Scrutiny over Medicaid Spending
States and providers are complaining about a new rule that would force them to be more transparent in Medicaid claim

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OK Physician Recruitment
Oklahoma is considering a $100,000 tax credit over five years to attract physicians to understand, rural areas.

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Obamacare Failing the Sick
Obamacare was supposed to help insure people with preexisting conditions, but narrow networks are leaving many out in the cold.

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Nurse Practitioner Record
Schools are graduating nurse practitioners at record levels.

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CMS Unveils New Trump Administration Policy on Medicaid Block Grants
Seema Verma, Administrator of the Centers for Medicare and Medicaid Services, stands aside President Donald Trump.

The Pulse

Oklahoma Governor Embraces Medicaid Block Grant Proposal
By Bonner Cohen
Underscoring his commitment to Medicaid block grants, Gov. Kevin Stitt of Oklahoma joined the Trump administration in Washington D.C. for its Healthy Adult Opportunity announcement and said his state will be the first to sign up.

“CMS (the Centers for Medicare and Medicaid Services) and the Trump administration have been listening to the needs of states like Oklahoma,” Stitt said. “Thank you for putting health care back to where it belongs—

EXPAND MEDICAID, p. 4

CALIF. COLLECTS CHILDHOOD STRESS INFO
California is incentivizing Medicaid physicians to screen adults and children for “Adverse Childhood Experiences,” raising privacy concerns — PP. 11

CALIF. COLLECTS CHILDHOOD STRESS INFO
California is incentivizing Medicaid physicians to screen adults and children for “Adverse Childhood Experiences,” raising privacy concerns — PP. 11
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Shortage of Psych Beds Puts Spotlight on Michigan’s CON Law

By Kelsey Hackem

As Michigan continues to struggle with how to address a lack of available beds in its psychiatric hospital in the town of Caro, the legislature is proceeding with hearings on legislation to exempt, among other areas, psychiatric beds from certificate of need (CON) approval.

Specifically, Senate Bill 672 would repeal the CON requirement for licensed psychiatric beds and children and adolescent patient psychiatric beds. Hearings and testimony regarding the change occurred on December 5 and 12, 2019, and will continue to be debated in the legislature.

The bill cleared a Republican controlled senate committee February 26 along party lines. Republicans control both chambers of the state legislature. Gov. Gretchen Whitmer is a Democrat.

According to the Michigan Department of Community Health, the state’s CON program is intended to ensure only needed services are developed in Michigan. Supporters of the legislation to exempt psychiatric beds argue CON hinders the ability to provide desperately necessary mental health treatment in the state.

John Snook, executive director of the Treatment Advocacy Center, a national organization, says such a CON requirement reduces the number of psychiatric beds and keeps people from getting mental health treatment they need.

“Certificate of need requirements for psychiatric beds unnecessarily hinder treatment access and put up costly roadblocks at a time when the system can ill afford it,” Snook said.

The bill cleared a Republican controlled senate committee on February 26 along party lines. Republicans control both chambers of the state legislature. Gov. Gretchen Whitmer is a Democrat.

Sees Multistate Problem

The CON problem continues to strain the mental health care system in Michigan and other states. John McNamara, manager of state government relations for McLaren Health, who testified in favor of the exemption at the December 5, 2019 hearing, says exempting psychiatric beds from CON review can help alleviate the mental health crisis.

“We see that there is a national epidemic,” stated McNamara. “It’s not an epidemic here; it is an epidemic everywhere. We think this is one of the many things that need to happen in order to help address that epidemic. Adding psych beds is not going to be the be-all, end-all, but we believe it’s one of the many necessary things that needs to happen to adequately address the mental health crisis our nation is facing.”

Snook says other states are also grappling with psychiatric bed shortages caused by these regulations.

“This issue has come up in a number of states,” Snook said. “I can think of cases in both Iowa and Virginia, in which CON requirements limited psychiatric capacity, despite obvious needs within the state.”

Jails Fill the Void

The demand for mental health treatment and psychiatric beds has become a prominent issue in Michigan.

“Anyone who has paid attention to headlines coming out of Michigan over the past five years should understand that the state is in desperate need of additional treatment bed capacity,” said Snook. “Without access to needed care, people end up in the systems that can’t say no: our emergency rooms and jails.”

While Michigan continues to grapple with its shortage of psychiatric beds and how to provide quality mental health treatment for its residents, CON is standing in the way of efforts to expand and improve care, says Snook.

“I can only speak to psychiatric care, but given the crisis that Michigan is undergoing, state officials should look long and hard at anything that raises the costs and complexity of building needed psychiatric capacity,” Snook said.

ERs as Waiting Rooms

The shortage of psychiatric beds appears to be increasing the burden on emergency rooms.

During his testimony, McNamara told legislators about a patient who was referred to the emergency room by a nursing home because he was hurting himself and tried to harm staff and other residents. He remained in the emergency room for 264 days until McLaren Health could find a nursing home that would accept the patient.

This story is not unique to McLaren Heath, and there are other examples of patients spending extended periods in emergency rooms instead of being able to go to a facility designed to provide mental health care. McNamara says.

“We recently had a pediatric and adolescent in our ER for three and half weeks because there was nowhere for them to go,” McNamara told the lawmakers. “Every health system is going to have similar stories.”

Kelsey E. Hackem (khackem@gmail.com) writes from Washington.
Oklahoma Governor Embraces Medicaid Block Grant Proposal

Continued from page 1

with the states.”

Lawmakers in Alaska, Georgia and Tennessee have also expressed interest in Medicaid block grants. Stitt has been the most visible cheerleader for such a plan as a way to rein in costs for a program originally designed as a health care safety net for disabled people of low income.

OK Medicaid Crossroads

What makes Oklahoma’s situation unique is that the Trump initiative coincides with a pending ballot measure in the Sooner State that, if approved by voters, would substantially expand Medicaid in its current form, in the state. The Affordable Care Act allows states to expand Medicaid, and Oklahoma has yet to do so.

Supporters of the ballot measure known as State Question 802 collected more than 313,000 signatures to have Medicaid expansion put on a statewide ballot. The plan, which would amend the state constitution, would cover about 200,000 people under the age of 65—about 5 percent of the state’s population—whose income doesn’t exceed 133 percent of the federal poverty level. Estimates of the proposed Medicaid expansion’s cost range from $150 million to $375 million per year.

Stitt’s plan is entirely different. His proposal, called SoonerCare2.0, would move Medicaid recipients away from a “fee-for-service” model by adopting block-grant funding and requiring able-bodied Medicaid enrollees to work, attend school, or attend a certification program.

SoonerCare2.0 would also require enrollees to pay moderate premiums for health care. Stitt believes adoption of State Question 802 will be too costly and SoonerCare2.0 will better serve Oklahoma’s rural population, particularly in confronting the opioid crisis.

No date has been set for voters to decide on State Question 802. The decision lies with Stitt. As for SoonerCare2.0, its fate could hinge on whether the courts rule CMS has the legal authority to adopt a block-grant system.

Funding Medicaid Expansion

If State Question 802 is approved and the courts reject the CMS block-grant plan, Oklahoma will be on the hook to fund its 10 percent share of an expanded Medicaid pool. The traditionally tax-averse state would have to look at budget cuts, tax increases, or fees on hospitals and other medical providers to cover the additional costs. Funding will be crucial because the proposed Medicaid expansion would go into effect no later than July 1, 2021.

“If S.Q. 802 passes, our state agencies will experience deep cuts, because the ballot measure offers no mechanism to pay for it,” Stitt spokeswoman Baylee Lakey said in a statement. “The governor does not support this unfunded mandate.”

Bonner R. Cohen, Ph.D., (b Cohen@nationalcenter.org) is a senior fellow at the National Center for Public Policy Research and a senior policy analyst with the Committee for a Constructive Tomorrow.

Oklahoma Mulls Tax Credit to Attract Doctors to Rural Areas

By Ashley Bateman

Oklahoma legislators considering a bill that would allow physicians to claim a $25,000 tax credit if they practice in underserved, rural communities.

House Bill 3823, introduced on February 10 by House Speaker Charles McCall (R-Atoka) would begin in 2021 and apply to practices in communities with population of under 25,000 and located at least 25 miles from a community with a population greater than 25,000. The physicians would have to reside in the same county where the qualifying income was earned. Credits can be claimed for a maximum of five years. In a news release, McCall said he would seek to expand the timeframe if the credit attracts more doctors.

McCall says Oklahoma ranks near the bottom of states in access to primary care in rural areas and needs a multifaceted solution.

“This would allow those doctors to take that money they saved and invest it in their practices,” McCall states in the press release.

Desperate States

Tax credits to encourage care for underserved populations or communities are gaining popularity in states across the country.

The South Carolina Medical Association is advocating for an amendment to the state’s tax code that would offer tax credits for doctors providing patients free care through charity organizations. The Rural Health Information Hub, which monitors rural health care throughout the United States, reports Louisiana, Maine, New Mexico, and Oregon offer up to a $5,000 income tax credit for some or all forms of rural health care delivery.

It is too early to determine the impact of tax credits on care, says Davis Patterson, Ph.D., director of the Collaborative for Rural Primary Care Research, Education, and Practice.

“To my knowledge, no one has studied tax incentives for physicians,” Patterson told Health Care News.

Patterson says tax credits are not as common as student loan repayment incentives to encourage rural health care.

“I think the effectiveness [of tax credits] would depend on how the tax incentive is structured, the total amount offered, and how it is targeted,” Patterson said.

Loan Repayment Successes

Loan repayments have been shown to attract and retain practitioners in rural areas, Patterson says.

“Long-term retention can be harder to predict, though,” Patterson said. “More important may be making sure that providers have favorable working conditions, a motivation to care for rural communities, [and] a good fit with rural living ...”

DAVIS PATTERSON, PH.D.

