat mental illness is difficult. It is the role of psychologists to diagnose and treat mental illness through methods of talk therapy. If they believe that medication would support the patient's treatment, then they refer the patient to a psychiatrist to get a prescription. Only psychiatrists, who are medical doctors, can prescribe medication for mental health; psychologists cannot prescribe medications.[52] Unfortunately, these appointments are difficult to find:

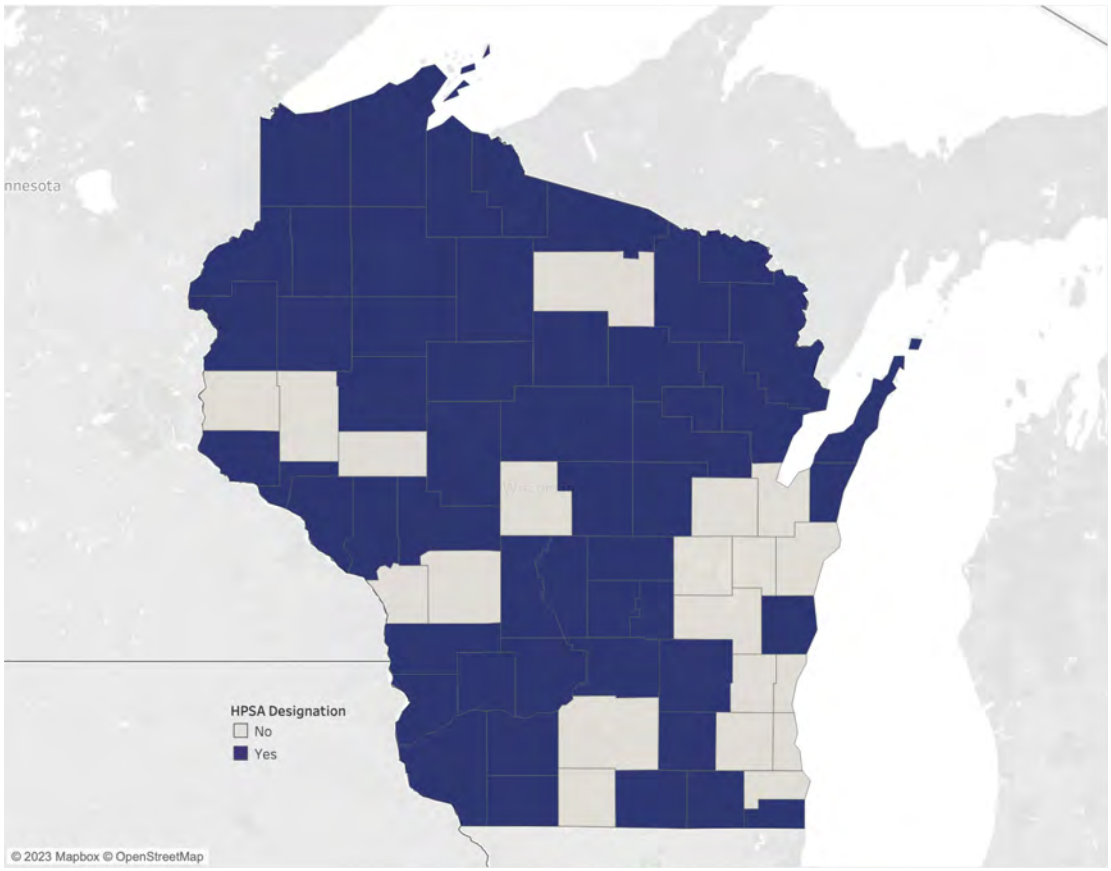
- It can take between 25 to 90 days to get an initial visit with a psychiatrist [53]
- An initial appointment with a psychiatrist can cost hundreds of dollars [54]
- About half of all psychiatrists do not accept insurance [55]
- Only 10.8% offer talk therapy [56]

Solution:

Psychologists can expand access to mental healthcare if they are allowed to prescribe medication to their patients after receiving additional education and training. Because they typically spend more time with their patients, psychologists are likely better equipped to understand the needs of their patients and whether medication is absolutely necessary. For example, talk therapy appointments with a psychologist typically lasts for 45 to 50 minutes.[57] With a psychiatrist, appointments last only about 15 minutes.[58]

Example:

Currently, five states plus Guam have passed laws that provide a pathway for psychologists to prescribe medication. To be on the safe side, their requirements can include a post-doctoral master's degree in psychopharmacology, clinical rotations, supervised probationary prescription periods, and passing the psychopharmacology exam, as well as restrictions, such as no prescriptions for minors or of illicit drugs.[59] New Mexico has the least burdensome requirements for prescribing psychologists, requiring 850 hours of instruction and clinical experience plus two years of supervision under a conditional certificate.



Mental Health HPSA Areas in Wisconsin

Wisconsin Office of Rural Health, Feb. 2020.

Freedom to Practice:
Expanding Pharmacist Scope of Practice

Problem:

Access to preventive healthcare can often be made unnecessarily difficult. Going to a doctor can be costly: many choose to avoid an appointment until it is absolutely necessary just because of the cost.[60] Additionally, as noted elsewhere, over 1.6 million people in Wisconsin live in a "Healthcare Professional Shortage Area" (HPSA).[61] Without enough healthcare professionals, people may have to drive long distances or book appointments weeks or months in advance, further making doctors inaccessible.

