Lowering New York's Drawbridge for Common Sense Healthcare Reform

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ABSTRACT. Healthcare problems in New York State include, but are not limited to, exorbitant costs of care, punitive insurance prices, long wait times, and a shortage of healthcare practitioners. The best step forward for dramatically improving healthcare in New York relies on a combination of solutions that include abolishing unnecessary criteria for licensure, enabling the expansion of telemedicine and telehealth solutions, and creating the environment for retail and cash-only options to curb the influence of insurance conglomerates. Additional solutions lie in physicians and bureaucrats accepting cannabis and other alternatives as valid medicine amidst the opioid crisis.

Introduction

Gubernatorial candidate Larry Sharpe's (L) position on healthcare is to focus on healthcare reform and lowering prices, instead of health insurance reform. The best way forward for healthcare in the State of New York will require a wide expansion of telehealth options, and consumer driven solutions that increase options for consumers while lowering costs. Larry Sharpe maintains the position that dramatically improving healthcare in New York relies on a combination of solutions that include abolishing unnecessary criteria for physician licensure, enabling the expansion of telemedicine and telehealth solutions, and creating the environment for retail and cash-only options to curb the influence of insurance cartels. These reforms are designed not to cheapen the knowledge or competency required to provide healthcare in New York, but to eliminate the unfair barriers from practicing and bottlenecks for approval that shrink the supply on healthcare options, degrading quality and raising costs.

Ending the scarcity caused by licensure requirements

One recurring theme that can be found throughout the entire healthcare sector, from medical schools to hospitals to pharmacies, is artificial scarcity. In other words, scarcity that would not exist were it not for policies and laws. The greatest contributor to scarcity and higher prices according to the law of supply and demand is licensure laws. Let it be made explicit: there are thousands of doctors who completed medical school, but simply cannot get training because of a lack of open slots. In a 2017 article appropriately titled 'Understand Your Odds of Getting into Residency,' MD Magazine reported that, per the National Residency Matching Program results from 2016, there were more than 35,000 applicants for approximately 27,000 PGY1 positions (Moawad 2017). Licensure laws governing physicians are purported to be for quality control and consumer protection, but they instead serve to increase scarcity of the supply of 'qualified' doctors and other healthcare providers. The practice of fewer doctors for higher medical bills was born at the inaugural meeting of the American Medical Association (AMA) in 1847. At this meeting, Dr.

Stanford Chaille of Tennessee said in an address to his peers, "If educational requirements were higher, there would be fewer doctors and larger profits for the diminished number" (Hamowy 1979). This attitude took on momentum and the trend of medical crony capitalism by law continued for over 170 years.

By the turn of the twentieth century, the AMA had wildly succeeded in passing laws regulating and restricting medical practices in dozens of states. However, those same laws were worthless as long as agencies didn't enforce them. The secretary of the Tennessee State Board of Medical Examiners lamented in 1887, "The enforcement of medical laws interest chiefly physicians, not the general public…" (JAMA, 1887). State and county medical societies had to hire their own lawyers to sue nonconforming practitioners, as prosecutors by and large refused to prosecute defendants in cases where the only plaintiffs were competing doctors (Hamowy 1979). Instances like these are not isolated, but examples of repetitive patterns that characterize American healthcare to the present day. At this time, the monopoly on healthcare in New York is a public-private cartel formed by the State Health Department, Liaison Committee on Medical Education (LCME), and the American Osteopathic Association (AOA).

Some fanfare over telemedicine and statewide healthcare reforms has entered the media in recent months due to the release of the State Health Department's Regulatory Modernization Initiative (RMI) report titled "Spurring Health Care Innovation Through Regulatory Modernization: Putting Patients First." One recurring problem the report identifies is how New York patients often have needs for overlapping traditional medical and behavioral health treatment, while the current regulatory environment creates 'silos' that delay and often cause redundancy in care. The report states that the Health Department will 'propose regulations' that allow for a new type of multidisciplinary licensure wherein qualified providers can provide multiple types of diagnoses and treatment for patients with categorically different, but nonetheless overlapping, healthcare needs (New York Health Department 2018). The position of the Sharpe Campaign is that, rather than create a new type of medical license, the Office of the Professions must roll back the non-professional requirements for licensure, thereby increasing the pool of providers whose qualifications are based on skills and training. They also want healthcare professionals to incur as little debt as possible, reducing the economic barriers to entry and making it easier for practitioners to start their own practices.

