First Generic EpiPen Hits Market
The first generic EpiPen is now being sold, and its price is markedly lower than the Mylan brand-name version. The Mylan pharmaceutical company had previously been censured for setting exorbitantly high prices for its EpiPen.

CA Toys with Individual Mandate
California’s new governor, Gavin Newsom, is proposing the creation of an individual mandate that would force most citizens of the state to purchase health insurance or else pay a penalty.

Heartland’s Dental Therapy Brief
Two experts at The Heartland Institute have released a new Policy Brief that covers in detail the benefits of expanding dental therapy in the United States, including lower costs for consumers and greater access to care.

WH Promotes CON Law Repeal
As part of their report on competition and choice in the health care sector, the Trump administration is encouraging states to rethink their certificate of need laws.

Calif. Considers Implementing Individual Mandate
The California Legislature is considering an individual mandate that would effectively force young, healthy Californians to purchase health insurance. In December 2017, Congress passed the Tax Cuts and Jobs Act, which lowered tax rates for millions of Americans and reduced Obamacare’s individual mandate penalty to $0.

The Obamacare mandate required young, healthy individuals who might not purchase health insurance, to buy insurance or pay a tax penalty.

Although there is no longer a federal individual mandate penalty, several states have taken matters into their own hands, forcing residents to buy health insurance. In 2018, New Jersey, California, and North Dakota implemented individual mandate penalties.

By Jake Grant

A federal judge ruled in favor of a state-led coalition arguing that the Affordable Care Act (ACA) is unconstitutional following the repeal of the individual mandate.

In December, a Texas judge ruled in favor of a 20-state Republican coalition, led by Texas Attorney General Ken Paxton.

The ruling highlights growing concern over the future of the nation’s health care system. While Republicans rally against Obamacare, Democrats continue to support the ACA and their single payer model, Medicare for All.

By Ashley Bateman

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Trump Administration Seeks To Expand Access to Dental Care

By Cory Compton

President Donald Trump signed into law the Action for Dental Health Act (ADHA) with the aim to increase dental care access for under-served Americans.

The ADHA allows organizations to qualify for federal grants designed for oral health prevention initiatives and programs.

The law amends the Public Health Service Act to allow nonprofit community-based organizations, state and tribal health departments, dental education programs, and dental associations to be eligible for the federal grants, which are provided through the Centers for Disease Control and Prevention in conjunction with the Health Resources and Services Administration (HRSA).

The measure also expands an HRSA program that awards grants to states that increase oral health care services access.

‘Increase Access & Drive Down Costs’

On December 3, the White House released a report on health care reform urging states to increase dental therapy and reduce supervision restrictions on dental hygiene to expand access to oral health care.

The report notes that health care markets can increase access and reduce costs by removing or revising “certain federal and state regulations and policies that inhibit choice and competition.”

“Healthcare occupations, such as dental therapy, can increase access and drive down costs for consumers, while still ensuring safe care. States should be particularly wary of undue statutory and regulatory impediments to the development of such new occupations.”

WHITE HOUSE REPORT

“A lot has changed in 20 years,” Adams stated during the meeting. The report, spearheaded by the National Institute of Dental and Craniofacial Research, will update and document inequities in disease burden and care access, address the adequacy of the provider workforce “head on,” and investigate how dentistry has impacted the opioid crisis, Adams explained.

“Workforce issues are touchy for some,” Adams said. “Some issues that have been taboo ... we must have the courage to address them.” The new study will also address issues such as oral health across one’s lifespan, the possibility of integrating medical and dental care, how access to oral health impacts communities and the economy, and the amount of damage caused by the opioid epidemic.

Time for Change

Charlie Katebi, a state government relations manager for The Heartland Institute, which publishes Health Care News, said the administration’s attention to making dental care more affordable is commendable and comes at the right time.

“The Heartland Institute has been interested in how to address reform in the dental care area for some time, so we are thrilled with this development,” Katebi said. “It has long been time for change, and we hope the administration continues its research on dental therapy as a way to provide this important health care resource to under-served populations and as a way to address a shortage in the field so that quality dental care becomes affordable and widely available.”