Solution:

Almost 90% of the US population lives within five miles of a community pharmacy.[62] Since they are often the closest available healthcare provider, especially in rural areas, expanding their scope of practice can increase access to necessary primary care.[63] In all 50 states, pharmacists can already provide vaccines to patients, but they have the knowledge and skillset to perform other services as well.[64] During the pandemic, many states took emergency action to expand the legal scope of practice for many health professionals, including pharmacists, which should continue.[65]

Example:

North Dakota allows pharmacists a relatively expanded scope of practice; for example, they may

- Prescribe and dispense medication under a collaborative practice agreement with a physician or nurse practitioner
- Provide bones mass tests
- Provide bone density tests
- Provide thyroid-stimulating hormone testing
- Provide cholestorol and triglyceride tests[66]

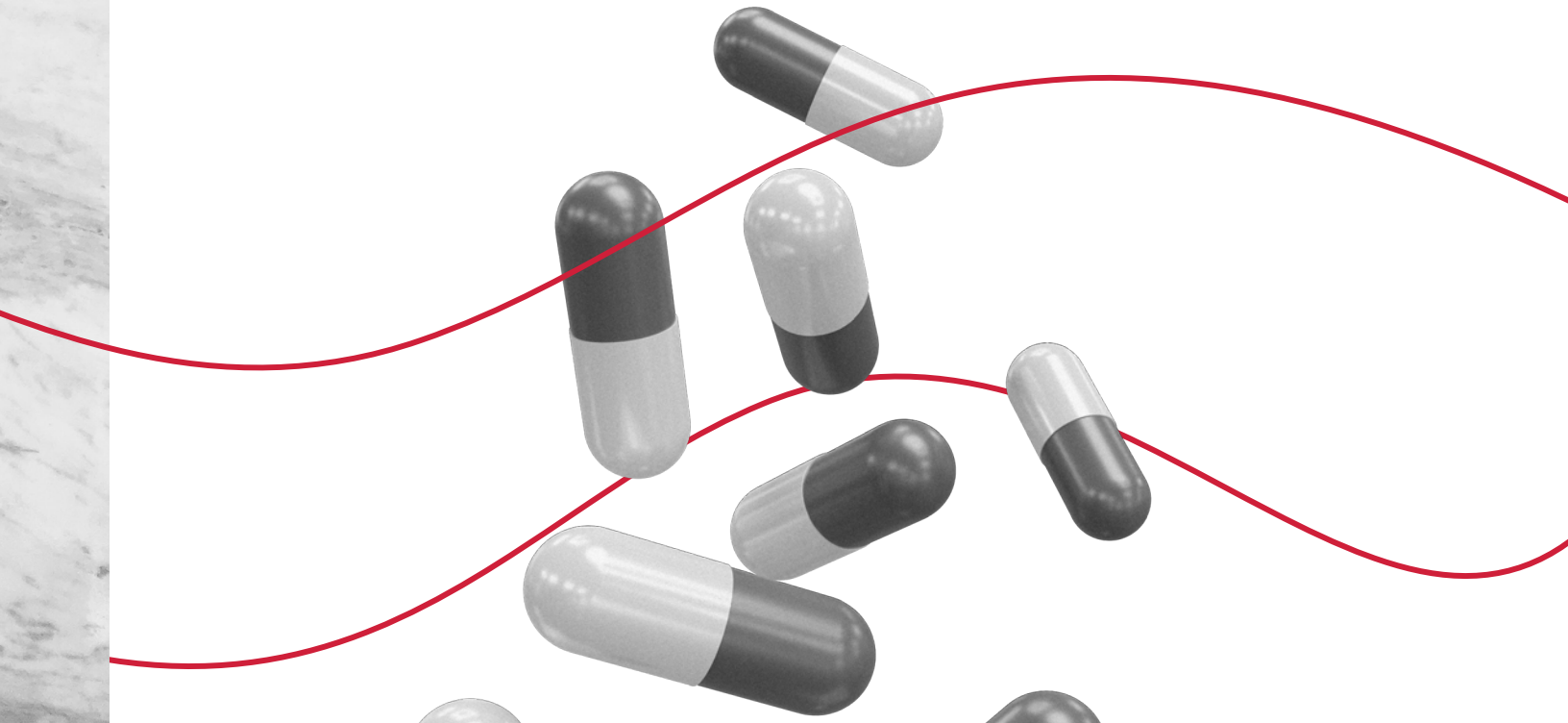
California has made it so they can prescribe treatments like HIV pre- and post-exposure prophylaxis, among others.[67]

Next Steps:

Wisconsin should consider expanding pharmacist scope of practice like in other states. Some low-hanging fruit here includes:

- Extending routine, non-controlled medication prescriptions for one to two months
- Testing and administering medication for common viral and bacterial illness like influenza and strep throat
- Prescribing non- or low-sedating antihistamines, corticosteroids, and decongestants
- Vaccinating children under the age of three
- Tuberculosis skin testing and interpretation.[68]

In 2019, legislation that would allow pharmacists to prescribe hormonal contraception was passed in the Wisconsin Assembly with a bipartisan 82-13 vote[69] but it was not taken up by the Senate. in 2021, it was again introduced and passed in the Assembly but did not make it through the Senate.[70]



Freedom to Practice:
Assistant Physician

Problem:

The Association of American Medical Colleges estimates that there will be a shortage of 17,800 to 48,000 primary care doctors by 2034.[71] Making matters worse is that there are more medical school graduates than there are residency program spots. In 2022, there were 39, 204 available spots for 42,549 applicants, meaning thousands of medical students each year go "unmatched" to a residency.[72] Without "matching" to a residency program, those graduates are unable to complete the third step of the U.S. Medical Licensing Exam (USMLE) and cannot practice medicine until they try the residency matching process a year later. At best, this slows down the pipeline of desperately needed doctors. At worst, it may prevent individuals from becoming doctors at all.