The existing body of state licensure laws severely restricts the pool of available doctors in New York, with the law of supply and demand shrinking the pool of authorized healthcare providers and driving up the cost of their services. The NRMP statistic cited earlier is that there were 35,000 applicants for only 27,000 slots. Approximately 20,000 of these applicants graduated from US medical schools while the rest, nearly half, graduated from a foreign medical school (Moawad 2017). The doctor shortage across the United States, especially in the highly regulatory New York State, is clearly artificial and manufactured by the current regulatory and statutory environment. This can be changed. One temporary reform proposed by Candidate Sharpe is for all medical school graduates awaiting residency programs and other bureaucratic checkboxes to be licensed as Physician Assistants (PAs), since completing medical school automatically satisfies all New York

requirements for PAs except for passing the Physician Assistant National Certifying Examination (PANCE), which is a computer test. Rather than keeping medical school graduates in limbo for years, New York must allow these freshly-trained medical workers to work at least in some medical capacity.

In addition to restricting which medical school graduates do or don't get a license, licensure laws also micromanage education to the point of adding unnecessary curriculum. Title 8, Article 131, Section 6524 of New York's Education Law and Part 60 of the Commissioner's Regulations require completion of 60 semester hours of college study with a program registered with the State of New York, or an equivalent institution as determined by the State Department of Education (Office of the Professions 2017). This is not a medical training requirement, but rather a general college education requirement. Candidate Sharpe would like to end the 60-semester-hour pre-professional educational requirement. This action would maintain the four-year medical school requirement while allowing aspiring healthcare providers to begin medical training as a career path directly out of high school. Most importantly, this course of action would reduce the minimum time needed to create doctors from eight years to four. The Sharpe administration would also end the 32-semester-hour classroom requirement for Physician Assistants. Furthermore, Sharpe would stop public universities from requiring that students complete additional coursework before beginning medical school (private universities would still be free to add whatever prerequisites that they wish). Similar reforms would be applied to nurses and other healthcare professionals. Instead of unrelated general studies requirements, nurses could focus their studies on learning to provide quality care. Modularity within the healthcare curriculums would also be improved so that people wanting to change fields within healthcare wouldn't need to repeat coursework.

An additional burden leading to the shortage of qualified doctors in New York state relates to the residency training requirements. While graduates of New York State-registered programs are required to complete only one year of residency with an approved program, graduates of non-accredited programs -- or accredited programs not recognized by New York State -- must complete three (Office of the Professions, 2017). Broadening the pool of approved programs for the one-year residency requirement to all medical programs recognized by the International Medical Education Directory (IMED) would eliminate an otherwise arbitrary standard, and keep New York's requirements on par with those of most other states.

Physicians nationwide sit for the US Medical Licensing Examination (USMLE), a uniform exam where aspiring physicians demonstrate their knowledge and skills. However, New York State is slow to license physicians from out of state by endorsement (Office of the Professions 2017). In other words, physicians with licenses from other states who have tested in the same way as New York doctors, but perhaps not gone to the pre-approved schools, are considered somehow less qualified. The best way to undo this unnecessary restriction on the pool of doctors is to expand licensure by endorsement and for New York to participate in the Interstate Medical Licensure Compact (IMLCC). The IMLCC offers state health departments and physicians across America access to expedited licensure in one state if they are already licensed to practice in another (American Medical Association

2017). Officially participating in the IMLCC is one of the strongest signals the state government can possibly send to the American medical community that New York state wants more doctors and is willing to work with those eager to serve patients within the state.