Cory Compton (thecomptonjr@gmail.com) writes from Cheboygan, Michigan.
MI Dental Therapy Bill Passes House Committee

By Cory Compton

Senate Bill 541, which would create a new type of mid-level dental care professional in the state of Michigan, passed a Michigan House committee and has been sent to the House floor.

Bill SB 541 originally passed in the Michigan State Senate in 2017. If signed into law, it would create ‘dental therapists,’ a new type of mid-level dental care professional authorized to perform basic dental procedures such as simple tooth extractions and fillings. The bill also outlines licensing, education, training, and supervision requirements.

Supporters of the bill include clinics and health centers, many of whose clients are on Medicaid, are uninsured, or are under-insured. Their dentists say having dental therapists would allow them to serve more clients.

Helping The Underserved

Amy Zaagman, executive director of the Michigan Council for Maternal and Child Health, says the bill’s purpose is to provide additional help for underserved populations that licensed dentists alone cannot support.

“This is about thoughtfully creating an additional team member who could see under-served populations,” she said. “We have areas of the state where we just literally don’t have enough providers to care for the population.”

Supporting Those in Need

Zaagman also says the bill has been specifically designed for serving those in need. Dental therapists would only be able to practice in dental shortage areas or in safety net settings such as federally qualified health centers and rural health centers.

“If this bill passes, it would be the first time that Michigan would be restricting a health care professional to serving really only the underserved population either by geography, by insurance type, or by the setting in which they would work,” said Zaagman. “If a dental therapist wanted to go work or was asked to come work by a private practice dentist who was not in a shortage area … The dental therapist would have to see 50 percent of Medicaid or uninsured patients.”

Dental Care Impacts General Care

Zaagman says the importance of providing dental services to underserved populations is notable due to the impact oral health has on overall physical health.

“We know that oral health has an impact on employability,” Zaagman said. “We know it has an impact on school attendance. We know it has an impact on productivity at work … and we know it impacts someone’s quality of life.”

Positive Development

The Mackinac Center, which advocates for free-market solutions in Michigan, sees the long-term benefits for the creation of dental therapists.

“Creating a new dental therapist license would be a positive development for Michigan,” a spokesman for the Mackinac Center told The Heartland Institute. “Our state has many areas where dental services are in short supply, and these professionals would be able to help meet the needs of residents living in those areas. The move would be a wise long-term investment, as preventative dental care helps fight against rising medical costs down the road.”

Right Idea, Right Time

Matthew Glans, senior policy analyst for The Heartland Institute, which publishes Health Care News, says dental therapy has been bubbling up at the state level and has recently been embraced by the Trump administration, indicating it’s time may have finally come.

“It’s heartening to see that the positive benefits of offering affordable dental care are finally being recognized,” Glans said. “Not just by states like Michigan and Arizona, but in the halls of the federal government. It may mean that finally the people who are truly underserved in the health care sector, as well as dentists who can use the extra hands, are finally being heard. What dental therapy does to address a shortage in dental care can not be overstated. The added bonus is that as more people are receiving better dental care — which often leads to better health overall — the market grows and becomes healthier with a new industry developing out of the dental care field. The benefits are felt by patients and providers alike, which is usually an indication that a policy prescription is on the right track.”

Cory Compton (thecomptonjr@gmail.com) writes from Cheboygan, Michigan.
Drug maker Sandoz announced it will debut a generic EpiPen model that provides a more affordable option for the rising number of allergy patients in the United States.

The epinephrine auto-injector, also known as the EpiPen, has dominated the market for years, but high prices and limited supply have paved the way for new vendors to arise. Epinephrine counters life-threatening allergic reactions. Injectors vary as to dose and design.

EpiPen seller Mylan’s initial series of patents on the autoinjector were approved in 1987 with an expiration date of 2025. The company now sells a generic version alongside one other generic on the market.