If S.Q. 802 passes, our state agencies will experience deep cuts, because the ballot measure offers no mechanism to pay for it. The governor does not support this unfunded mandate.”

Baylee Lakey
Spokeswoman for
Oklahoma Gov. Kevin Stitt


Ashley Bateman (bateaman.ae@ googlemail.com) writes from Alexandria, Virginia.
Out-of-Pocket Costs for Employer Health Insurance Reach New High, Study Finds

By Bonner Cohen

Average annual health care spending for people with employer-sponsored insurance rose to an all-time high in 2018 in the United States, a recent study finds.

Per-person spending rose to $5,892, according to the report, published in February by the Health Care Costs Institute (HCCI). Researchers used data from more than 2.5 billion medical and prescription drug claims for approximately 40 million individuals under the age of 65 enrolled in employer-sponsored health insurance annually between 2014 and 2018. The study relied on deidentified commercial health insurance claims contributed by Aetna, Humana, Kaiser Permanente, and UnitedHealthcare.

Four categories of service were examined in the report: inpatient admissions, outpatient visits and procedures, professional services, and prescription drugs. All data were weighted to reflect the age, sex, and geographic mix of the employer-sponsored population (see “Key Findings on Health Care Spending,” this page).

Contributing Factors Identified
After accounting for inflation, annual health care costs rose by $610 over the five-year period. The study found three factors contributed to this increase.

Seventy-five percent of the growth, or $453, can be attributed to price growth in medical services. Twenty-one percent, or $210, was caused by increases in the quantity of services used, with much of that occurring in the last year of the five-year period. Four percent, or $27, of the increase results from aging of the workforce.

Between 2014 and 2018, health care spending per person for individuals with employee-sponsored insurance grew at an average annual rate of 4.3 percent, above the 3.4 percent average annual rate of growth in U.S. per capita GDP, the report states. Price growth for health care continued to slow, the report states, rising by 2.6 percent in 2018, the lowest rate of growth between 2014 and 2018.

State-Specific Numbers Provided
Along with its report, HCCI released an “interactive dashboard” that shows health care pricing trends state by state.

At $7,974, Alaska had by far the highest per-person spending in 2018. Other high-cost states are Wyoming ($7,217), West Virginia ($7,138), New Hampshire ($7,090), Wisconsin ($6,772), New York ($6,734), and New Jersey ($6,708). Arkansas had the lowest per-person spending at $4,734, followed by Utah ($4,767), Arizona ($5,049), Kansas ($5,108), Maryland ($5,147), and Nevada ($5,270).

The state-by-state comparisons contain some surprises. West Virginia, for example, is generally not considered a high-cost state, but it ranks near the top in the recent rise of per-person health care costs. The report offers no explanation for this, but West Virginia’s higher costs could reflect the opioid crisis, which has hit the Mountaineer State particularly hard.

Prices Increased Everywhere
In the 2014-2018 timeframe, spending increased in every state, varying from 9.7 percent in Maine to 28.4 percent in New York. Average prices also increased in every state between 2014 and 2018, with the highest price growth in the District of Columbia (20.6 percent) and the lowest price growth in Louisiana (9.5 percent).

“Sixteen states had price growth above the national average, with D.C. and New York seeing prices rise above 20 percent between 2014 and 2018,” John Hargraves, a senior researcher at HCCI, stated at a press conference. “Prices grew less than 11 percent in only two states, Mississippi and Louisiana.”

Jane Fuglesten Biniek, another senior researcher at HCCI, emphasizes the importance of the data in the report.

“One-hundred-fifty million people in the U.S. have employer-sponsored health insurance, and historically there has not been a lot of information about them as a group,” Fuglesten Biniek said.

Bonner R. Cohen, Ph.D. (bcohen@nationalcenter.org) is a senior fellow at the National Center for Public Policy Research and a senior policy analyst with the Committee for a Constructive Tomorrow.

Key Findings on Health Care Spending

The Health Care Cost Institute has calculated the various elements of rising U.S. health care costs in 2018:

- The 2018 average per-person spending of $5,892 includes amounts paid for medical and pharmacy claims but does not subtract difficult-to-obtain manufacturer rebates for prescription drugs.
- Average out-of-pocket spending increased to $907 per person. Health care spending grew by 4.4 percent in 2018, slightly above the 2017 growth of 4.2 percent, and the third consecutive year of growth above 4.0 percent.
- After adjusting for inflation, prices accounted for three-quarters of the spending growth between 2014 and 2018, contributing $453 to per-person spending over the five-year period.
- The cost of the average process grew by 2.6 percent in 2018. Although that is the lowest rate of growth over the period, consistent year-over-year price increases mean prices were 15 percent higher in 2018 than in 2014.
- Utilization grew 1.8 percent from 2017 to 2018, the fastest pace observed during the five-year period. Because of the higher price levels, the effect of the increase in utilization in 2018 on total spending was higher than it would have been in 2014.

CMS Unveils New Trump Administration Policy on Medicaid Block Grants

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programs within a defined budget. Participation in HAO would be strictly voluntary and is open to all states.

Limited Population, Defined Budget
HAO’s focus is on a limited population: people under 65 who are not eligible for Medicaid on the basis of disability or need for long-term care services, and who are not eligible for Medicaid under any state plan. Other very low-income children, parents, pregnant women, elderly adults, and people eligible for Medicaid on the basis of a disability will not be affected by the program, except “from the improvements that result from states reinvesting savings into strengthening their overall programs,” a CMS news release states.

Under HAO, states will be required to follow all federal disability and civil rights laws, provide CMS with regular reporting on performance metrics, adhere to key statutory protections for tribal beneficiaries, maintain benefits that meet Essential Health Benefits (EHB) standards, and ensure the aggregate limits on premiums or cost sharing do not exceed 5 percent of family income. States choosing to participate will be granted authority to implement several measures (see sidebar).

Block Grants, Medicaid Expansion
States that expanded Medicaid eligibility under the Affordable Care (ACA) receive open-ended federal matching funds for Medicaid, with the federal government paying 90 percent of the costs of expansion and the states covering the remaining 10 percent. The ACA permitted states to expand Medicaid coverage, and the number of people enrolled in the program rose to almost 75 million.

With higher numbers came higher costs, and the HAO is an effort to rein in those costs. How much participating states would receive in their block grants would be based on overall or per-capita budget targets tied to inflation. Total expenditures for covered populations in excess of the annual budget will not be eligible for Federal Financial Participation. The budgets will be negotiated between CMS and the states based on the state’s historic costs and other factors, including national and regional trends.

Mixed Reaction
Many health care providers contested the proposal. The American Medical Association (AMA) “opposes caps on federal Medicaid funding, such as block grants, because they would increase the number of uninsured and undermine Medicaid’s role as an indispensable safety net,” Patrice Harris, AMA president, said in a statement.

Lawsuits are common in major regulatory actions, and opponents of HAO are certain to take the administration to court. Plaintiffs, notably special-interest advocates, can be expected to argue CMS lacks the authority to change the funding mechanism.

Other entities involved in implementing Medicaid are decidedly less hostile. Most states subcontract Medicaid to managed-care organizations such as Anthem, Centene, and UnitedHealthcare. These companies, which cover more than 21 million Medicaid patients nationwide, may face headwinds on Wall Street if the proposal goes through, says one analyst, but investors need not worry.

“We believe the probability that block grants will be implemented is extremely low,” Steven Halper, analyst at Cantor Fitzgerald, wrote, according to Barron’s.

‘States Looking for Relief’
The health insurance industry declined to take a position on the administration’s move.

“We support offering state policymakers flexibility to design their Medicaid programs to best meet the needs of their citizens,” America’s Health Insurance Plans said in a statement, adding, “funding mechanisms for Medicaid should not undermine Americans’ access to the care they need and deserve.”

More certain about HAO’s success is Joseph Antos, a health care and retirement policy scholar at the American Enterprise Institute and policy advisor to The Heartland Institute, which publishes Health Care News.

“HAO is an attempt to address two longstanding concerns,” Antos said. “States do not have enough flexibility to run their own Medicaid programs, and matching grants discourage state efforts to promote efficiency in Medicaid. This initiative is the latest in a series of waiver opportunities for states looking for relief from the administrative hassle required to make even modest changes in their programs.”

JOSEPH ANTOS, AMERICAN ENTERPRISE INSTITUTE

“The [Healthy Adult Opportunity] is an attempt to address two longstanding concerns. States do not have enough flexibility to run their own Medicaid programs, and matching grants discourage state efforts to promote efficiency in Medicaid. This initiative is the latest in a series of waiver opportunities for states looking for relief from the administrative hassle required to make even modest changes in their programs.”

Bonner R. Cohen, Ph.D., (bcohen@nationalcenter.org) is a senior fellow at the National Center for Public Policy Research and a senior policy analyst with the Committee for a Constructive Tomorrow.

State Authority Under Healthy Adult Opportunity Proposal

1. Adjust cost-sharing requirements to incentivize high-value care.
2. Align benefits more closely to what is available through a commercial benefit package.
3. Improve negotiating power to lower drug costs by adopting a closed formulary—a list of medications Medicaid covers—similar to those provided in the commercial market.
4. Make timely programmatic adjustments without federal approval.
5. Deliver care through innovative care systems.
6. Waive retroactive coverage and hospital presumptive eligibility requirements.

Source: Centers for Medicare and Medicaid Services.
Medicaid Transparency Rule Is Raising Hackles of States, Providers

By Jesse Hathaway

Governors, health care providers, and several lawmakers want the Centers for Medicare and Medicaid Services (CMS) to retract a rule designed to increase transparency in Medicaid spending.

More than 3,900 comments from the public were accepted by the CMS regarding the Medicaid Fiscal Accountability Rule (MFAR), a rule published in the Federal Register in November 2019.

Oregon Gov. Kate Brown, U.S. Sen. Jeff Merkley (D-OR), Michigan Gov. Gretchen Whitmer, the American Hospital Association, the American Health Care Association, nursing homes, and lawmakers in other states have submitted comments to CMS calling for the retraction of the proposal. The comment period ended on February 1, 2020.