While sweeping reforms like joining the IMLCC and PA licensure for doctors without residency are expected to alleviate the manpower shortage in New York healthcare, the Sharpe administration would also address ways the artificial scarcity extends to other medical professions. The Nurse Practitioner Modernization Act, which went into effect in New York in 2015, expanded the options for nurse practitioners with an independent practice. Under the old state law, Nurse Practitioners (NPs) had to collaborate by written agreement with a physician. Since 2015, NPs in New York have the option of continuing to practice in accordance with a written practice agreement with a collaborating physician, or to practice and have collaborative relationships with one or more qualified physicians or New York State Health Department licensed health care facilities, such as hospitals, nursing homes, ambulatory surgery centers, or diagnostic and treatment centers (Office of the Professions 2018). The Sharpe administration would expand the earlier reform to enable New York NPs to enter into collaborative agreements with telemedicine doctors and physicians from other telehealth facilities anywhere in the United States, as long as the physician or facility is of the same specialty as the nurse practitioner.

Telemedicine solutions

Telemedicine offers New Yorkers a revolutionary way to circumnavigate the physician shortage as well as the prohibitively high cost of traditional visits to a clinic. Under the New York Consolidated Law Service Public Health Sec. 2805-u, state law defines 'telemedicine' as the delivery of clinical healthcare through any two-way means of audiovisual communication to facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient's health care while the patient and provider are at geographically separate locations. The term 'telehealth' refers generally to everything related to healthcare rendered through telemedicine (Center for Connected Health Policy 2018). Teleradiology is the most utilized form of telemedicine in the world and accounts for more than half of the telemedicine patients in the United States (Weinstein et al 2018). The end goal of enabling New Yorkers to benefit from telemedicine is allowing them the benefit of telemedicine practitioners from anywhere in the United States.

One reform recommended by the Health Department RMI report is that New York 'take a landmark step forward' in improving access to providers and treatment options through telemedicine. RMI proposes to do this by expanding the list of eligible originating sites (New York Health Department 2018). Expanding the list of originating sites is a good first step, but should only be regarded as a first step and nowhere near a sweeping solution.

Title 10 Part 405 of the NYCRR requires telemedicine providers operating inside New York State to do a health check at the remote site. That means the provider must either travel to the patient's local clinic or hospital, or order a health check from that remote hospital,

requiring that a patient must essentially have two separate health checks for one issue. Abolishing the on-site assessment requirement would save patients in both time and physician costs, and allow the physicians to spend their time more sensibly.

The loosening of these two regulations would enable more people access to telemedicine without affecting quality of service. It would also allow more physicians from out of state to participate in the providing of these services.

Though more than half of American telemedicine patients are looking for radiology services, telemedicine outreach has produced evidence of telemedicine's validity in serving the needs of patients with dire needs in underserved areas. A JAMA Psychiatry report from 2015 studied the effects of a telemedicine outreach program that reached out to veterans suffering from post-traumatic stress disorder (PTSD). These were veterans living in rural areas with little access to traditional healthcare facilities, and their severe PTSD was accompanied by various psychiatric and physical comorbidities that stem from severe depression, including alcohol and drug abuse. Veterans who participated in the telemedicine outreach program, an evidence-based psychotherapy program, emerged 18 times more likely to participate in cognitive processing therapy, which improves the severity of PTSD and anxiety (Fortney et al 2015). This increased access to mental health services would be a boon to all New Yorkers.

Improving provider access and bypassing them as needed

In addition to creating the environment for more health systems to develop and thrive, the needs of patients who would rather bypass hospitals completely must also be addressed. House calls are becoming increasingly common. Medicare statistics show that in 2013, about 2.6 million Medicare claims were filed for patient home visits and house calls, an increase from 2.3 million visits in 2009 and 1.4 million visits in 1999 (Friedman 2015). House calls are expected to continue increasing as Baby Boomers get older and become increasingly less mobile or ambulatory. Providing full-time employment is the best way for health systems to retain doctors and other providers in rural and other underserved communities. Once employed by a health system, state law prohibits these hospitalists from doing house calls, even though house calls are growing in demand by the year. Physicians in all Article 28-licensed health systems and even non-Article 28 clinics should be allowed to make house calls and be compensated for them.