**Increasing Competition**

Wayne Winegarden, a senior fellow in business and economics at the Pacific Research Institute, says the generic version of EpiPen will add much-needed competition to the marketplace for epinephrine injection.

“You can never have too many options,” said Winegarden. “It’s obviously a very good thing to have more competition in the generic space.”

Winegarden also says drug companies often use their patents to hold a monopoly on the market until their investment into the production of a drug becomes profitable, but says the monopoly should end there.

“One that cost is recouped, you want the marketplace to be as competitive as possible,” Winegarden said. “To have more competition, that’s the way the process is supposed to work.”

**Shortages and Higher Costs**

Mylan garnered media attention early this year when the cost of a pair of EpiPens rose from $94 to $608. Many place the blame for high health care costs on prescription drugs, but Winegarden says there are several other factors that drive up health care costs.

“Drugs are in the news but the issue is total health care spending,” Winegarden said. “Health insurance should be there to manage risks so that when you have a really expensive drug you need or a really expensive surgery or team therapy, those are the financial risks insurance are supposed to cover.”

Winegarden added that adding generics to the market is still a step in the right direction, although it will not solve the problem entirely.

“Adding in new competition is the exact right thing to be doing,” Winegarden continued. “It could be this is enough competition and they drive down the price enough that no [other maker] is going to enter [as a competitor].”

By Ashley Bateman

“More is better in the marketplace. If you keep the market free from regulation, it means lower risk to drug makers looking to compete, and more incentive for them to try. And more competitors is better for the consumer because those drug makers will fight to be not only the best but to bring the product to the consumer at a lower cost to beat their competitor. Addressing the shortage has several advantages in the case of the EpiPen.”

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**Innovation Fuels Competition**

Ed Hudgins, research director at The Heartland Institute, which publishes Health Care News, says that drug makers’ approaches to making generic drugs could fuel innovation in the marketplace, adding competition and leading to lower costs.

“More is better in the marketplace,” Hudgins said. “If you keep the market free from regulation, it means lower risk to drug makers looking to compete, and more incentive for them to try. And more competitors is better for the consumer because those drug makers will fight to be not only the best but to bring the product to the consumer at a lower cost to beat their competitor. Addressing the shortage has several advantages in the case of the EpiPen.”

**Cost/Benefit**

Winegarden says it’s important to remember that the cost of health care should be proportional to how effective it is.

“What matters most overall is how expenditures on health care compare to the quality of health care,” Winegarden said. “Our expenditures in health care can be increasing, but if we’re curing diseases it could be worthwhile.”

Ashley Bateman (bateman.ae@googlemail.com) writes from Alexandria, Virginia.
Obamacare Ruling Puts Focus on Medicare for All

Continued from page 1

States that have enacted single payer programs have been burdened with rising costs. To fund Vermont’s program, Democratic Gov. Peter Shumlin called for a 150 percent increase in income taxes, which still failed to generate enough funding.

Medicare for All

Medicare for All, a form of single payer health care, would put the government in full control of the health insurance market at the expense of taxpayers, says Robert Graboyes, senior research fellow at George Mason University’s Mercatus Center. “The single payer option is hot political news, but it’s rather cold economic news,” said Graboyes. “First of all, it’s not going anywhere legislatively anytime soon and the economics of it simply don’t add up.”

In his report, “The Costs of a National Single-Payer Healthcare System,” Senior Research Strategist at George Mason University’s Mercatus Center Charles Blahous, found that by conservative estimates, Medicare for All would add $32.6 trillion to the federal budget during its first decade, a projection of 10.7 percent of the GDP by 2022 with costs increasing over time. “These estimates are conservative because they assume the legislation achieves its sponsors’ goals of dramatically reducing payments to health providers, in addition to substantially reducing drug prices and administrative costs,” the report notes.