Solution:

Assistant Physicians (APs) are a relatively new category of medical professionals in the United States. They were introduced as a way to provide unmatched medical school graduates with an opportunity to gain clinical experience and further their medical careers while they work toward obtaining a residency position. Assistant Physicians have a scope of practice that is comparable a Physician's Assistant and can practice primary care in rural areas or other high-need areas, under the supervision of a licensed physician, with whom they have a signed collaborative practice agreement. Applicants must have graduated from an accredited medical school and passed the first two steps of the USMLE.

Example:

Six states have passed laws that authorize the practice of APs. Missouri was the first to pass a law in 2014, and The Missouri Board of Registration for the Healing Arts started accepting applicants in 2017. It is estimated that APs have filled the primary care shortage in the state by 3% since then.[73] Missouri AP licenses can be renewed indefinitely, while other states limit renewal as they expect APs to eventually match with a residency. Here are three different enacted renewal systems:

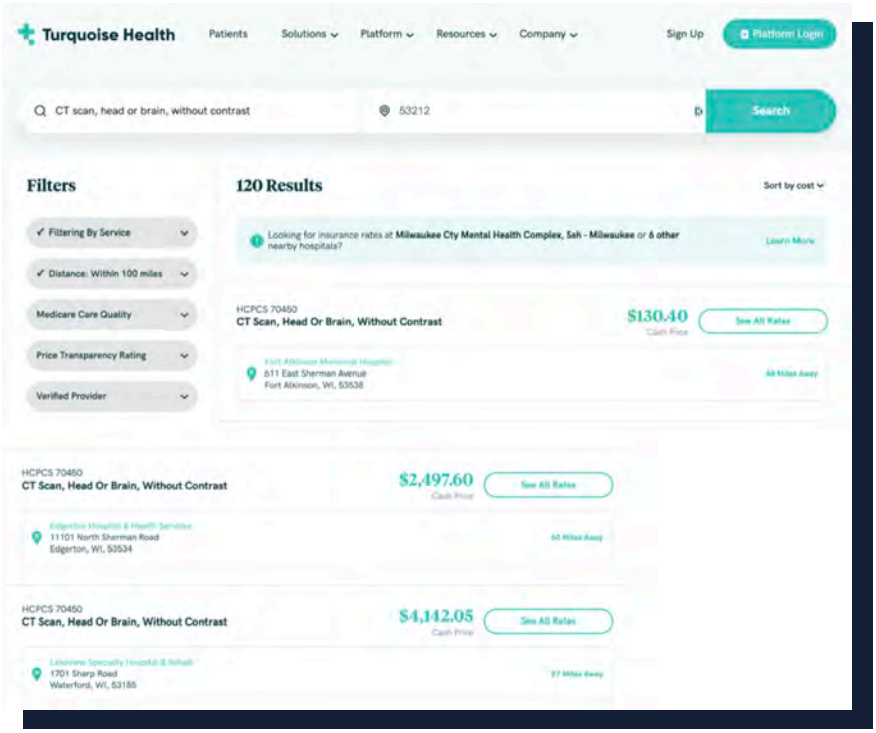
- Idaho's are not renewable
- Louisiana allows a maximum of two, one-year license renewals
- Missouri's are renewable indefinitely

Additionally, Missouri considered legislation in 2021 that would have allowed APs to apply for an unrestricted General Physician license after completing five years of collaborative practice with a licensed physician, 100 hours of continued education classes per year, and passing Step 3 of the USMLE. This did not pass but might be worthy of consideration.

Rising Healthcare Costs:
Price Transparency

Problem:

Currently, patients do not know how much they will have to pay for a doctor's appointment or for treatment until they've already received it. The cost of care is determined by recondite deals made between hospitals, insurance companies, and other third-party payers. Although not all healthcare services can be planned ahead of time, about 80% of them can be and are considered "shoppable."[74] But the lack of visibility into pricing obstructs patients' ability to shop around, which in turn disincentivizes hospitals from even trying to price affordably. This also means that what one patient pays can differ wildly from another depending on which insurance and hospitals they use—even though research has shown that there is no correlation between higher prices and better health treatment or outcomes.[75] For example, the cost of a CT scan in Wisconsin can range from $130.40 to $2,803 for the exact same service (pictured).[76]



Background:

Price transparency has already been promulgated federally. A rule for hospitals went into effect on January 1 st , 2021, and one for insurers on July 1 st , 2022.[77] Both of these rules require that hospitals and insurance companies offer pricing information in a machine-readable format and a consumer-friendly display for almost all services.

However, there is little guidance on what a consumer-friendly display looks like—even more concerning, the penalties for noncompliance are low and rarely enforced. As of February of 2023, only 24.5% of hospitals nationwide were in compliance.[78]

Solution:

By implementing a price transparency law that codifies with federal rules with stricter penalties and enforcement, patients would be empowered to lower their personal healthcare costs by shopping for their healthcare services, comparing prices, and deciding where they want to receive their treatment or service.