In the 2016 presidential election, Libertarian candidate Governor Gary Johnson said he wanted to see more Uber-style doctors in American healthcare. 'Uber doctors' is essentially what house calls are. One example of technology bringing patients closer to diagnosis and treatment at affordable prices is Heal. The smartphone app guarantees users a visit from a member doctor in 20 to 60 minutes for a $99 flat fee. Like in-office services, the services that Heal doctors can provide are limited, but still serve crucial needs for much of the population: they can diagnose and treat moderate illnesses such as bronchitis, give flu shots, provide stitches, or write a prescription (Jolly 2015). Increasing numbers of doctors are opting in to do house calls. House calls completely bypass medical insurance

and the prohibitive costs associated.

More importantly, the market for house calls reduces the need and demand for hospitalization. This is accomplished in multiple ways. A 2015 JUROS article stresses the need for preventative care, which is severely underutilized in the US. Preventative care is comprised of low-tech and low-maintenance care that can easily be provided by 'Uber doctors' doing house calls. The Journal of Information published the results of a study that began with a group of teenagers and followed their medical costs for decades. The study concluded that preventative medicine in the form of obesity education and intervention can reduce a generation's direct medical costs by $10 billion by 2050 (He 2015). There is no reason for doctors to be beholden to bill insurance companies hundreds of dollars for a 15-minute consultation that could have been a house call. Moreover, house calls from doctors and home-based care from other kinds of healthcare providers ultimately reduce the demand for hospitalization by bringing the hospital workers to the patient's home. This slashes high hospital bills and also creates jobs for nurses and other home healthcare workers outside of health systems. For these substantial benefits to patients and practitioners alike, New York must allow its health system doctors to participate in the house call markets.

Healthcare Savings Accounts for Government Employees

Reforms favoring cash-based medicine should extend to state employees. This proposed reform seeks to convert state employees' healthcare plans into HSAs (Health Savings Account). HCDAs (HealthCare Debit Account), which will be a type of HSA (Health Savings Account), are savings accounts dedicated specifically for healthcare expenses and are paid into by the state or employer, regardless of whether or not the recipient pays into it. The US Department of Health promises that 'using untaxed dollars in an HSA to pay for deductibles, copayments, coinsurance, and some other expenses, you can lower your overall health care costs' (Healthcare.gov 2018). The initial savings comes from income being tax-exempt, as more of a worker's income is deposited into the HSA. These savings would increase if, in addition to being able to control their HSAs, state employees would have the added benefit of being able to pay for services at retail clinics or retail hospitals rather than be forced to use higher-priced providers and facilities covered by state-provided healthcare plans. HSA spending in such a plan must go toward the deductible.

In the case of union workers, who may have contracts that guarantee healthcare they don't pay into, the Larry Sharpe campaign offers a modified version of this plan. We call these HCDAs. It is a type of HSA that is paid into by the state or employer, regardless of whether or not the recipient pays into it If the state is paying for the HCDA entirely, the insurance plan would take effect, without any additional deductible, once the HCDA is exhausted. However, as long as the HCDA has money in it that was provided by the government, then the insurance plan will not be in effect.

Cash-only providers, and providers of à la carte care, offer an excellent model that more independent providers and smaller health systems should follow. One such example that

should be closely studied for its policies, procedures, and cost-beneficial practices is the Oklahoma City Surgery Center. Among the savings patients (consumers) benefit from at this cash-only provider is a 50% lower bill for rotator cuff surgery than patients would be able to get at insurance-based health systems, even after negotiated discounts (Gillespie 2017). The benefit of 50% less-expensive surgeries translates into patients saving tens of thousands of dollars. As the New York State Department of Labor (2018) reports that the median income is $44,600, it's easy to see how even saving just a few thousand dollars could make all the difference to working class New Yorkers.