“In reality, the actual bill would be far higher, even under those sunny assumptions,” Graboyes said. “It would have to double federal and corporate income taxes just to break even. For any of the finance mechanisms that are available under the federal government, to raise that kind of revenue … you’d very likely tank the entire U.S. economy. Single payer sounds like a lovely idea until you get into the nuts and bolts of it.”

Obamacare Unconstitutional

Graboyes says he understands why the Texas judge ruled Obamacare unconstitutional. “As for the ACA as it now stands, I’m not an attorney but I certainly understand the logic of the ruling,” Graboyes said.

In 2012, the court upheld the constitutionality of the ACA. Congress has virtually limitless authority on taxation, Graboyes says. “In this latest court ruling the judge takes note of the fact as of last year, when the law and individual mandate penalty was changed, he read it as … you can no longer claim that this is a tax if it’s not collecting revenue. To keep the law going could no longer hold.”

Graboyes says no matter what happens with the Obamacare case, which many expect could end up back on the doorstep of the Supreme Court, the decision has further deteriorated the likelihood that the legislation will remain intact.

“Single payer is not a practical option in the near future, especially not with a Republican Senate and Republican president,” Graboyes said. “The ACA has been on shaky ground for many years. I don’t know that it’s getting any more secure as the days pass, and now it has this legal challenge. It’s my understanding nothing will happen operationally; they will allow this ruling to wind its way upward, first to the appeals court and potentially back to the Supreme Court, and I think from many perspectives prudence dictates you cannot shut down the whole rodeo just because of this; you have to see how this is going to play out in the courts.”

“It’s kind of difficult to imagine big things happening when you have a brand new and very committed Democratic House and strengthened Republican Senate and Donald Trump still in the White House,” Graboyes said. “I don’t know of any major alternatives that are in the works. Even if someone dropped a miracle plan tomorrow, it takes a long time to wind that thing through the process of becoming law. I’m sure on both sides you’ll have a lot of posturing and positioning and lining up with an eye on the 2020 elections.”

Ashley Bateman (bateman.ae@googlemail.com) writes from Alexandria, Virginia.

New Survey Shows Support for AHPs

Americans widely support association health plans (AHP), even in states where Democratic attorneys general have sued to prevent small businesses from banding together and offering these plans to employees, according to a new survey from AssociationHealthPlans.com.

AHPs allow small businesses and other groups to pool employees and members into a large health insurance pool, thereby driving down risk and costs. Thanks to Trump administration rule changes, AHPs are now more available and offered across state lines.

The survey polled 1,119 adults nationwide and asked the following question: “Should small businesses and sole-proprietors be allowed to band together to offer the same kind of lower-cost health insurance plans that large companies already offer?”

The survey found 77.6 percent of survey respondents answered “yes” — more than three times higher than those that oppose AHPs. (77.6 percent “yes” to 22.4 percent “no”). Support for AHPs, which recently began selling across state lines, was actually, according to the poll, slightly higher than the national average in states involved in the lawsuit.

“The overwhelming public support — 77 percent — observed in the survey may come from a desire for fundamental fairness between small and large businesses,” said health policy expert Kev Coleman, president and founder of AssociationHealthPlans.com in a statement about the survey. “Big companies have used ‘large group’ health plans to lower health insurance costs for decades. Why shouldn’t smaller businesses have access to the same plans?”

—Staff Reports

**INTERNET INFO**

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“Heartland’s research and advocacy for science-based policies that improve people’s lives have been very helpful to me and my colleagues.”

REPRESENTATIVE ISAAC LATTERELL
SOUTH DAKOTA
Vermont, and the District of Columbia implemented individual mandates laws, with more states considering mandates as well.

‘Violation of Individual Liberty’
Justin Haskins, executive editor and research fellow at The Heartland Institute, which publishes Health Care News, says it is immoral to force individuals to buy expensive health insurance.

“Imposing an individual mandate to purchase health insurance is an egregious violation of individual liberty,” Haskins said. “The government has absolutely no business forcing people to buy products simply because they are living and breathing, and that’s precisely what individual mandates do.