In turn, introducing competition into the healthcare market will incentivize hospitals and insurance companies to respond to the preferences of their customers and lower costs overall. A peer-reviewed study researched the effects of New Hampshire's price transparency website (pictured) on healthcare prices immediately before and after it was implemented.[79] It found that patients saved about $7.9 million and insurers saved $36 million.

Next Steps:

Wisconsin should codify the federal price transparency rules and implement full price transparency that better enforces compliance and accessibility to price information for consumers.

Rising Healthcare Costs:

Shared Savings Program for State Employees

Problem:

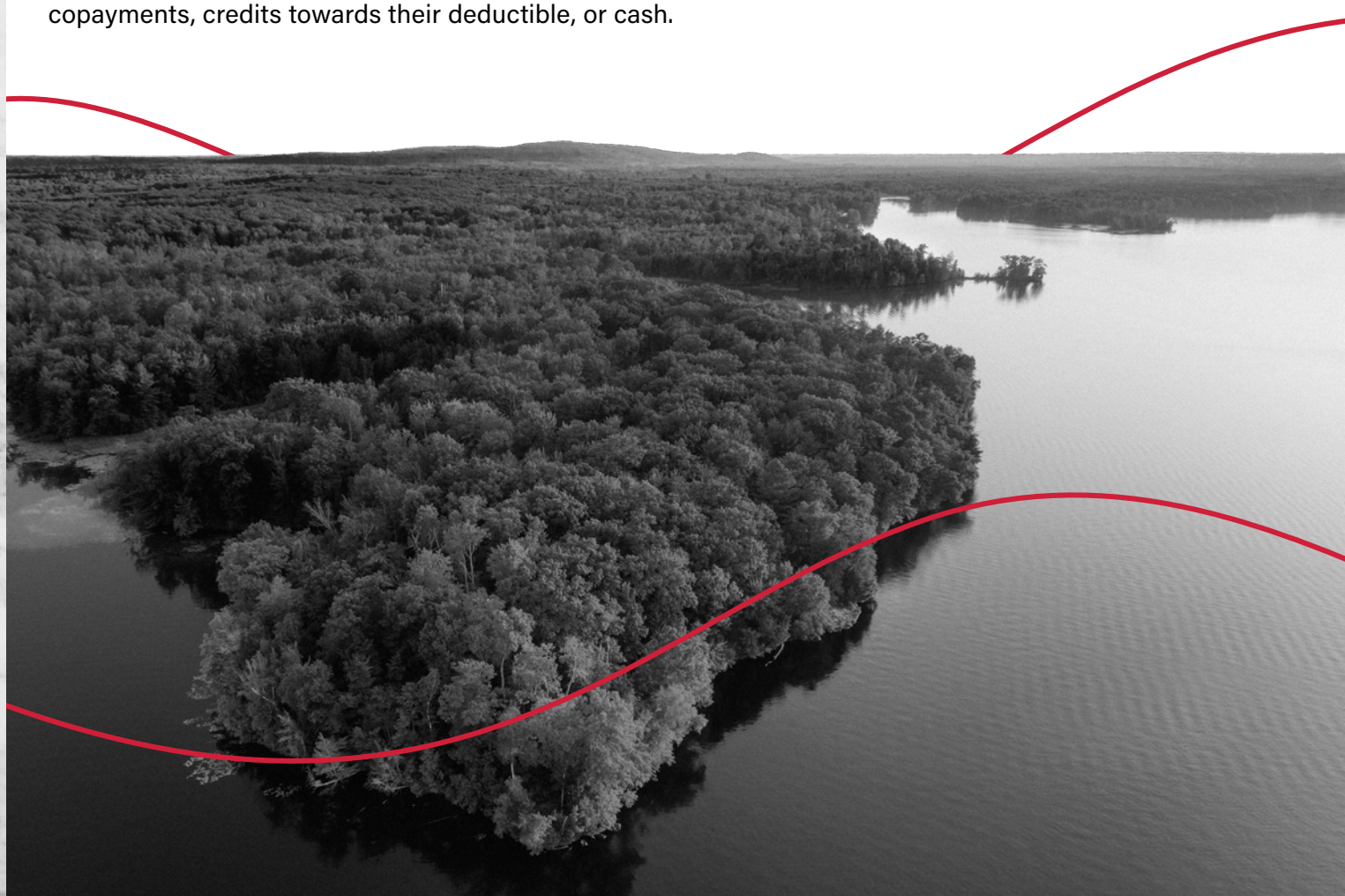
If the state were to implement price transparency, savings would only materialize if patients have a reason to use the information—i.e., if they save that money for themselves.

In the context of Wisconsin's government employees (both state and local), their employment arrangement should account for this. There is a public interest in Wisconsin's 278,000 full-time local and state government workers saving money for themselves as well as for the government ledger and the taxpayers.[80]

Solution:

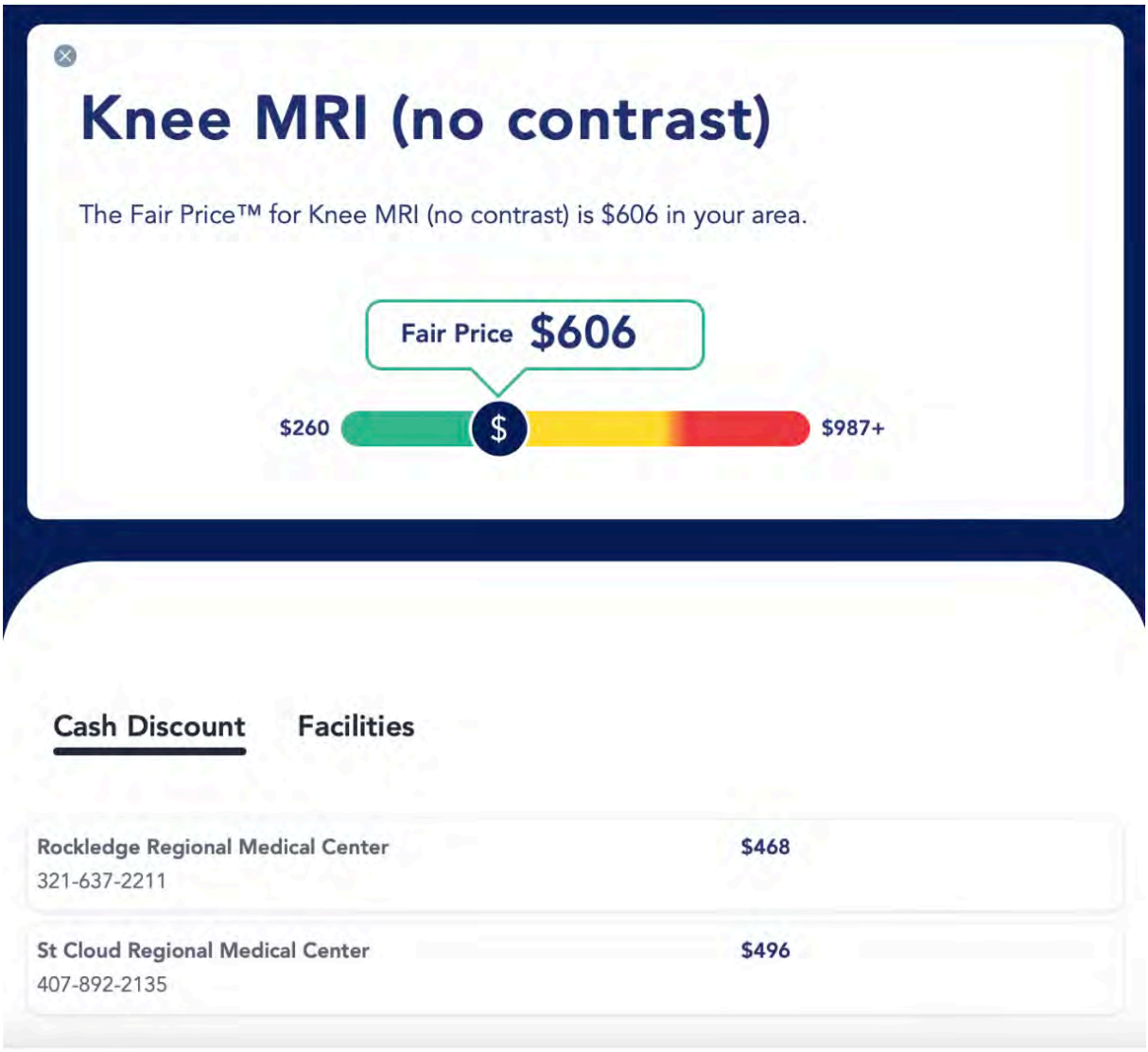
This can be done through a shared savings program. With a shared savings program, when an individual shops for and chooses a lower-cost option, the amount saved from that choice would be shared between the employer and the individual, giving the individual an incentive to find less-expensive healthcare options.

For example, if the state insurance expected to pay $1,000 for a procedure, but the patient chose an option that was $700, then the difference of $300 would be split with the patient through reductions in copayments, credits towards their deductible, or cash.



Example:

Florida has implemented a shared savings program for both full- and part-time state employees enrolled in the State Group health plan, which is operated by the Department of Management Services.[81] Enrollees can use programs like Florida's Healthcare Bluebook (pictured)[82] and SurgeryPlus[83] to look for bundled or rewardable services. By doing this, they receive benefits that can be credited to a special savings or spending account provided by the State Group health plan or used to pay for out-of-pocket medical costs.



Rising Healthcare Costs:

Repeal Minimum Markup for Prescription Drugs

Background:

One part of rising medical costs is that of prescription drugs and other medications. Since 2008, the launch price of new brand-name prescription drugs has risen 20% every single year.[84] The median launch price rose from $2,115 in 2008 to $180,000 in 2021. In 2019, it is estimated that Wisconsinites paid $1.3 billion for prescription drugs.[85]

Problem:

Wisconsin's Unfair Sales Act, passed in 1939, requires the price of a good to be set at a certain percentage above the wholesale price. It requires that medical products cannot be sold at a price below what the retailer paid—mandating a "minimum markup" in the good's price.[86]

Background:

This law was passed right after the Great Depression with concerns that large retailers would price out competition, only to charge much higher prices once they were the only retailers left. Regardless of whether it made sense right after the Great Depression—if that were the case today, we would expect to see fewer small businesses in states where there is no minimum markup law. Research, however, has shown that this is not the case— and would likely never happen.[87]