If enacted, MFAR would establish new reporting requirements for supplemental payments to health care providers and change how state governments may finance their Medicaid programs.

Casting Light on Shadowy Practices

Brian Blase, an economist who served on the White House’s National Economic Council and is a senior fellow at the Galen Institute, says MFAR would give lawmakers and taxpayers more transparency into how state governments are spending Medicaid money.

“The key thing to realize is that the federal government provides an open-ended reimbursement,” Blase said. “Every dollar that states submit is a claim to CMS, and the federal government cuts the state a check for a portion of that. Roughly two-thirds of all federal money that states receive is in the form of these Medicaid supplemental payments to health care providers. That’s more than $400 billion a year that states receive.”

Blase says MFAR would require states to give the federal government information at the provider level.

“[The federal government] would know how much is coming in as provider taxes or other intergovernmental transfers to shore up public expenditures,” Blase said.

One practice is for state or local governments to tax providers and have providers submit that tax to the state as a claim. The federal government then pays for that claim, and the state can reimburse the provider for the tax in what is known as a supplemental payment.

Under MFAR, the federal government would know how much the state is really paying providers.

“You’d have transparency,” Blase said. “You’d know where the Medicaid payments are coming from and where the Medicaid funds are going. You’d be able to get greater insight into the nature of these kickbacks.”

Ending the Gravy Train

Some state governments are angry about the possibility of the Medicaid financing gravy train coming to a stop, says Conor Norris, a research analyst with St. Francis University’s Knee Center for the Study of Occupational Regulation.

“The CMS proposal has several facets, which include updating health-care-related taxes and improving transparency by requiring states to submit more data, but these are largely not controversial,” Norris said. “The source of controversy is an attempt by CMS to rein in questionable financing methods implemented by the states. Because the federal government matches the funds supplied by states, they can increase the federal money they receive by using accounting tricks. The proposal gives the CMS more authority to determine whether the supplemental payments to health care providers are legitimate.”

Slowing Medicaid Inflation

Medicaid’s reimbursement structure creates a free-spending feedback loop that drives up Medicaid costs, Blase says.

“When states expand eligibility or benefits, that brings more money into the state from the federal government,” Blase said. “In periods of recession, when states are looking to cut back because they often have to balance their budgets—they don’t look at Medicaid, or it’s the last place they look, because every dollar they cut they would lose a commensurate share of federal financing.”

Blase said, “You’ve got a relationship that, because of the open-ended reimbursement, leads to inflation and inflationary tendencies in Medicaid program growth.”

MFAR would help crack down on the use of provider taxes to improperly pad reimbursement checks given to states, Blase says.

“A state will say to hospitals, ‘We’re going to tax you each $1 million, take that $1 million, and tell the federal government that we spent that $1 million on you,’” Blase said. “The average state reimbursement is about 60 percent, so the federal government will reimburse that $1 million at 60 percent.

“It’s an accounting gimmick,” Blase said. “The state submits the claim to the federal government and the federal government sends $600,000. The states then spend that on the provider or use it for some other purpose.”

According to the Kaiser Family Foundation, total Medicaid spending was $616 billion in 2019.

Increasing Accountability

More data and transparency could help the federal government be better stewards of taxpayer money, Norris says.

“A lack of data and reporting from the state agencies hampers the ability of CMS to gauge problems and monitor the effectiveness of Medicaid,” Norris said. “Reforms that would help increase accountability and provide more information to CMS should be considered.”

Jesse Hathaway (think@heartland.org) is a policy advisor with The Heartland Institute.
By Jesse Hathaway

The U.S. Court of Appeals for the District of Columbia Circuit upheld a March 2019 lower court decision that blocked Arkansas from implementing a work rule designed to help able-bodied Medicaid enrollees move back into the workforce.

Arkansas sought the work rule under Section 1115 of the Social Security Act, which authorizes the U.S. Department of Health and Human Services (HHS) and Centers for Medicare and Medicaid Services (CMS) to approve requests from state governments to tailor Medicaid to their respective needs.

CMS approved Arkansas’ waiver in March 2018, following the state’s decision to expand Medicaid in 2014. Three enrollees challenged the rule in the Federal District Court for the District of Columbia in August 2018, and in March 2019 the plaintiffs prevailed. Judge James E. Boasberg blocked Arkansas’ work rule and a similar one in Kentucky.

According to U.S. Court of Appeals Judge David Sentelle, who ruled to uphold the Arkansas work rule decision, HHS Secretary Alex Azar did not properly explain how adding work requirements to Medicaid eligibility rules would promote the entitlement program’s stated purpose as written in federal law.

“The statute and the case law demonstrate that the primary objective of Medicaid is to provide access to medical care,” Sentelle wrote in the February 14 ruling. “There might be secondary benefits that the government was hoping to incentivize, such as healthier outcomes for beneficiaries or more engagement in their health care, but the ‘means [Congress] has deemed appropriate’ is providing health care coverage. In sum, ‘the intent of Congress is clear’ that Medicaid’s objective is to provide health care coverage, and, as a result, the Secretary ‘must give effect to [that] unambiguously expressed intent of Congress.’”

Sustaining the Poverty Trap

The status quo of not requiring able-bodied enrollees to work can trap people into a cycle of joblessness and dependency, says Rea Hederman Jr., executive director of the Economic Research Center at The Buckeye Institute (see related article, page 21).

“Under Medicaid expansion, healthy, single adults have left the workforce or reduced their work hours to become or remain eligible for Medicaid,” Hederman said in a news release. Hederman says The Buckeye Institute’s research confirms Medicaid robs enrollees of a chance to build wealth.

“The report, Healthy and Working: Benefits of Work Requirements for Medicaid Recipients, reveals that these [court] decisions risk reducing workers’ lifetime earnings by close to $1 million for people who transition off of Medicaid, by more than $212,000 for women who remain on Medicaid for their entire working life, and by more than $323,000 for men who remain on Medicaid,” Hederman wrote.

Work requirements are compassionate, Hederman writes. “Work and community engagement requirements can lead to better job opportunities with better quality private insurance, higher earnings, and can increase economic prosperity,” Hederman wrote.

Arizona, Ohio, South Carolina, and Wisconsin have been granted permission to include work requirements in their Medicaid programs, but they have not yet done so. CMS is considering similar waiver requests from Georgia, Idaho, Mississippi, Montana, Oklahoma, South Dakota, Tennessee, and Virginia.

Jesse Hathaway (think@heartland.org) is a policy advisor with The Heartland Institute.

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On the Edge: America Faces the Entitlements Cliff

Mark E. Litow & Merrill Matthews, Ph.D.

The United States is approaching an entitlements cliff.

Will we meander over the edge, be dragged down to the bottom—or will we recognize the imminent dangers and take a step back to fiscal security?

New from the Institute for Policy Innovation

Available at Amazon
Illinois Sets Price Control on Insulin

By Ashley Herzog

Illinois Gov. J. B. Pritzker signed into law a bill capping the out-of-pocket price of insulin at $100 for a 30-day supply.

According to the governor’s office, 1.3 million adults in Illinois rely on insulin, “but regular price hikes make insulin difficult to afford for the uninsured and those whose coverage requires significant cost sharing.”

The bill, formerly known as S.B. 667, was signed into law on January 24. Colorado passed a similar bill in May 2019.

Production Costs, ‘Kickbacks’

Lawmakers and the public are largely unaware of the factors that make insulin so expensive, said Roger Klein, M.D., J.D., a physician, attorney, and policy advisor to The Heartland Institute, which publishes Health Care News.

“There are many reasons for the high cost of insulin,” Klein said. “The cost of production has undoubtedly risen, so some of the price increases are justified.”

The price of insulin is complicated by the existence of pharmacy benefit managers (PBMs), who work for large employers to negotiate drug prices, Klein says.

“There are three insulin manufacturers—Sanofi, Lilly, and Nova Nordisk—who compete with each other to get their products on PBM formularies,” Klein said.

Insurance companies assign drugs into formularies, which are lists of medications they will cover.

“PBMs gravitate to brands that give them the highest rebates,” Klein said.

Insulin producers might increase the price of their drugs so they can entice PBMs with bigger discounts, says Klein.

“As long as insurance premiums can rise to reflect the high prices, the game goes on,” Klein said. “It seems like there is little concern for the patient who either has no insurance or is left paying a higher copay. Rebates are actually kickbacks, as they enrich the middleman and not the end consumer.”

Controls and Shortages

Price controls frighten producers because they can lose money if the cost of production rises. Producers may cut back on production, which could lead to product shortages, Klein says.

“They will look to reap profits elsewhere,” Klein said. “Only real, unencumbered competition will put prices just where they need to be.”

There are ways government can improve competition by exploring alternatives, says Alieta Eck, M.D., a physician and policy advisor to The Heartland Institute.

“Our regulatory apparatus needs to find ways to increase competition through facilitated approval of new insulin products, particularly biosimilars,” Eck said. “We [also] need to better understand the advantages and disadvantages of newer, highly expensive insulin analogs relative to human insulin and perhaps make greater use of the latter. This would result in substitution of much less costly products without loss of clinical effectiveness while placing competitive pressure on prices for human insulin analogs.”

Insulin analogs are synthetically made products genetically altered to allow better delivery.

Patient Power

Direct primary care (DPC) could also help bring down drug costs, because DPC members typically pay for drugs out of pocket, Klein says. DPC does not accept third-party payers but instead charges members a low, flat, monthly fee for care.

“Patients who pay [directly] will learn that buying insulin in 10cc bottles is far less expensive than buying the fancy 3cc pens where the dose is dialed in,” Klein said. “The latter may be more convenient, but the technology makes the pens far more expensive.

“When patients care what medicines cost, they will purchase the best value, and competition will drive prices down,” Klein said.