“Even worse, individual mandates hurt lower-income working Americans and middle-income families more than any other group,” Haskins said. “Wealthy people can afford to pay the penalty, but many working people cannot. Although everyone should purchase health insurance, the numerous mandates, regulations, and taxes created in California and by the Obama-era federal government have made health insurance premiums and deductibles so high that for many people, they simply can’t afford to purchase or use health insurance bought in an Obamacare exchange. To punish these people, many of whom are already living paycheck to paycheck, because they can’t afford a product the government has made unaffordable is highly immoral and abusive.”

CA Prepares for Individual Mandate
Following his election as California governor in November, Gavin Newsom declared his intent to introduce a mandate in the state that will force individuals to purchase health care coverage or pay a fee, effectively implementing Obamacare at the California state level.

The Sacramento Bee reported that many of Newsom’s administrative hires signal a dedication to bringing universal health care to the state of California. Chief of Staff Ann O’Leary once was employed in President Bill Clinton’s administration working on Children’s Health Insurance Program (CHIP), a program that offers affordable health care to children for families that are well-off enough not to qualify for Medicaid but financially strained enough not to be able to afford private insurance.

Newsom’s Cabinet Secretary Ana Matosantos formerly worked for California Gov. Jerry Brown and has extensive experience implementing Obamacare in California. She also reportedly worked with the state legislature to expand health-care coverage for low-income Californians.

‘Disastrous for the Individual Market’
Sally Pipes, Pacific Research Institute’s president, CEO, and Thomas W. Smith Fellow in Health Care Policy, says California legislators might pass the individual mandate in the upcoming legislative session.

“With the Democrats having a super majority in the state Assembly and Senate, it is possible that California may pass and Gov. Newsom may sign an individual mandate,” Pipes said. “This would be disastrous for those in the individual market.”

Pipes says the arguments proponents of the government mandate make are fundamentally flawed.

“Obamacare’s proponents claim that state-level individual mandates would compel young and healthy people to buy coverage through the exchanges,” Pipes said. “This, they say, would ensure a healthy risk pool and prevent insurers from leaving the exchanges or drastically hiking premiums. Their assertions are divorced from reality. The last four years of Obamacare have proven that even a government directive hasn’t compelled the young and healthy to buy insurance they can’t afford. The resulting massive premium hikes have priced millions out of the insurance market altogether. That’s why 55 percent of Americans supported repealing the individual mandate in the 2017 tax reform law, a popular provision in an otherwise-unpopular law.”

Taxes, Taxes, Taxes
Pipes says the mandate would be little more than a tax hike with no benefit to consumers.

“Reinstating the mandate at the state level would effectively be a tax hike on poor and working-class Californians,” Pipes said. “It would pick the pockets of millions of Californians who already can’t afford coverage under Obamacare—without stabilizing the insurance market.”

Jake Grant (jakg42294@gmail.com) writes from Alexandria, Virginia.
Democrats to Appeal Obamacare Ruling

By Katie Zehnder

Congressional Democrats and a coalition of state-led Democratic attorneys general intend to appeal a U.S. District Court ruling that declared Obamacare is unconstitutional.

On December 14, Texas U.S. District Court Judge Reed O’Connor ruled the Affordable Care Act (ACA), better known as Obamacare, is unconstitutional but declared it would remain in effect while the ruling is appealed.

On January 1, the Tuesday prior to the swearing in of the new U.S. Congress, Democrats announced they had established a framework to authorize House Speaker Nancy Pelosi (D-CA) to intervene in the recent Obamacare ruling.

A coalition of Democratic attorneys general, led by California’s Xavier Becerra, also announced their intention to appeal the Texas ruling. Congressional Democrats have also expressed intent to appeal the decision.

According to news reports, Becerra called the Texas ruling “an assault on 133 million Americans with preexisting conditions, on the 20 million Americans who rely on the ACA’s consumer protections.”