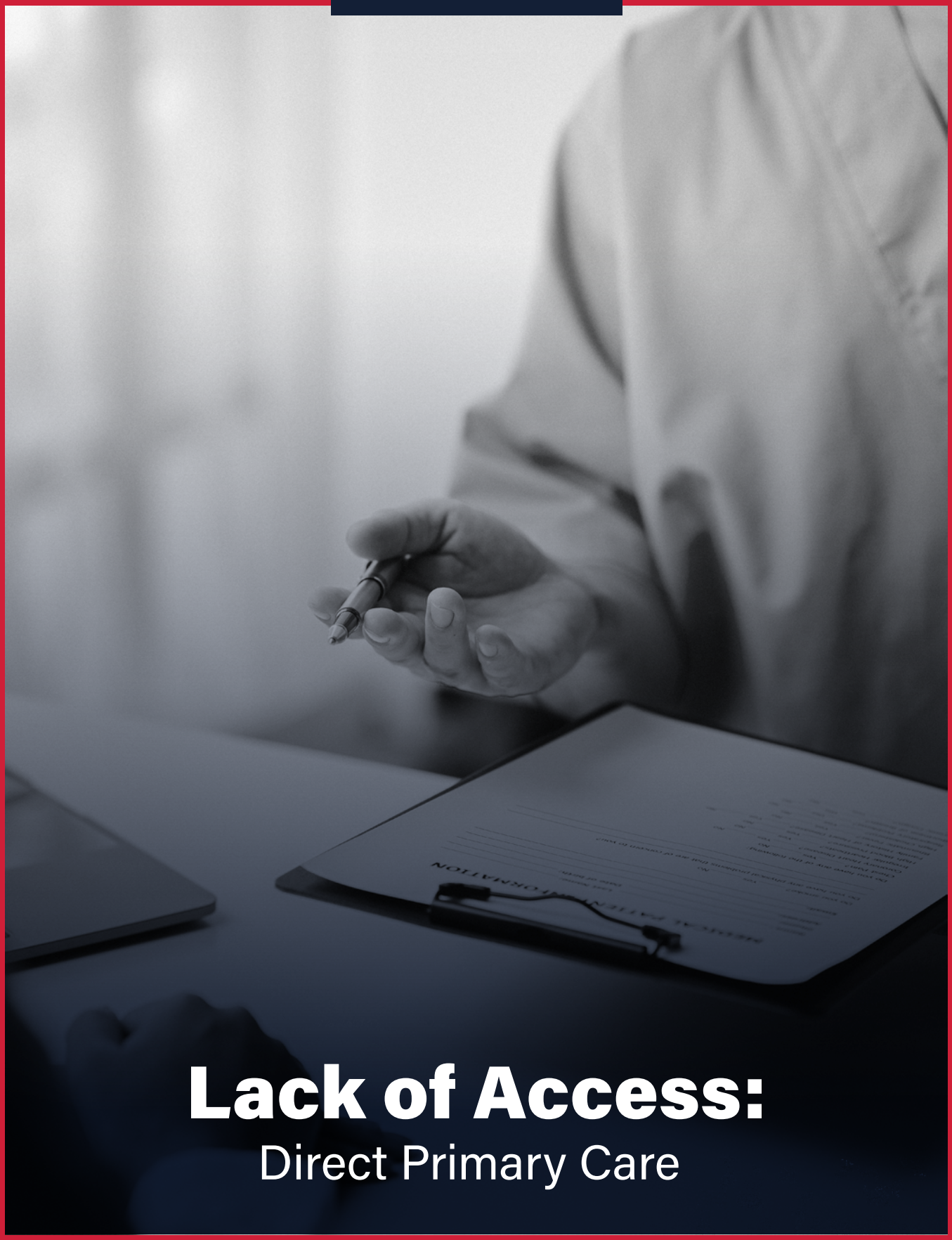
Moreover, the Federal Trade Commission has concluded that the law in Wisconsin is unnecessary because of anti-trust laws at the federal level.[88]

Solution:

Wisconsin should repeal the Unfair Sales Act. This would make it legal to sell prescription drugs below cost, which retailers would do banking on getting more consumers through the door—a huge win for people dependent on those prescription drugs.

Next Steps:

There were efforts to exempt prescription drugs from the Unfair Sales Act in 2010.[89] In 2015, state legislators tried and failed to repeal the Unfair Sales Act completely.[90] Then in 2021, legislators introduced a narrower bill to exempt qualified medical expenses from the Unfair Sales Act.[91] Any of these would serve patients by making it legal to sell prescription drugs at a lower cost.



Lack of Access:

Direct Primary Care

Problem:

With high deductible health insurance plans, patients are paying more for doctors' visits even as wait times to see a doctor or specialist have gotten longer.[92, 93] Because of this, patients are inclined to avoid visiting the doctor unless necessary, likely missing out on important preventive care that improves overall health outcomes. Even when they do visit, doctors' high volumes of patients mean shorter appointment times where they cannot discuss the patients' health concerns at length or in depth.[94]

Solution:

Direct Primary Care (DPC) is an arrangement where patients sign up for a direct monthly membership at a physician-run clinic. The low monthly fee typically includes

- Virtually unlimited medical visits
- Virtually unlimited personal communication with your doctor
- Some tests or labs
- Certain medications

Additionally, DPC doctors have fewer patients, so wait times are much shorter and appointments can be longer. These longer appointment times are associated with a higher level of satisfaction from the patient as they can discuss their health concerns thoroughly and build more understanding with their doctor.[95] The low fixed rate and better physician relationships make it a great option for anyone who needs regular preventive medical care.