Ashley Herzog (aebristow85@gmail.com) writes from Avon Lake, Ohio.

Patients Encounter Loopholes with Colorado’s Insulin Cap

Patients in Colorado are learning the state’s insulin price cap, which went into effect January, is not all it’s cracked up to be.

The Denver Post reported on a woman who expected to pay $100 each month for each of her children, but ended up getting a bill for $5,600 because she is enrolled in a self-insured plan, which is exempt from the cap.

“I am not sure why a legislator would bother to create a law if insurance companies can just run around it 50 different ways,” Melissa Knott told the paper.

The law does not include people covered by Medicare, and the cap only applies to individual prescriptions, not the out-of-pocket total cost per month. Some patients require a variety of insulin products which necessitate separate prescriptions.

As with many policies to control costs, the state’s insulin cap has winners and losers, says Linda Gorman, director of the Health Care Policy Center at the Colorado-based Independence Institute.

“The cap is the same regardless of the amount of insulin a patient uses, which means that it disproportionately benefits those who use more insulin or need more expensive insulins to control their blood sugar,” Gorman said.

Someone Has to Pay

Instead of having the state’s general fund pay for the insulin subsidy, lawmakers shifted the burden onto insurance companies, Gorman says. The cap applies to what insurers can charge their enrollees, not what drug companies charge for insulin. To cover this unmet cost, insurers will likely change coverage, Gorman says.

“Insurers will stop covering the easier dosing, injection pens, and the more expensive insulins that offer better control and fewer side effects. Or they will figure out a way to force other policyholders to further subsidize diabetics.”

LINDA GORMAN, DIRECTOR, HEALTH CARE POLICY CENTER

“This is a fishing expedition that will increase costs for major insulin producers, as the fiscal note mentions,” Gorman said.

“As is typical, supporters claim [their efforts] are reducing health care costs,” Gorman said. “What they have really done is shifted them around. This increases overall system costs and will raise total health care costs in the future.”

—Staff reports
The very fabric of America is under attack—our freedoms, our republic, and our constitutional rights have become contested terrain. The Epoch Times, a media committed to truthful and responsible journalism, is a rare bastion of hope and stability in these testing times.

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California Doctors to Screen Children for ‘Toxic Stress’

By Kelsey Hackem

Beginning this year, California will pay doctors to screen low-income Medi-Cal patients for adverse childhood experiences (ACE), also known as “toxic stress.”

California’s movement to screen children for toxic stress began in January 2019, when Gov. Gavin Newsom included $45 million for the initiative in his budget proposal. California is the first state to create a formal reimbursement strategy for ACE screening.

Dr. Nadine Burke Harris, who was named California’s first surgeon general in February 2019, spearheaded the effort to implement the screenings. Harris stated her goal is to implement universal stress screenings for all children as part of their regular physical exams. The ACE screenings will involve roughly 5.3 million children, or 40 percent of all California’s children.

State-Approved Questionnaires

For children under the age of 12, parents or caregivers will be asked to fill out state-approved questionnaires about potential stressful experiences in a child’s life. For children between 12 and 19, both parents and the child will be asked to answer questions about ACE. The California Department of Health Care Services will pay Medi-Cal providers $29 for each screening they conduct for adults and children enrolled in Medi-Cal. By July, Medi-Cal providers must self-attest that they have been trained in ACE screening.

Screening a child for toxic stress involves asking a parent to count how many of the following 10 problems a child has encountered: physical, sexual or emotional abuse; physical or emotional neglect; a parent’s mental illness; substance dependence; a parent’s incarceration; parental separation or divorce; and domestic violence.

Each factor counts as one point, and the higher the score, the higher the risk that the child has unhealthy stress levels.

ACE screening could also subject teens to questions about topics such as divorce, family income, and unstable household environments.

Toxic Screening?

The more toxic issue is the screening itself, Twila Brase, president of the Citizens’ Council for Health Freedom, said in a press release.

“What's truly toxic about this is the government's push to intrusively categorize, evaluate, and survey children and their families,” Brase said. “The screenings are voluntary, but parents and children may feel coerced or pressured to fill them out.”

Brase says she is concerned about the privacy of children, as the responses to the questionnaires could be entered into their electronic health record.

“California is acting first, then asking questions later,” Brase stated. “The collection and storage of this information is not without risk, and the damage could be irreversible.

“This information will be a part of every child's 'cradle to grave' electronic health record, which is evolving into a comprehensive 'dossier' on the child,” Brase stated. “What goes in these electronic health records rarely ever comes out. Therefore, as California builds complete profiles of children and their families, this could have serious implications as children age. It could stigmatize and create labels that these children will never be able to escape, even in adulthood.”

Also wary of the consequences is Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons.

“This sounds like an invitation to get child protective services involved in every home,” Orient said. “That could mean more money having to be spent on foster care programs, huge legal bills, and permanent, underserved stigma to parents. 'Nosy-body' sounds far too benign.”

Kelsey E. Hackem (khackem@gmail.com) writes from Washington state.

INTERNET INFO

Trauma Screenings and Trauma-informed Care Provider Training, California Department of Health Care Services: https://www.dhcs.ca.gov/provgovpart/Pages/TraumaCare.aspx

Schools Graduate Record Number of Nurse Practitioners

By Ashley Bateman

The number of nurse practitioners (NPs) in the United States has doubled in less than seven years, a new study finds.

The report, “Implications of the Rapid Growth of the Nurse Practitioner Workforce in the U.S.,” published in February in Health Affairs, reviews the years 2010-17 and finds the number of NPs grew from 91,000 to 190,000 and the number of the registered nurses (RNs) decreased by 80,000 nationwide.

“In the future, hospitals must innovate and test creative ideas to replace RNs who have left their positions to become NPs,” states the report. The report notes NPs are working in hospitals, physician offices, and outpatient care centers, and their earnings have grown by 5.5 percent (adjusted for inflation). The report urges educators to track growth in earnings for signs that NPs could be flooding the market.

NP education programs increased from 356 to 467, the report notes, and have graduated new NPs at a rate similar to that of traditional medical schools. Several schools offer virtual programs.

Factors Driving Growth

One development driving growth appears to be states expanding scope-of-practice laws.

Increasingly, states have allowed NPs to practice independently of physicians and prescribe medications. According to the American Association of Nurse Practitioners (AANP), 22 states allow what is known as “full practice authority,” by which NPs can function under licensure of the state board of nursing and can diagnose, treat, and prescribe medication without the supervision of a physician. Sixteen states allow reduced practice, and 12 states refuse to all NPs to work independently.

Work conditions are also attracting more people to the NP profession, especially RNs in hospital settings, says Brittany Hay, NP and assistant professor at the University of South Florida College of Nursing.

“Most people who are becoming NPs have a desire to do more and to provide more comprehensive care and to make a difference in the lives of patients in a different way,” Hay said. “Instead of seeing them in the hospital [as nurses], where [patients] are already experiencing health problems that haven’t been controlled or risk factors that haven’t been well-managed, a lot of nurses are driven to become [NPs]. It’s too late when they are in the [intensive care unit].”

Too Many NPs?

The shift of nurses to primary care from acute care in hospital settings will increasingly change patients’ experience, say Marilyn Singleton, M.D., president of the Association of American Physicians and Surgeons, and Rebekah Bernard, M.D., a board member of Physicians for Patient Protection.

“The lure of an outpatient setting and higher pay and setting one’s own hours would lead some nurses, particularly new grads, to abandon hospital nursing,” Singleton said.

“There is already a shortage of nurses in this country, and as more nurses become NPs, the number of bedside nurses will decrease,” Bernard said. “Nursing organizations that aggressively promote NP degrees have done little to increase the number of bedside nurses.”

REBEKAH BERNARD, M.D.
BOARD MEMBER, PHYSICIANS FOR PATIENT PROTECTION

Bernard says a 2010 report by the Institute of Medicine’s Future of Nursing program did not push for nurses with more advanced degrees instead of associate level RNs.

Singleton and Bernard say NPs are replacing doctors in many cases.

“The market will attempt to absorb NP graduates by using them to replace physicians,” said Bernard.

“Hospitals are buying up physician practices and replacing the doctors with nurses, looking to reduce costs,” Singleton said. “I’m sure there is always room for health care workers. The question [is whether] the new crop of workers has the knowledge and skills to perform the tasks they claim to be independently qualified for.

“Even older nurse practitioners decry the level of training and proliferation of online [NP] schools,” Singleton said. “When these programs started, hands-on nursing experience was required. Now, one can obtain an NP entirely on didactic learning.”

Remedying Physician Shortages

One reason states have granted NPs full practice authority is in response to the shortage of physicians, especially in rural areas.

“We have a lot of federally qualified health centers that are more rural, and supervisory physicians aren’t available in some cases,” Hays said.

Singleton advocates increasing Medicare funding to allow for more physician residencies and having states allow medical school graduates without residencies to provide more care, Singleton states.

“[These tracks] allow medical school graduates who did not obtaining a residency to be assistant physicians until they are able to ‘match’ in a residency program,” Singleton said. “This allows supervised young doctors to work in underserved areas.”

Arkansas, Kansas, Missouri, and Utah have enacted such tracks, and Arizona, Georgia, New Hampshire, Oklahoma, and Washington are considering legislation to do so. The Resident Physician Shortage Reduction Act of 2019 (H.R. 1763), introduced by Reps. Terri Sewell (D-AL) and John Katko (R-NY), would add up to 15,000 Medicare-funded residency positions over five years. This bill is a partner to Senate Bill 348, introduced in January.

Titles and Duties

Over the years, the term “provider” has entered the standard medical care lexicon to describe any professional providing patient care, Singleton says.

“The term tends to equalize, in the patient’s mind, the talents of the individual professionals with amazingly different ranges of training and skills,” Singleton said. “There will come a time when [patients] will not be told the difference, even though certain states and a pending federal bill require titles of health professionals to be prominently displayed.”