No Individual Mandate, No ACA

O’Connor’s ruling is based on the argument that Obamacare cannot function as intended without the individual mandate, which was eliminated under the Tax Cuts and Jobs Act, signed by President Trump in 2017.

The individual mandate imposed a penalty on consumers who did not have health insurance. Those who chose not to purchase health insurance were essentially “punished” with a hefty tax.

Charlie Katebi, a state government relations manager with The Heartland Institute, which publishes Health Care News, says Democrats are trying to rescue Obamacare.

“It’s no surprise that Democrats are using their new powers in the House to weigh in on the current lawsuit against Obamacare,” Katebi said. “Sadly, Democrats are apparently more interested in maintaining a collapsing law instead of working with Republicans to provide families with high-quality and affordable health insurance.”

‘The Right Decision’

Arianna Wilkerson, government relations coordinator at The Heartland Institute, says the Texas judge made the right decision in the case and Democrats would do well to embrace some of the free-market reforms in health care introduced by the Trump administration rather than prop up a collapsing system.

“It’s no surprise the first step of the Democratically controlled House is to prop up the collapsing Obamacare system and help overturn the recent ruling of Texas v. United States.” Wilkerson said. “Since the elimination in 2017 of the tax penalty levied on people without insurance, there is a strong case to make that Obamacare is, in fact, unconstitutional. Instead of attempting to shore up the Obamacare exchanges, which have suffered from a dearth of insurers and skyrocketing premiums, House Democrats should focus on promoting alternative solutions that give Americans real options for affordable health care while ensuring certain consumer protections.”

‘Just a First Step’

Justin Haskins, research fellow with The Heartland Institute, says that Obamacare was just a first step toward greater government control of health care.

“Government-run health care, as disastrous as it would be, has been a dream of progressive legislators for some time,” Haskins said. “They thought they had achieved the beginning stages of it with Obamacare and were, of course, unlikely to let it go easily.”

‘New Options’

The state-led coalition of Democratic attorney generals says they will appeal based on the fact that more than $600 billion in federal funding for health care is at stake, and that an invalidation of the law would risk the health insurance status of 12 million Americans, stripping 8 million low-income citizens of billions of tax credits.

Haskins says that Democrats are not taking into account the many new options available to low-income individuals thanks to reforms made by the Trump administration.

“Fortunately, short-term plans are now widely available to fill the gap for people who would be affected by Obamacare rightly being declared unconstitutional,” Haskins said.

Katie Zehnder (kathzeh@mail.regent.edu) writes from Virginia Beach, Virginia.

The Truth about Alternatives to Smoking

Get your free copy of Vaping, E-Cigarettes, and Public Policy Toward Alternatives to Smoking today! Visit heartland.org/topics/alcohol-tobacco.
By Leo Pusateri

A coalition of the American Hospital Association, Association of American Medical Colleges, and three hospitals sued the U.S. Department of Health and Human Services (HHS) over a new “site-neutral” policy that reduces Medicare payments to hospital-owned outpatient clinics.

Currently, hospital-owned outpatient facilities receive a premium from HHS for similar services compared with non-affiliated outpatient clinics. Under the new policy, HHS will reimburse non-affiliated outpatient clinics. Under the new policy, HHS will reimburse non-affiliated outpatient clinics. Under the new policy, HHS will reimburse non-affiliated outpatient clinics. Under the new policy, HHS will reimburse non-affiliated outpatient clinics. Under the new policy, HHS will reimburse non-affiliated outpatient clinics.

Balancing an Imbalance

Avik Roy, president of the Foundation for Research on Equal Opportunity, says the current system acts more or less as a ‘regulatory capture’ mechanism for hospitals, leading to favorable economic between having it in a hospital-affiliated outpatient clinic and monopolization of outpatient medical services.

“Under the current system, for example, if a service of a Medicare patient at an independent, unaffiliated outpatient clinic was to cost $1000, the exact same service at a hospital-affiliated outpatient clinic might cost Medicare $1200,” Roy said. “The reason is that hospital-affiliated clinics are allowed to charge a ‘facility fee’ under Medicare that is on top of the actual fee for the service, even though there is no difference economic between having it in a freestanding facility or having it in a hospital facility.”