Another case that merits further study and likely implementation in new and upcoming New York-based health systems is the membership-based practice Atlas MD. Kansas-based physician Doug Nunamaker developed the concept for this practice after concluding that the traditional insurance-centered healthcare had created multiple burdens for his private practice. A large administrative staff was required to process all the insurance paperwork, in turn forcing Dr. Nunamaker to take on more patients pay his large staff (Hargreaves 2013).

When this entire insurance-centered model for health systems and private practices is abandoned in exchange for a practical cash-based model, the savings are significant. A monthly membership fee ranging from $10 for children and $100 for senior citizens provides unlimited access to in-office services like stitches and EKG tests. Out-of-office treatments are significantly reduced in cost. Whereas Dr. Nunamaker once billed insurance companies $90 for a cholesterol test, patients pay $3 out of pocket for the same service. The implication is that the $87 difference would otherwise cover the labor expense for multiple medical billing specialists--an administrative expense 29 times that of the procedure itself. Whereas MRI scans cost over $2,000, Atlas MD members pay $400 (Hargreaves 2013). With the Oklahoma City Surgery Center and the Kansas-based Atlas MD network, the price reduction in different types of care and treatment is apparent in both cash-based models. These savings also reflect what tests and treatments actually cost versus the inflated costs of insurance-based healthcare.

What Nunmaker went through illuminates one of the unseen costs to healthcare. It is easy to see how having to hire more staff is an expense and a burden. What's unseen is that, instead of resources being spent on training or employing new doctors, PAs, nurses, and chemists whose combined efforts could reduce healthcare costs, resources in today's health markets are squandered in training and employing people just to navigate medical insurance paperwork.

Another version of cash-only models that is accessible to most Americans is the retail clinic. The easiest example to spot in today's economy is the CVS Minute Clinic. For anywhere between $30 and $100, patients can get care as walk-in customers. Services range from routine health checks to vaccinations and physicals. The American Journal of Managed Care published a 2013 study comparing the medical costs of 6,000 Minute Clinic customers with 6,000 patients who sought non-retail healthcare. Not surprisingly, retail clinic users saved an average of $185 in medical costs in the baseline period, and then saved $242 from follow up health checks over the next six months (Sussman et al 2013). Had these retail

clinic customers sought their follow up care at cash-centered hospitals similar to the Oklahoma City Surgery Center, rather than insurance-driven health systems, the cost savings could be estimated in the thousands rather than the hundreds.

Addressing the medical insurance conglomerates

Medical insurance is punitively expensive. The least expensive plans in New York's current health insurance markets available to citizens living in the Bronx are over $400 for single persons. The cheapest plans offered by Fidelis, MetroPlus, and HealthFirst come with $4,000 deductibles. Similar plans in Buffalo cost between $350 and $400, also with $4,000 deductibles (NY State of Health 2018). Spending thousands of dollars before companies offer a penny of coverage is unsustainable for New York's middle and working class citizens.

One of Larry Sharpe's policy goals is the maximum enabling of both cash-only doctors and healthcare providers who provide diagnosis and treatment on an à la carte basis and direct primary care providers. For most modern New Yorkers, healthcare is almost impossible to access without having medical insurance. The purpose of having a medical insurance plan is to protect the consumer's own self and/or the consumer's family. In the words of the US Health Department and Human Services, 'It protects you and your family financially in the event of an unexpected serious illness or injury that could be very expensive' (Agency for Healthcare Research and Quality). This antiquated approach to medical insurance ignores the present reality of today's health insurance market in New York: having a medical insurance plan has become a preventatively high expense in and of itself. For countless thousands of middle and working class Americans who are diabetic, it's comparatively more affordable to pay the $1,300 that it costs each month for insulin, than it is to take on an insurance plan requiring $7,600 in deductible payments before any insurance benefits will kick in for consumers (Sable-Smith 2018). In other words, the rational actors economics model shows that it's better to have a $1,300 monthly medical expense and no insurance than a $7,600 bill and the same $1,300 expense.