The issue should not be seen as pitting NPs against physicians, Hays says.

“It’s about collaboration that can bring the most holistic care to patients,” Hays said. “Every discipline is finding where they fit. We have an aging population with multi-morbidity who require a lot of ongoing care.”

Ashley Bateman (bateman.ae@googlemail.com) writes from Alexandria, Virginia.
Change in U.S. Life Expectancy Is Unconnected to Health Care System

Editor’s note: The Centers for Disease Control and Prevention’s National Center for Health Statistics released new figures on life expectancy and the leading causes of death. Life expectancy in the United States for someone born in 2018 is 78.7 years, up one-tenth of a year from 2017 but still below the peak in 2014 at 78.9 years.

The rankings of leading causes of death remained the same, with deaths decreasing or staying the same in every category except influenza/pneumonia and suicide, where deaths increased. Health Care News discussed the report with Medicare expert Robert Moffit, Ph.D., a senior fellow in domestic policy studies at The Heritage Foundation.

Health Care News: The United States spends $3.5 billion on health care each year, more than any other country. Life expectancy here, however, is nearly five years lower than in some countries, such as Japan. What are we to make of this from a public policy standpoint?

Moffit: It is commonly argued that America spends more on health care and has the lowest life expectancy at birth (78.8 years), compared to Japan, for example, with the highest level of life expectancy (83.9 years). There is no simple relationship between health spending and life expectancy. Health spending on medical technologies, treatments, and procedures to combat cancer, especially breast and prostate cancer, heart disease, and stroke, have had a positive impact on life expectancy, particularly among Americans over the age of 65.

Based on the professional literature, the evidence there is strong. Spending to battle these major killers has been a sound investment and a great return on investment. Concerning life expectancy in general and the current state of our “health care system,” there is a lot to unpack.

Health Care News: So, let’s break it down. The United States has a quasi-private health care system where nearly 40 percent of Americans are in public coverage programs such as Medicare or Medicaid and the rest pay for health care privately. How does this mixed system affect longevity?

Moffit: The United States, unlike, say Britain or Canada, does not have anything vaguely resembling a “system.” Rather, American health care is financed and delivered through large third-party payment systems, with different rules of eligibility and different streams of public and private funding. That is why international comparisons of the performance of the American “system” are often flawed.

A person on a government program like Medicaid, for example, is likely to face steeper problems getting access to physicians and medical specialists and positive medical outcomes compared to, say, a person enrolled in an employer-sponsored health plan. Geography and demographics also play a major role: some states have higher rates of mortality, while others’ are relatively low.

Health Care News: Are you saying money is not always a factor?

Moffit: Beyond standard systemic health care financing and delivery factors and their impact on cost, quality, and coverage, there are behavioral and other risk factors, which have little if anything to do with whether or not health care dollars pass through public or private accounts.

American overconsumption of refined carbohydrates, among other factors, contributes to obesity rates that are the highest in the world- and thus is a direct contributor to the high rates of chronic disease, particularly diabetes. About three-quarters of all health spending is focused on treating or mediating the consequences of chronic disease. Indeed, a major 2017 study (Dwyer-Lingren et. al.) in the Journal of the American Medical Association, estimated that almost three-quarters of the variation in life expectancy in the United States was attributable to behavioral and metabolic risk factors.

In 2019, the Organization for Economic Cooperation and Development (OECD), which rated the United States as having the highest rates of obesity, also recorded that the United States was followed in this category by Australia, Britain and Canada, in that order.

The one thing that all three of these countries have in common, outside of the English language, is government-financed national health insurance.

Health Care News: It sounds like you’re suggesting that national health insurance is no guarantee of prolonged life.

Moffit: Right, health coverage is no guarantee. Few economically advanced countries record America’s high level of traffic fatalities or have the homicide and suicide rates of the United States. And then there is drug abuse and the opioid crisis. Of all the OECD member nations, the U.S. had the highest number of opioid-related deaths at 130 per million, followed by “single payer” Canada with 120 deaths per million. In answer to your specific question, it is hard to see how any of this is somehow related to “the free market.”

Health Care News: Life expectancy at birth peaked in the United States in 2014, right before Obamacare went into full effect. Obamacare, if anything, increased administrative costs for health care. Do you think that helps explain the decline in life expectancy since then?

Moffit: I have seen no evidence that would lead me to believe that Obamacare has impeded progress in American life expectancy. Yes, we are spending far too much on administration, and not just because of the administrative costs of private insurance, but also because the burdensome transactional and compliance costs of the most highly regulated sector of the American economy, and the failure of administration manifest in Medicare and Medicaid fraud and waste (in the tens of billions of dollars annually), are compounding these high administrative costs.

America is an economically advanced country, and its health care arrangements are very different from other economically advanced countries’. There are multiple variables affecting health and life expectancy.

The bottom line is this: life expectancy as a metric by itself does not, in any dispositive way, prove the superiority or inferiority of any particular organization or financing of health care. There are so many other external variables.

“The bottom line is this: life expectancy as a metric by itself does not, in any dispositive way, prove the superiority or inferiority of any particular organization or financing of health care. There are so many other external variables.”

ROBERT MOFFIT, PH.D., SENIOR FELLOW, THE HERITAGE FOUNDATION
By Bonner Cohen

Under election-year pressure to provide relief to constituents angered by surprise medical bills, lawmakers in both parties are working on proposals intended at least to show they are taking the problem seriously.

The legislative vehicle of choice is a measure for funding Medicare and Medicaid programs set to expire at the end of May. Three draft bills are competing to be attached to the Medicare and Medicaid legislation. With just three months remaining to come up with language acceptable to the Democrat-controlled House, Republican-controlled Senate, and the Trump White House, the three drafts pit the competing interests of hospitals, patients, and insurance providers against one another, further complicating the task of reaching a compromise.

In the House, two surprise-billing bills cleared committees in mid-February, with one passing the Ways and Means Committee and the other approved by the Education and Labor Committee. The third draft in play was adopted by the House Energy and Commerce Committee and the Senate Health, Education, Labor, and Pensions (HELP) Committee last year but failed to make it into the year-end budget deal.

The drafts have four elements in common: each addresses arbitration, rate-setting, transparency, and medical emergencies.

Baseball-Style Arbitration

The House Ways and Means Committee draft would use Major League Baseball-style arbitration to resolve disputes over out-of-network bills. Either party could initiate a 30-day negotiation, followed, if necessary, by a 30-day mediation with an independent third party.

There would be no set rate for out-of-network services, but during dispute resolution the third-party mediator would consider the median contracted rate specific to the plan, as well as rates for similar providers, services, and geographic areas. Under the draft, patients would receive a “true and honest estimate” before services are rendered, which would include cost, what providers will deliver the service, and whether providers are in-network.

Ambulance companies would have to report cost data to the U.S. Department of Health and Human Services, and insurance companies would have to report data on claims for the services. Providers would be prohibited from sending bills to patients receiving emergency medical services from nonparticipating providers or facilities.

Arbitration and Rate-Setting

The Education and Labor Committee draft blends set rates with arbitration and creates a benchmark rate for care that costs less than $750.

The rate would be set at the median in-network price for a service in a given geographic region. Air ambulance disputes below $25,000 would also have a benchmark rate applied to them. In disputes over services costing more than $750 or air ambulances costing more than $25,000, payers and providers could enter an independent dispute resolution process, which would determine the final payment for service.

As for transparency, the draft would prohibit certain out-of-network providers from presenting a bill unless a notice is sent 72 hours in advance of the elective out-of-network procedure and the patient signs a consent form.

Arbitration, Median Prices

Like the House Education and Labor Committee draft, the joint proposal between the HELP Committee and the House Energy and Commerce Committee, known as the Lower Health Care Costs Act, provides for arbitration in service disputes involving more than $750 and in air ambulance disputes of more than $25,000. Criteria the arbitrator must consider include training and experience of a provider, market share of both payer and provider, and acuity of the patient.

The party initiating the arbitration would not be allowed to bring the same party to arbitration for the same service for 90 days. It would require insurers to pay the median in-network rate in a given region for services costing less than $750.

Like the House Education and Labor draft, the proposal would prohibit certain out-of-network providers from sending a bill unless the provider gives notice of network status at least 72 hours before the patient receives the out-of-network care and the patient provides consent. Providers would also be required to publish certain in-network and out-of-network cost information, including deductibles, on members’ insurance cards. Patients would only be required to pay the in-network amounts for out-of-network care.

Hoping for Agreement

Though time for a compromise is rapidly running out and the political atmosphere for bipartisanship is highly unfavorable, elements of a deal can be found in the similarities between the House Education and Labor draft and the House Energy and Commerce/Senate HELP draft.

In a February 12 tweet, President Donald Trump underscored his support for bipartisan surprise billing legislation.

“Ending surprise medical billing moving ahead in Congress! Thanks to Ways & Means and Education/Labor Committees for your work on Bills (sic) to protect patients and end medical bill ripoffs! Work with Energy & Commerce, HELP committees to send BIPARTISAN bill to my desk.”

INTERNET INFO

Congress Considers Restricting Health Care Noncompete Clauses

By AnneMarie Schieber

A bill before Congress would limit the use of noncompete clauses in employment contracts, including an area where they’ve been under special scrutiny: health care.

The clauses restrict where an employee can work after leaving a job. Employers use noncompete clauses to protect trade secrets. In health care, the clauses can restrict physicians from exploring new and less-expensive delivery models such as direct care, telehealth, and home visits.

H.R. 5710, introduced by Reps. Scott Peters (D-CA), Mike Gallagher (R-WI), and Anna Eshoo (D-CA), is companion legislation to the Workforce Mobility Act introduced by Sens. Todd Young (R-IN) and Chris Murphy (D-CT). The House bill would require employers to notify employees of the limits of noncompete clauses and would delegate enforcement of such clauses to the Federal Trade Commission and U.S. Labor Department.