“Hospital facilities are basically able to arbitrage loopholes in Medicare in which they are able to make more money than a ‘stand-alone’ facility,” Roy said. “That’s obviously an unbalanced playing field that leads to a lot more hospital and provider consolidation, because if there’s an economic advantage to everything being owned by hospitals, then everything is going to be owned by hospitals. The end result of that is less competition and higher prices by regional monopolies. That is what the Trump administration is trying to rectify.”

Creating Competition, Not Monopolies

Roy says that under the previous reimbursement system, hospitals would use these loopholes to monopolize markets and drown out competition, which resulted in less choice, lower quality care, and higher prices.

“Hospitals use their monopoly power to charge insurance companies higher prices, and therefore consumers pay more in health insurance premiums,” Roy said. “So it is not in the consumer’s interests for prices to be higher nor for competition to be reduced. Patients always win when there is more competition among hospitals and health care providers, and when health care prices are lower. And because they have to compete on value and quality, freestanding facilities (unaffiliated with hospitals) are much more likely to deliver it than an incumbent hospital system that because it’s a monopoly and can throw its weight around doesn’t have to compete.”

Trump Takes Action

Roy gave credit to the Trump administration for finally taking action on a long-recognized problem to which previous administrations merely gave lip service.

“This is something that health care experts have wanted to rectify for a long time,” Roy said. “The Medicare Payment Advisory Commission (MEDPAC) has long recommended fixing this problem. The Obama administration proposed fixing this problem. Both Democrats and Republicans have talked about fixing this problem. It’s a problem people have talked about fixing for a long time, but politically, people did not want to take on the hospital industry, because the hospital industry is very powerful.”

The Benefits of Competition

Matthew Glans, senior policy analyst at The Heartland Institute, which publishes Health Care News, says any time competition is introduced in a market, the benefits are positive.

“The attempt to address the outsized bargaining power that some hospitals have is an underreported, and very positive, move that the Trump administration is making,” Glans said. “Any time one actor in a negotiation has all the chips on his side of the table, the other players are at a disadvantage. Addressing and trying to spread out that negotiating power to consumers and other health care providers trying to enter the marketplace is a good way to introduce competition, which leads to more affordable prices for consumers.”

Leo Pusateri (psycmeistr@fastmail.fm) writes from St. Cloud, Minnesota.
The Heartland Institute Releases Policy Brief on Dental Therapy

“The State Lawmaker’s Case for Legalizing Dental Therapy,” Michael T. Hamilton and Charlie Katebi,

The Heartland Institute, Jan. 2019:
https://www.heartland.org/_template-assets/documents/publications/DentalTherPB.pdf

By Sarah Lee

The Heartland Institute, which publishes Health Care News, has released a Policy Brief for state legislators on the myriad benefits of dental therapy.

The brief, published January 3, was written by Michael Hamilton, a writer and editor for Good Comma Editing LLC and a policy advisor for The Heartland Institute, and Charlie Katebi, a state government relations manager for Heartland.

The authors examine the debate over dental therapy, or the provision of dental care by health care professionals who are not licensed dentists but who have schooling comparable to dentists and who can help fill the gap in underserved populations.

The writers cite several reasons why “mid-level” oral health care providers should be allowed to practice and how more dental therapy options increases freedom for patients and providers.

“The liberty of patients and dentists is at risk of being lost or stolen by people who imagine giving dental therapists the freedom to practice will threaten oral health care as we know it,” Hamilton and Katebi write. “Opponents of dental therapy would use their freedom to obstruct the freedom of others—and all in the name of the common good.

Ultimately, state lawmakers face one question looming above all other questions, claims, and statistics generated by the dental therapy debate,” the authors continued. “Is the freedom of patients to choose their oral health care providers and the freedom of licensed dentists to choose their employees so dangerous that the state should deprive patients and dentists of their liberty?”