Punitively high health insurance prices drive up the cost of healthcare, and the competing costs of healthcare and insurance drive each other's prices and costs up even higher. As the HHS said, health insurance is meant to protect consumers from exorbitant costs, but exorbitant costs are a healthcare baseline in the year 2018. Medical insurance has been so codified into every aspect of healthcare, that doctors essentially become data entry clerks for insurance companies and to feed algorithmic software. A 2014 study published by JAMA International Medicine shows that doctors on average lose 48 minutes per day to data entry, and 33.9% claimed that navigating electronic health records (EHRs) makes accessing patient records more difficult and time consuming. Furthermore, the Physics Foundation reported in 2016 that only 11% of physicians found EHRs to be an improvement over old methods of records keeping while 60% found it detracted them from interacting with patients (Tucille 2018). These statistics do not even address other unforeseen difficulties like a lack of standardization in EHRs between various health systems.

Under current laws and policies regulating healthcare in New York, clinics and health systems bill the insurance companies for trivial services like routine health checks. Every kind of diagnosis, every kind of treatment, and every kind of prescription has a billing code. Doctors generally believe that malpractice lawsuits are a larger driver of 'defensive medicine,' wherein doctors order extra tests and treatments when unsure about a patient's condition, in case they get sued. Dr. Howard Brody of the Institute for the Medical Humanities argues that it's a myth that lawsuits are primarily at fault. He argues that doctors in lower-cost areas order evidence-based tests and treatments for their patients just as often as their counterparts in higher-cost areas do, but the doctors in lower-cost areas are more resistant to practice 'defensive medicine' unless there is sufficient evidence to the usefulness of the treatment or test (Brody 2010). The healthcare sector's control by insurance companies may be the worst contributor to exorbitant health insurance and healthcare costs. The ownership of a few insurance cartels over the entire healthcare process, including its severe inefficiencies, is responsible for 'offensive medicine' (Avraham 2011). Excessive care often happens because physicians who would ordinarily be inclined to provide treatment in certain cost-beneficial ways are employed by health systems and therefore obligated to follow policies and procedures that translate into excessive care for maximum reimbursement. Therefore, it is a cause for concern that only 33% of physicians are independent, which is a significant reduction from 48.5% in 2012 (Tuccille 2018). Either way, the current stranglehold of the insurance cartels over health systems and healthcare in New York has resulted, and continues to result, in high costs that are punitive if not outright preventative for patients.

As stated above, the current insurance-driven environment calls for insurance companies to be billed, or those companies to bill the consumer if his deductible isn't met, for trivial services like routine health checks. Insurance companies are billed at a higher rate than if the patient had paid cash at an alternative provider location. Doctors and the health systems they work for are then compensated more, but the compensation is not immediate. Instead, payment is deferred to a later date, as billing requests must navigate through the bureaucracy (Avraham 2011). Under this model, health systems become the first to take on expenses in care and treatment, but are the last to be compensated. This also drives up prices, as health systems struggle to stay out of the red and try to make up new for funds that won't arrive until much later.

Cannabis as medicine, not a crime

Cannabis and other hemp products like Kratom are not only a recreational phenomenon, but peer-reviewed evidence exists to support the usage of cannabis as medicine. Candidate Sharpe's healthcare policy addresses two major problems with prescription medication: punitive costs inflated by insurance companies, and the opioid addiction crisis in America. Cannabis and hemp as medicine offers solutions to this crisis. While there are certainly critics of medicinal usage of cannabis, The Harm Reduction Journal reported in 2017 that US states with medical cannabis laws have a 24.8% lower average of opioid overdose deaths than states that still outlaw medical cannabis (Lucas 2017). A 2016 survey of patients in Michigan published by the Journal of Pain concluded that cannabis use was

associated with a 64% decrease in opioid use, decreased side effects of medications, and an improved quality of life. Furthermore, a 2015 survey of medical marijuana patients in Canada concluded that 63% of respondents reported substituting cannabis for prescription drugs, with 32% of the pharmaceuticals being substituted for being prescription opioids (Lucas 2017). These peer-reviewed studies from academic medical journals support the validity and veracity of medical cannabis.