Noncompete clauses for physicians and health care workers have come under criticism because of their potential to interfere with patient care. A noncompete may restrict where a physician, for example, can practice after leaving an organization, or where patients can reach the physician. Employees may be forced to sign the agreements as a condition of employment.

The legislation would prohibit noncompete clauses, with several exceptions. The rule would not apply, for example, in the sale of a business or partnership or if there is an executive severance agreement in place, nor would it preclude agreements prohibiting the sharing of trade secrets.

One in Five Affected

Noncompete clauses have flourished over the years, according to the Economic Innovation Group (EIG).

EIG’s 2019 report on “The Use, Abuse, and Enforceability of Non-Compete and No-Poach Agreements,” says noncompete clauses covered one out of every five labor force participants in 2014.

“Given that these constraints prevent individuals from starting companies or taking better jobs in their chosen field, it is not difficult to see how the expansive use of these provisions could contribute to the observed declines in US. economic dynamism,” the report states.

EIG commends the bill because, among other outcomes, it will spur innovation.

“American workers should be free to compete in an open market,” stated John Lettieri, president and CEO of EIG.

AnneMarie Schieber (amschieber@heartland.org) is managing editor of Health Care News.

INTERNET INFO


Indiana Bills Address Physician Noncompete Clauses

By AnneMarie Schieber

Indiana lawmakers are considering three measures that would limit or ban noncompete clauses that medical employers such as hospitals impose on physicians regarding future employment.

Traditionally, employers have used noncompete clauses to protect trade secrets if an employee leaves.

Senate Bill 33, which would apply to contracts after June 30, 2020, would limit the duration of noncompete clauses to 24 months after the termination of employment. The bill would require the employer to provide a departing physician with a list of his or her patients, their contact information, and medical information, for a reasonable fee.

The bill would also give physicians an opportunity to “buy out” noncompete restrictions for a reasonable price determined by an arbitrator. Additionally, the bill would make noncompete clauses supplementary to an enforceable employment contract and require the clauses to have specific language regarding the geography of where the clauses would apply and the scope of practice under restraint. S.B. 33 would not apply to transactions involving the sale of a physician’s practice.

Prices Rising

Indiana state Sen. Victoria Spartz (R-Noblesville) says she sponsored S.B. 33 because the health care market in her state has changed dramatically over the years.

“We have some of the highest health care prices in the country. Already, 80 percent of physicians are employed by a hospital. We really need to free up physicians if they choose to leave. These contracts are very one-sided, and hospitals are very powerful.”

VICTORIA SPARTZ, INDIANA STATE SENATOR (R-NOBLESVILLE)

Habig told Health Care News he is pleased Spartz has taken interest.

“She integrated several of our suggestions,” Habig said. “It is definitely a step in the right direction, but my concern is it mostly codifies case law. I would like to generate some draft legislation not just for Indiana but all states for future efforts that apply to existing noncompetes and define competition statutorily.”

AnneMarie Schieber (amschieber@heartland.org) is managing editor of Health Care News.
By AnneMarie Schieber

The Affordable Care Act (ACA) is leaving numerous people with preexisting conditions by the wayside as insurers narrow their networks to the point of uselessness, a new report finds.

The Heritage Foundation’s February 21 report, How Obamacare Made Things Worse for Patients with Pre-existing Conditions, by health economists Devon Herrick, Ph.D., and John Goodman, Ph.D., of The Goodman Institute (see related commentary, page 17), describes why ACA proponents ended up pitching the plan as a solution to protect people from insurance company abuses, instead of as a proposal to “ insure the uninsured.”

Senate Democratic leader Chuck Schumer (D-NY) realized the latter selling point could make the plan a hard sell, the report notes.

“About 95 percent of those who vote already have insurance,” the report states, citing remarks Schumer made at the National Press Club in December.

Preexisting Condition Crusade

The new selling point of the ACA, aka Obamacare, evolved into a promise that people could sign up for health insurance even after they got sick, Herrick and Goodman write.

“The message is not aimed at voters who have individual insurance,” Herrick and Goodman write. “It is aimed at voters with employer coverage who fear they may end up in the individual market and be mistreated.”

The report says people who fell into this category comprised less than 1 percent of the population and were already protected under the federal Health Insurance Portability and Accountability Act.

“Most states complied by setting up risk pools, which provided subsidized insurance,” the authors write.

Even so, Obamacare proceeded full steam ahead with a massive overhaul of the individual insurance market, the authors note.

Obamacare Breakdown

Obamacare plans on the regulated exchanges looked attractive at first, the authors say. Many plans offered expansive networks, including premier hospitals. The individual plans resembled employer plans in the beginning, but the two markets diverged, the authors write.

Of plans in the individual market, 72 percent started squeezing their networks, whereas narrow networks existed in 5 percent to 7 percent of employer plans, according to a report by Avalere.

“The main reason Obamacare plans have narrow networks is to hold down costs,” Herrick and Goodman write.

“That leads to lower premiums and makes the plans more attractive to buyers, especially buyers who don’t have any health problems.”

Exchange Patients Locked Out

The report details instances of where sick people covered by an exchange plan are locked out of some of the nation’s top hospitals, cancer centers, physicians, and specialty drugs, even those in their own back yard.

For example, the MD Anderson Cancer Center accepts Medicaid but is not included in any network in Texas offered in the individual market. In Minnesota, 170,000 people covered by exchange plans are locked out of the state’s Mayo Clinic. Similarly, only one Ohio plan includes the Cleveland Clinic.

“The remaining insurers [in the individual market] are offering products that look a lot like Medicaid,” Herrick and Goodman state.

Even primary care in exchange plans can be problematic, the authors write. They cite a health care executive’s statement on CNBC that providers prioritize appointments to those in employer plans that pay higher fees.

Culprit: Community Rating

A hallmark of Obamacare has been community rating: the mandate that insurers must charge the same premium to all individuals regardless of risk factors. This drove the most ill enrollees to exchange plans and chased healthy enrollees into more affordable options.

The overall result has been “a race to the bottom,” the authors write.

“Millions of healthy people choose to remain uninsured. Only when they get sick, do they enroll, and then they tend to choose plans with the most generous subsidies and lowest out-of-pocket costs.”

The report notes 29 million people no longer carry insurance. The number of uninsured dropped dramatically after Obamacare went into full effect in 2014 and reached a low of 26.7 million in 2016, but it has risen every year since, because of these flaws in the concept. In 2010, the year the ACA was enacted, 46.7 million people did not carry health insurance, according to Kaiser Family Foundation.

Medicare (Advantage) for All

It is possible to create more responsive insurance markets if lawmakers look at the success of Medicare Advantage and incorporate some of its best features in a plan for all. Medicare Advantage offers private coverage to Medicare enrollees. Enrollees pay the same premium regardless of risk, but Medicare offers providers a risk adjustment for those with more expensive conditions to treat.

“Like all government programs, it is far from perfect,” Herrick and Goodman write.

The authors say risk adjustment can be done successfully without the government, but until then, the best solution is to turn Obamacare funds into state grants to help reform individual health insurance markets (see related commentary, page 17).

AnneMarie Schieber (amschieber@heartland.org) is managing editor of Health Care News.

### CON Repeal Attracts More Legislative Support in S. Carolina

An effort to repeal certificate of need (CON) laws in South Carolina has picked up momentum, with bills in both chambers of the state’s legislature finding more support.

H3823, introduced by Reps. G. Murrell Smith (R-Sumter) and Nancy Mace (R-Berkeley), has 29 sponsors. S0990, its companion bill in the Senate, is under discussion in the Medical Affairs Committee. The bills would fully repeal the state’s CON laws.

In a newsletter to its supporters, the Coalition to Repeal CON, a group of physicians, patients, and members of the public, says the support in the legislature and other signs indicate repeal could occur this year.

“The South Carolina Hospital Association (SCHA) took note of our efforts early on and has rumped up their opposition,” the newsletter states. SCHA “has submitted a proposal for ‘reform’ which has not been received very well by the legislators due to its lack of substance. This is good news for our effort, but they will be using significant resources to lobby against repeal.”

The Mercatus Center estimates CON repeal could save South Carolina $200 per capita each year in total health care spending.

“The philosophical war for repeal of the CON has been won,” the Coalition newsletter states. “Only the incumbent CON certificate holders are left to argue for its maintenance.”

—Staff reports

Official Connections:


COMMENTARY

Obamacare Rations Care for the Sick, Overcharges the Healthy

By Devon Herrick

The health care reform debate that led to Obamacare was initially about covering the uninsured, but in order to gain the support of ordinary people who already had coverage, proponents had to figure out a way to sway public opinion.

Proponents falsely claimed, “If you like your coverage, you can keep your coverage,” and Obamacare backers began touting the need for so-called protections for sick people.

Obamacare promised people with chronic conditions they could obtain health coverage at rates no higher than their healthy neighbors’. Americans would no longer be penalized for conditions like high blood pressure, high cholesterol, cancer, and heart disease. Prior to Obamacare, individuals with chronic conditions were often charged higher premiums, sometimes as much as 50 percent or even 100 percent higher than healthy individuals, due to the higher financial risk for insurers.

The financial penalty for preexisting conditions may sound high, but in retrospect it was cheap compared to the cost of Obamacare plans today. Moreover, Obamacare proponents exaggerated the number of people with preexisting conditions. University of Pennsylvania economist Mark Pauly estimates less than 1 percent of the population was unable to get health coverage due to a preexisting condition prior to ACA.

Community Rating Backfires

When Obamacare was passed, most supporters naively assumed ACA plans would be just like employer-provided health plans. That view was inconsistent with the new regulations requiring insurers to accept all applicants at (community) rates unadjusted for health risks. Obamacare supporters’ wishful thinking soon crashed headlong into economic reality.

Health care costs skyrocketed once health plans could not adjust premiums for risk. Some individuals gamed the system, joining when they needed expensive care and dropping out soon afterwards. As premiums shot up, people looked for ways to reduce their coverage or drop out entirely. Over time, most enrollees gravitated to plans with such high deductibles that few ever expected to receive any benefit.