Details:

The monthly membership cost can range from $25 to $125 a person, and requires no additional deductibles or copays.[96] A membership can save hundreds of dollars a year compared to paying for individual appointments before a deductible is met.[97]

Next Steps:

There are about 25 DPC providers that have been operating for some time, but Wisconsin should pass a law to clarify that DPC practices are not considered an insurance product, which would remove an important barrier that has discouraged DPC providers from expanding in Wisconsin.[98] 2021 Senate Bill 889 would have mostly accomplished these goals, but it failed to passed.[99] While there are still some details that need to be worked out with this legislation, it would largely do the following

- Define in statute what DPC is
- Exempt DPC practices from state insurance laws
- Require a disclaimer that DPC is not the same as insurance
- Have an outline of DPC required agreements

Lack of Access:

Farm Bureau Health Insurance Plan

Problem:

There are 312,000 Wisconsinites without health insurance. Additionally, there are 23 northern, rural counties where residents who wanted to acquire it have only one or two options on the Affordable Care Act insurance marketplace.[100]

Background:

These people could be served by the "Farm Bureau Health Plan," a medically underwritten health coverage plan. The Farm Bureau's plans, which range from covering catastrophic care to complete coverage, are made available to anyone who is a member. Note that being a member only involves signing up and paying dues—regardless if one works in that field or not. In Wisconsin, those dues range from $50 to $65 a year depending on your county.[101] Although members who apply for the health plan may be rejected based on medical history, this provides an accessible, affordable health coverage option for people who might not otherwise have any.

Moreover, while Farm Bureaus are the pioneers here, other trade groups could have the ability to do something similar for their members.

Solution:

State law should allow the state Farm Bureau to offer these plans. Six states already offer or plan to offer this option to residents as state-recognized health insurance; Tennessee, Iowa, Kansas, Indiana, South Dakota, and Texas.[102] In Iowa, 83% of those covered by their farm bureau's plan would otherwise go uninsured.[103]

Example:

Tennessee codified their Farm Bureau HealthPlan in 1993 and has shown the long-term success of this health coverage option. The law allows anyone to be a Farm Bureau member and to apply for their health plan. It offers four levels of coverage for members to choose from, with potentially 77% lower premiums and 79% lower deductibles depending on the member and the plan. Some other components of Tennessee's system include:

- Coverage for prescription drugs (all plans)
- Coverage for preventive care (all plans)
- Maternal, dental, vision, or telehealth coverage (some plans)
- A screening process to ensure that people do not wait until they are sick to sign up
- A 6- to 12-month waiting period for expenses related to certain conditions
- The High Deductible Health Plan is eligible for a Health Savings Account

Nine out of every ten members are accepted for health coverage.

Lack of Access:

Right to Try 2.0

Background:

The federal government and many states, including Wisconsin, passed Right to Try 1.0 legislation in 2018.[104] This allowed patients to receive potentially life-saving care, even if it had not yet been approved by the FDA, in a matter of days. There were still some stipulations, for instance:[105]

- The patient must have a life-threatening disease or condition
- The patient must have considered all treatment options approved by the FDA
- The patient must have the treatment recommended by their doctor who is in good standing and will not be directly compensated by the manufacturing company
- The patient must provide informed consent in writing to the risks involved in in good standing and will not be directly compensated by the manufacturing company
- The treatment must have completed a Phase 1[106] clinica

Problem:

As technology advances, there are now some treatments that can be personalized to the patient by using their personal DNA. Right to Try 1.0 requires an experimental treatment to pass a Phase 1 clinical trial to test the safety of the drug on humans.[107] This is a roadblock for personalized treatments that do not need a Phase 1 clinical trial because there is only one person who would ever use it. This is what Right to Try 2.0 addresses.

Solution:

With Right to Try 2.0 legislation, we can expand upon the original legislation by allowing this same process, but without the now-unnecessary step of a clinical trial, for personalized treatments that are based on the patient's genomic sequence, human chromosomes, deoxyribonucleic acid, ribonucleic acid, genes, gene products, or metabolites.

Next Steps:

Some states, such as Arizona,[108] have already taken the lead on this policy. Arizona passed a law in 2022 that sets the same patient safety provisions and requires Federalwide Assurance policies for patient protection, but otherwise eliminates the Phase 1 requirement for treatments specific to the patient's genetics.[109] Wisconsin should expand upon Right to Try as well.

Lack of Access:

Nursing Home Bed Moratorium

Problem:

Wisconsin prevents nursing homes from adding beds without government approval, even temporarily.[110]

Background:

This limit restricts how many nursing home beds are available. Note, too, that hospitals may discharge patients to a nursing home when they cannot go home but no longer need to be in the hospital.[111] If they are unable to find a bed for this type of patient, they have to continue caring for that patient in the hospital. This makes it harder to care for other patients who specifically need room in a hospital.