Other peer-reviewed sources support integrating medical marijuana into clinical cancer care. Current Oncology published a journal article concluding that in vitro and animal-model studies support a possible direct anticancer effect of cannabinoids through different mechanisms that involve apoptosis, angiogenesis, and inhibition of metastasis (Abrams 2016). Cannabis fights not only cancer, but is useful in curbing the side effects from chemotherapy like anorexia, chemotherapy-induced nausea and vomiting, pain, insomnia, and depression (Abrams 2016). The body of supporting quantitative evidence continues. In 2016 the journal Health Affairs published statistics from the Medicare Part D Prescription Drug Event Standard Analytic File. These statistics covered opioid prescriptions written in states with cannabis laws versus those written in anti-cannabis states. Not surprisingly, some of the differences include 31,810 opioid prescriptions for pain in non-cannabis states versus 28,165; 9,398 prescriptions for seizures and 7,557 for sleep disorders compared to 8,028 and 6,942 in medical cannabis states. Plus, estimated annual changes in national Medicare spending after implementation of state medical cannabis laws reflect a $545,194,125 reduction (Bradford & Bradford 2016).

After a serious study of the most recent peer-reviewed medical journal articles, there is no longer any doubt that medical marijuana is proven to make a positive difference in healthcare. It fights opioids, it fights cancer, and it reduces medical costs both for private citizens and taxpayers. The rigid opposition to cannabis in today's medical community is arguably ideological, stemming from America's long War on Drugs and the longtime association of cannabis with dangerous street drugs, and from an economic vantage point. After all, with 63% of some populations substituting cannabis for pharmaceutical drugs, medical cannabis use means pharmacies suffer, and conventional doctors are unable to bill insurance companies for prescriptions.

Conclusion

This white paper on Larry Sharpe's healthcare policy only scratches the surface, but should be seen as the compass for the radical reforms prioritized by his gubernatorial administration. The greatest contributors to the exorbitant rise of healthcare costs and the decline of quality are physician and hospital licensure laws; the Health Department's bureaucratic bottleneck; a general shortage of physicians, other healthcare workers, and facilities; and the medical insurance cartels.

The comprehensive checklist for Libertarian healthcare reforms in New York State begins with loosening the restrictive licensure criteria drawn up by the State Health Department, the LCME, and the AOA; eliminating the unnecessary undergrad requirements, lowering the period of doctor training from eight years to four; PA licensure for medical school for MD

candidates waiting for residency; expanding residency and licensure to include graduates of medical programs accredited by any agency recognized by any state or territorial government health department in the US; reducing the three-year residency requirement for non-Article 28 physicians to one year; eliminating the second health check requirement for telemedicine doctors; allowing independently practicing NPs to collaborate with telehealth providers and facilities; allowing telemedicine doctors to serve as the physician on site for understaffed emergency departments; creating windows wherein applications are considered approved if the Health Department fails to respond within said window; introducing HCDAs for state employees approved for retail medical expenses; allowing the growth and expansion of retail and cash-only clinics and health systems to curb the monopoly of the insurance cartels; and to use cannabis and hemp to stem the opioid crisis.

Larry Sharpe's position on healthcare is that consumer driven markets and ethical behaviors are crucial to improving medicine in New York and the United States. Over-regulation by the Health Department and medical cartels, not the market economy, has harmed healthcare in New York, restricted the pool of available providers, and encouraged predatory practices. By removing the chains from aspiring doctors and medical entrepreneurs, healthcare prices can be reigned in as costs go down rather than up. Freedom works when governments and the people who control them simply get out of the way and let society grow, evolve, and prosper.

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