Raising premiums and deductibles wasn’t insurers’ only strategy to stem losses on money-losing customers. Once health plans lost the ability to adjust premiums for risk, they were forced to find savings elsewhere. Plans reduced reimbursements to providers, and those who refused to accept the reductions were removed from their covered networks.

The typical Obamacare plan today bears a close resemblance to Medicaid managed care plans, except with high deductibles and high cost-sharing. Many exchange plans are managed by the same firms that specialize in Medicaid managed care. Managed care uses subtle methods to reduce costs by rationing care. Thus, managed care is a competitive advantage for plans not allowed to adjust premiums for risk.

At its inception, Obamacare plans restricted enrollees’ choice of doctors and hospitals. One study found 72 percent of insurers feature more restrictive networks in the plans offered through the federally managed exchange HealthCare.gov. This compares to only 5 to 7 percent of employee health plans that limit worker choices to a narrow network of physicians and hospitals.

The consulting firm Avalere found ACA exchange plans contract with approximately one-third fewer doctors and hospitals than commercial plans, on average. This included 42 percent fewer heart specialists and cancer doctors, one-third fewer mental health and primary care providers, and one-quarter fewer hospitals.

Doctors Reluctant

Another reason provider networks became more restrictive is that doctors refuse to affiliate with Obamacare plans, often because of low fees. In addition, many providers may want to avoid patients whose health plan deductibles run into the thousands of dollars instead of, say, hundreds of dollars. Doctors and hospitals find it more difficult to collect fees for services provided before their patients’ health plan deductibles have been met.

A direct result of ACA regulations and the program’s design is that top hospitals are often out of reach for many Obamacare enrollees. The University of Texas MD Anderson Cancer Center is not on any exchange plans in Texas. Memorial Sloan Kettering Cancer Center is not in any of the typical gold, silver, or bronze individual plans on the New York exchange. The flagship Mayo Clinic is inaccessible to many Obamacare plan enrollees in Minnesota.

The ACA marketplace was not designed to meet consumer needs like other markets. It was predicated on rationing care for sick enrollees and price-gouging healthy enrollees. It didn’t have to be this way. Medicare Advantage plans are an example of a system where expensive enrollees are not shunned, because the federal government compensates plans for seniors’ health status.

Economist John Cochrane has shown how market-based risk adjustment without government involvement can work. A report by the Goodman Institute expands on how Congress can empower state governments to create genuinely free markets. Now we just need to get started on designing a better system.

Devon Herrick, Ph.D. (devonherrick@sbcglobal.net) is a health care economist with the National Policy Center and a policy advisor to The Heartland Institute.
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REPRESENTATIVE ISAAC LATTERELL
SOUTH DAKOTA
By Sally Pipes

U.S. Department of Health and Human Services Secretary Alex Azar, head of President Donald Trump’s task force on the coronavirus, declared a public health emergency in response to the global outbreak of the pathogen.

The coronavirus has claimed more than 900 lives around the world so far, including that of Dr. Li Wenliang, the Chinese doctor who first warned of its potential dangers. There are more than 40,000 reported cases worldwide, including 12 in the United States. With the pathogen having reached our shores, the federal and state governments are imposing increasing restrictions on travel and public gatherings while health care providers and government agencies gear up testing and treatment.

Countries with single-payer health care may have a more difficult time dealing with the problem. In the not-too-distant past, Canada and the United Kingdom have struggled to handle outbreaks of everything from severe acute respiratory syndrome (SARS) to the seasonal flu.

That’s largely because these countries’ government-run, “Medicare-for-all”-style systems do not have enough health care personnel, hospital beds, and other resources to meet the needs of their populations even in good times. A public health threat such as a pandemic can stretch single-payer health care to its breaking point.

First identified in Wuhan, China, the coronavirus causes a potentially deadly form of viral pneumonia. The pathogen belongs to the same family as SARS, which caused a global pandemic nearly two decades ago. Containing pathogens such as coronavirus requires fast action and close coordination among physicians, hospitals, and public health officials. That’s tough to do when there aren’t enough doctors or hospital beds to accommodate the sick.

Canadian Patients in Hallways
During the first half of 2019, nearly half of the Canadian province of Ontario’s acute care hospitals were over 100 percent capacity, according to an analysis conducted by CBC News. Almost one-fourth of the province’s hospitals averaged 100 percent capacity or more over that period.

As the CBC reported last month, “overcrowding has become so common in Ontario hospitals that patient beds are now placed in hallways and conference rooms not only at times of peak demand, but routinely day after day.”

Such crowding could make quarantining patients difficult, if not impossible, during an outbreak. Leaving someone with coronavirus in a hallway or other communal space could expose countless patients and staff to the highly contagious pathogen.

Canada experienced this kind of thing firsthand during the SARS pandemic of 2002-2003. Nearly 375 people contracted SARS in Ontario, and 44 of them died. For context, SARS infected just 27 people in the United States, and killed none.

According to the final report of the Canadian government’s SARS commission, 72 percent of Canadians infected with SARS contracted the disease “in a health care setting.” Forty-five percent of that group were health care workers.

The report laid the blame on Canada’s “public health and emergency infrastructures,” which “were in a sorry state of decay.” Another government report concurred, saying the Canadian health care system “lacked adequate resources, was professionally impoverished and was generally incapable of fulfilling its mandate.”

Flu Derailed U.K. Hospitals
Single-payer systems don’t just struggle with pandemics. Every year, the United Kingdom’s National Health Service (NHS) grapples with patient care during flu season. The British press calls this perennial disaster “the winter crisis.”

During the 2018-2019 winter, one in four patients waited more than four hours in major emergency departments in the U.K. That year, those departments were so crowded that over 1 percent of ambulances carrying patients were kept waiting outside hospitals for more than 90 minutes.

In January 2018, NHS postponed approximately 55,000 operations because of an outbreak of seasonal illnesses such as the flu. A doctor in central England apologized for what he called “third-world conditions” such as 12-hour waits and patients being treated in corridors at his hospital. Another physician likened the scene in his London hospital to “battlefield medicine.”

The Canadian and British health care systems show just how hard it can be to battle an outbreak under single-payer. Let’s not replicate their experiences by adopting “Medicare-for-all.”

Sally Pipes (SPipes@pacificresearch.org) is president and Thomas W. Smith Fellow in health care policy at the Pacific Research Institute. An earlier version of this article was published by foxnews.com on February 10, 2020. Reprinted with permission.

The New Chicago Way
Lessons from Other Big Cities
Ed Bachrach and Austin Berg

“If more intelligent, articulate citizens like Ed Bachrach and Austin Berg would take the time and make the effort to understand and publicize the fiscal realities, we would at least have a chance of finding real public support for solutions. This book is an urgent plea for change.”—Richard Ravitch, former lieutenant governor of New York

“The New Chicago Way reveals how serious Chicago’s government problems are and how they are related to each other. More important, it provides a comprehensive solution to those problems.”—Dick Simpson, author of The Good Fight: Life Lessons from a Chicago Progressive

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Goodman Institute Shows How to Fix Health Care Without More Taxes, Mandates

By John Goodman and AnneMarie Schieber

I

f there is a way to fix the nation’s broken health care system without raising taxes or mandating coverage, chances are The Goodman Institute for Public Policy Research and its founder, John C. Goodman, have figured it out. The Wall Street Journal calls Goodman “the father of health savings accounts (HSAs),” and Modern Healthcare says Goodman is one of four people who have most influenced the health care system.

Thanks to the pioneering efforts of Goodman and his colleagues, 25 million people are managing some of their own health care dollars in HSA accounts they own and control. Perhaps an equal number have access to a similar type of account, called a Health Reimbursement Arrangement (HRA).

Many of the most important innovations in the health care marketplace, such as walk-in clinics and mail order pharmacies, emerged in response to patients spending money out-of-pocket instead of relying on a third party to pay the bill.

Repairing Obamacare Damage

In 2016, Goodman Institute scholars helped produce a comprehensive bill to repeal and replace Obamacare, sponsored by Rep. Pete Sessions (R-TX), then the House Rules Committee chairman, and Sen. Bill Cassidy (R-LA), whom Goodman calls the Senate’s most knowledgeable person on health care policy. The bill was based on 12 bold ideas through executive orders.

One of the most important changes is allowing employers to help their employees obtain individually owned health insurance which they can take with them from job to job and in and out of the labor market. Another important change will make it easier for seniors to obtain inexpensive concierge care.

Influencing Policy

Goodman recently teamed with Marie Fishpaw of The Heritage Foundation to advocate five major health care reforms. Their white paper lists a bill of rights that health care policy should include (see related article, this page) in order to be more responsive to consumers.

Goodman and Fishpaw note the Trump administration has been pursuing these health care policy goals. The core ideas have also been endorsed by the House Republican Study Committee, the Job Creators Network, and many other think tanks.

Goodman Institute scholar Thomas Saving is a former trustee of Social Security and Medicare. Saving and his colleagues have produced the only study ever done on how to privatize Medicare without loss of benefits or higher taxes.

In an article in Health Affairs, Goodman and Saving advocate liberating seniors from Medicare price fixing by allowing them to have health saving accounts and allowing physician services and fees to be determined in the marketplace.

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John C. Goodman, Ph.D. (info@goodmaninstitute.org) is founder, president, and chief executive officer of The Goodman Institute for Public Policy. AnneMarie Schieber (amschieber@heartland.org) is managing editor of Health Care News.
Institute Advises on Health Care Reforms

By AnneMarie Schieber

The founders of The Buckeye Institute in Ohio decided to become one of the nation’s leading advocates for Medicaid waivers when they saw how little choice there was in their state.

After Obamacare was implemented, insurance companies started exiting Ohio, which left Ohioans with fewer insurance options and increased costs. Adding to the uncertainty, Ohio’s governor defied the state legislature and decided to expand Medicaid in 2013.