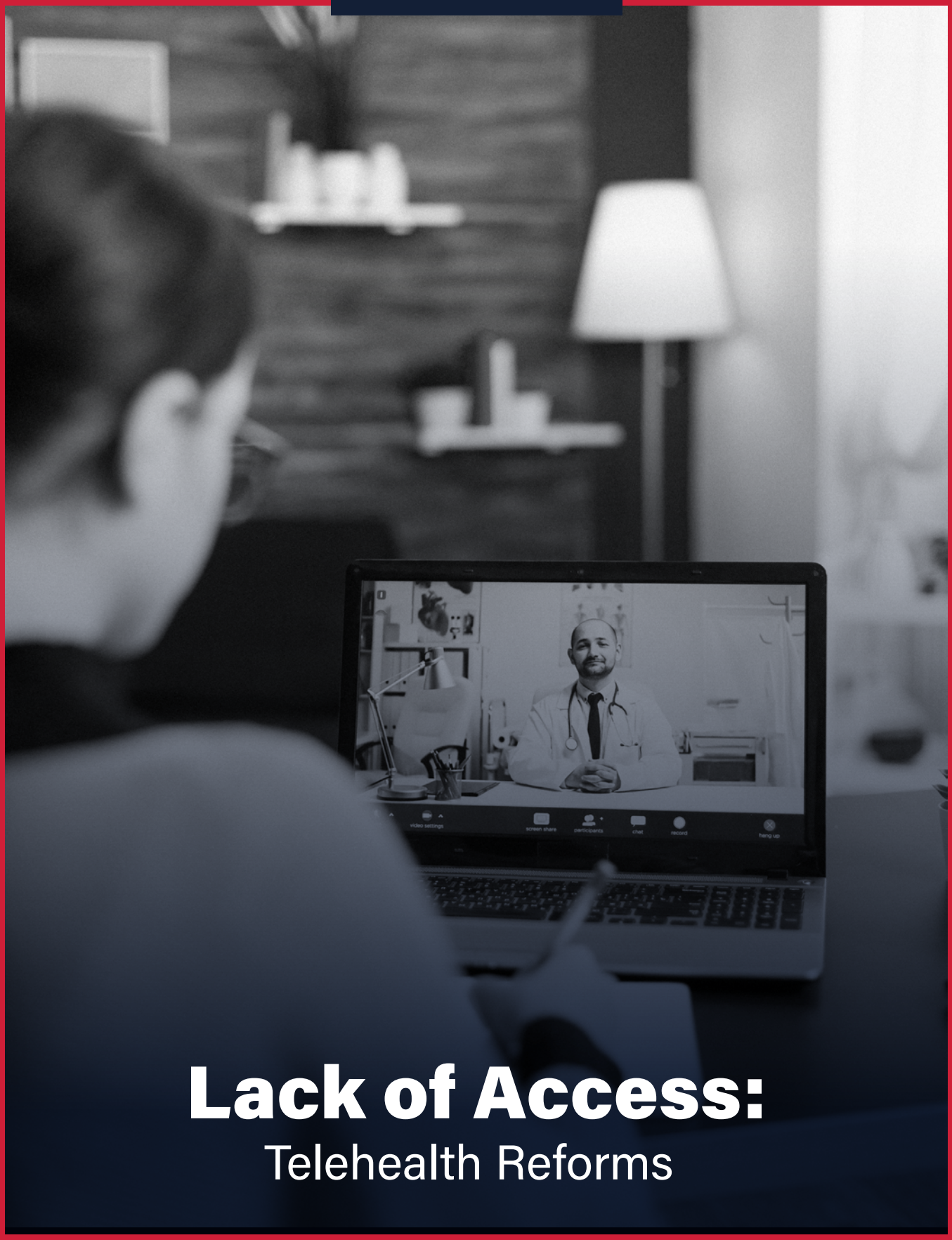
All of this is especially relevant given Wisconsin's age: in 2020, the number of residents over the age of 60 made up 25% of Wisconsin's population.[112]

Explainer:

The state enforces this moratorium with the stated goal "In order to enable the state to budget accurately for medical assistance and to allocate fiscal resources most appropriately."[113] In practice, this rule suppresses quality, since new organizations are prevented from forming to compete with existing facilities. This moratorium also hamstrings emergency medical responses (e.g. with COVID-19). It's also worth noting that these laws are pretty common nationwide, and that America's rate of hospital beds[114] per capita nationally is lower than many other developed nations."[115]

Solution:

By removing the moratorium on the number of nursing home beds, nursing homes can meet the demand of care without being limited by artificial government restrictions. Additionally, this will relieve hospitals by giving them another place to discharge recovering patients.



Lack of Access:

Telehealth Reforms

Background:

During the pandemic, the ability to speak with a doctor through media such as videoconferencing, phone calls, and text messages became vitally important. However, the need for telehealth continues as many still face issues with access to medical care.

Problem:

Wisconsin has made great strides in telehealth services, but there are still areas of improvement[116]—according to a 50-state report of telehealth practices, there are four areas of telehealth access that Wisconsin can improve on.[117] One of these is the expansion of APRN scope of practice which is discussed elsewhere; the following are the other three.

Solution 1:

Wisconsin should expand modality neutrality, i.e. when doctors and patients can communicate by any virtual means, from video chat to remote monitoring to recorded messages. The currently-restricted aspects of modality neutrality are remote patient monitoring and store-and-forward communication. Essentially, restrictions on the transmitting of medical information, such as blood sugar levels or X-ray images, inhibit modality neutrality and uninterrupted patient care.

Solution 2:

Wisconsin does not have a clear pathway for medical professionals in good standing to see patients in other states. (Exceptions exist when consulting another provider or in an emergency.) There should be a clear and straightforward process for providers to accept patients from out-of-state and provide needed care wherever their patient lives.

Next Steps:

Indiana has a telehealth certification process that allows out-of-state providers to practice telehealth without a full state license; we should consider a certification like that.[118]

Solution 3:

Wisconsin currently limits the use of telehealth to physicians and physician associates only. Our code should be updated to include broad language that allows all providers to access telehealth so that patients can access any provider who is part of their healthcare. Using federal regulations' definition of healthcare providers,[119] that would be:

- Doctors of Medicine or Osteopathic Medicine
- Dentists
- Nurse Practitioners
- Nurse-midwives
- Podiatrists
- Clinical Psychologists
- Optometrists
- Chiropractors

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