“We warned that Medicaid expansion would be more expensive than the state was projecting,” said Rea S. Hederman Jr., vice president of policy and executive director of the Economic Research Center at the institute. “Now, Medicaid takes up one-fifth of the state’s budget, and it’s growing.”

The Buckeye Institute recognized that Ohio—and other states—could take advantage of Medicaid 1115 and Affordable Care Act (ACA) 1332 waivers to make the program more fiscally responsible and limit the damage of Obamacare. Waivers allow states to experiment with new ways to meet their coverage goals.

Buckeye’s efforts to raise awareness about how states can use federal health care waivers put the organization in the national spotlight. In 2018, Hederman helped convince the Trump administration to remove federal restrictions on the use of section 1332 waivers.

For that work, Buckeye was nominated for a 2019 Bob Williams Award for Outstanding Policy Achievement by the State Policy Network. Additionally, Ohio was among the first states to seek and get approval for a work requirement for able-bodied Medicaid enrollees. Buckeye’s leadership on these issues has led other states grappling with Medicaid expansion to seek Buckeye’s expertise and advice: Buckeye experts have been asked to testify in and write op-eds for Florida, Iowa, and Tennessee, among other states.

Comprehensive Reforms

Medicaid reform is not the only area where Buckeye is putting an emphasis on free-market health care. It is pushing for better scope-of-practice laws so nurse practitioners and other midlevel providers can fully use their licenses to help Ohioans, something particularly vital for the state as it faces a shortage of physicians in some communities.

Buckeye has also helped push policies to encourage charity care to improve primary care access. One such policy method has been to remove obstacles for charity organizations that want to provide free, quick, short-term health care in communities where there is a particular temporary need. Buckeye’s work has led to policies that allow health professionals in other states to offer that care as well.

Insurance is also on Buckeye’s list of issues in need of reform. The organization, along with the Cato Institute, recently filed an amicus brief calling on the U.S. Court of Appeals for the District of Columbia Circuit to uphold a district court decision allowing for 12-month short-term, limited duration insurance plans (see related article, this page). As a result of Buckeye’s comprehensive efforts to reform health care, Ohio and other states now have an alternative to the previous one-size-fits-all federal health care policies, and consumers can enjoy more choice and flexibility.

AnneMarie Schieber (amschieber@heartland.org) is managing editor of Health Care News.

Court Brief: Consumers Need More Short-Term Insurance Protection

Two think tanks filed an amicus brief asking the D.C. Court of Appeals to uphold a U.S. District Court decision concerning the duration of short-term, limited-duration insurance plans (STLDI).

In the January 29 brief, The Buckeye Institute and the Cato Institute argue the Trump administration acted within its authority when it reinstated a rule to allow STLDIs to last for 12 months. The brief also argues the three-month limitation implemented under the Obama Administration is too short to provide adequate coverage.

“The Congressional Budget Office estimates that approximately 700,000 Americans, who would otherwise be uninsured, are covered by short-term insurance plans, making it clear that limiting the length of time people can be covered to three months doesn’t just limit choice and competition, but it also threatens to inflict real harm on real people,” said Robert Alt, president and chief executive officer of The Buckeye Institute, in a press release.

In October 2017, the Trump administration issued new rules that would expand association health plans and short-term plans. The rules were immediately challenged in federal district court in the District of Columbia. In July 2019, Senior Judge Richard Leon ruled in favor of the short-term rule change. The ruling was appealed within weeks and is now before the U.S. Court of Appeals for the District of Columbia Circuit.

Short-term plans give consumers an affordable health insurance option between jobs. The plans could be used before the November enrollment period in the individual market or until the person finds a new job. In 2016, the Obama administration minimized the duration of the plans to three months.

“Even the National Association of Insurance Commissioners found that the three-month limit could strip health insurance coverage from consumers after they fall ill,” Alt said.

-Staff reports

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Colorado Considers Expanding Telemedicine

By Ashely Herzog

Colorado lawmakers are considering a bill to expand telemedicine in an effort to improve health care access for Medicaid patients.

Under current Colorado law, Medicaid does not reimburse health care providers for “remote visits.” Colorado House Bill 20-1092 and a companion bill in the state Senate would change that by allowing telemedicine consultations to qualify as office visits.

The bills state telemedicine could save Medicaid money over time.

“Telemedicine helps connect Medicaid enrollees to health care providers through live video and audio, enabling enrollees to receive the care and consultation they need without traveling to visit a provider in another city or area of the state,” the bill states.

“Telemedicine visits can lead to cost savings for the Medicaid system by improving access to primary care and helping to avoid unnecessary trips to emergency departments.”

Seeing the Future

Telemedicine is the future of health care, says Matt Glans, a senior policy analyst at The Heartland Institute, which publishes Health Care News.

“It allows physicians to offer quality care to patients anywhere they are needed,” Glans said. “Currently, 200 telemedicine networks with 3,500 service sites operate across the United States, according to the American Telemedicine Association, and the number of telehealth providers is only expected to grow.”

Concern over quality of care has been unwarranted, Glans says.

“While some critics are concerned about the quality of care provided through telemedicine, telehealth patients have been found to be less prone to suffer from chronic depression, anxiety, and stress,” Glans said. “Telehealth patients have a 38 percent lower hospital admission rate, according to a study from the American Journal of Managed Care. A 2018 study from the Agency for Healthcare Research and Quality also found telehealth is clinically effective. Competition will also quickly weed out bad actors, and most patients receive high quality care via telehealth already.”

Cutting Costs

Telemedicine can lower costs for patients, says Linda Gorman, director of the Health Care Policy Center at the Independence Institute.

“People don’t have to travel, so it lowers patient cost,” Gorman said. “It is widely used in private sector specialist consults, so having Medicaid pay for it might improve the care that Medicaid provides.”

Some opposition to telemedicine is driven by special interests, Gorman says.

“People who are against telemedicine are often protecting their markets — pharmacists in other states can be very sticky when an out-of-state physician wants to prescribe through them — and physicians can be concerned about national competition,” Gorman said.

Finding the Niche

Gorman says the challenge is in determining the best role for telemedicine.

“Will an elderly person who is deaf and computer-illiterate be well-served?” Gorman asked. “How about a homeless drug addict? Is surgery using a robot and an internet connection a good idea? Are there medical disciplines in which a physical exam is irreplaceable? We simply don’t know.”

Such questions are not stopping patients, especially those who lack transportation or live in rural areas where a remote visit with a doctor can be highly convenient, Glans says.

“Telehealth is very popular with patients,” Glans said. “For example, among telehealth patients receiving services on a mobile app, 80 percent preferred telehealth compared to a traditional in-office encounter, a 2016 study by West Monroe Partners reveals.”

Colorado’s interest in expanding telemedicine in Medicaid follows action in California in the autumn of 2019 when Medi-Cal introduced a policy to allow providers to determine whether such a visit would be appropriate. California is now considering a bill that would remove the requirement that a telemedicine visit be preceded by a face-to-face visit.

Ashley Herzog (aebristow85@gmail.com) writes from Avon Lake, Ohio.

Physician Introduces Free Platform to Help Launch Telemedicine

A New York neurologist is offering a free platform to help launch telemedicine.

Samant Virk, M.D., says he developed the telemedicine platform MediSprout out of frustration in his 15 years of practice.

“We have technology in my office to help with insurance, with payments, with prescribing, with getting authorization,” Virk said on The Heartland Daily Podcast. “But we don’t have technology to do the one thing that is important, and that is to see our patients.”

Unlike conventional online telemedicine platforms, in which consumers can connect with a doctor they don’t know or may never see again, MediSprout connects physicians with their established patients. MediSprout charges consumers $4 for each virtual visit, and there is no charge to physicians.

“People don’t have to travel, get in a car, sit in a waiting room, take time off from work,” Virk said.

The technology may allow physicians to see more patients.

“If you can see more patients in a day, you can help more people, and maybe we can make a dent in that idea that there is a doctor shortage,” Virk said.

One-third of the one billion medical office visits a year could be virtualized immediately, and 75 percent could be virtualized within a decade, Virk says.

Third-party payers must also get on board, Virk says.

“Unfortunately, in health care, as medical providers, we’re the only sector that doesn’t control our own cost structure,” Virk said. “Without a predictable mechanism to be reimbursed for the service by insurance companies, it makes it hard for clinicians to adopt it.”

—Staff reports
In big cities and small towns throughout America, bullying, teen suicides, sexual harassment, school shootings, and other violence targeting students have become far too common. In the wake of these tragedies, we need to ask: Why should any child be forced to remain in an unsafe school?

The Heartland Institute has published a new book that holds the key to answering that question and liberating children from failing and dangerous schools. *Child Safety Accounts: Combating Student Bullying and School Violence by Empowering Parents*, by Heartland’s Vicki Alger, Tim Benson, and Lennie Jarratt, is a revolutionary school reform idea that is being picked up in states across the country – and even in Congress.

Many people don’t realize the issues students face daily, including:

- Roughly four out of five public schools report violent criminal incidents.
- About 20 percent of all students aged 12 to 18 report being bullied.
- More than 30 percent of sixth grade students have been bullied.
- Bullying rates at public schools are 28 percent higher than private schools.
- The U.S. Department of Education estimates about 10 percent of students experience some form of sexual misconduct by a school employee.
- The suicide rate for adolescents aged 13 to 18 increased by nearly 31 percent from 2010 to 2015.

No child should be forced to stay in a school if he or she has been or is currently being victimized. Being trapped in unsafe conditions on a daily basis creates mental health trauma, decreases learning, and sometimes causes students to lose all hope and attempt suicide. Child Safety Accounts can help reduce student bullying and improve the education prospects of any child.

LEARN MORE about this vital reform, get your copy of the book, or request one of the authors as a speaker here ChildSafetyAccounts.com.
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