More Liberty, Less Criminalization

Hamilton says that liberating patients and providers through dental therapy is a rational and mutually beneficial course of action, and will produce positive outcomes that criminalizing dental therapy can never achieve.

“People forget that the most fundamental determinant of a positive patient experience is the freedom to choose which providers they wish to obtain care from,” Hamilton says. “To deprive them of this freedom on the pretense of protecting their best interest is irrational.

“Similarly, dentists should be free to vet, hire, and supervise dental therapists that they wish to be responsible for,” Hamilton adds. “It makes no sense to rob a minority of enterprising dentists of this ability when those dentists have the same letters after their names as the dental lobby opposing dental therapist licensure.”

No Fear

Katebi says that one reason for some states’ reluctance to embrace dental therapy is a misapplied fear that dental therapists are a second-tier level of care compared to dentists.

“People want quality health care, and state legislators naturally want to make sure they’re not doing anything that will threaten oral health care as we know it. Opponents of dental therapy bring up concerns about the quality of care.”

Provider Trust

Hamilton says that once people understand the relationship between dentists and their dental therapists, many of the fears about quality of care should dissipate.

“No dentist will be forced to hire a dental therapist,” Hamilton says. “Dentists who do hire therapists willingly claim responsibility for the quality of care they provide under the dentist’s supervision. No patient will be forced to receive treatment from a dental therapist. Nevertheless, patients can rest assured that therapists emerge from their training programs with equal or more training in their narrow scope of practice than do dentists, who have a much wider scope of practice.”

Patient Trust

Hamilton and Katebi say that one of the most important aspects of the dental therapy debate, and the one they try to cover extensively in their paper, is that patients should be allowed to make their own decisions about their dental care.

“The freedom to choose a provider is a concept we have moved away from in this country with the adoption of a health care system that was moving toward centralization and control by the federal government,” Katebi said.

“That kind of system is detrimental to both providers and patients because it puts a burden on doctors to comply with bureaucratic requirements and destroys the individual doctor-patient relationship. Dental therapy brings some of that choice back to health care because people will have the choice of going to a regular dentist or utilizing a dental therapist for maintenance such as cleanings. Letting people choose in health care is direction we should be determined to move toward.”

Hamilton agrees with his colleague and says choosing a health care provider is no different than the responsible voters have of choosing legislators.

“Average people are qualified to choose which dental care providers they trust, whether they are dentists, dental therapists, or dental hygienists,” Hamilton said. “If the federal and state constitutions deem the common man qualified to choose the most qualified lawmakers, surely he can recognize good care from bad.”

Sarah Lee (slee@heartland.org) is the managing editor of Health Care News.
Warren Bill Would Allow Government to Manufacture Generic Drugs

By Leo Pusateri

Sen. Elizabeth Warren (D-MA) has introduced the Affordable Drug Manufacturing Act, which would create the Office of Drug Manufacturing and allow the federal government to manufacture generic drugs in cases where drugs aren’t available, during price spikes, or when a drug is deemed essential by the World Health Organization.

Under the proposed legislation, drug patents could be sold to manufacturers as long as they are made available at a fair price.

In 2018, The Trump administration approved a record number of generic drugs and removed so-called “gag clauses” that prevented pharmacists from telling customers that cheaper generic drugs were available.

‘Government-Induced Price Pressure’

Edward Hudgins, research director for The Heartland Institute, which publishes Health Care News, notes Warren’s bill does nothing to address underlying reasons for high drug prices, many derived from regulation and other government-induced price pressures.

“Warren’s proposal for a government-manufacturing facility for genetic drugs to deal with the high costs of such products deliberately ignores the reasons some drug prices are so high,” Hudgins said. “Already in this country, 82 percent of prescribed drugs are unbranded generics, compared to only 21 percent on average in Europe. The problem is not a lack of generics. It is that we don’t have a free market in health care and health insurance but, rather, a confused and contradictory mess of government regulations produced by politicians like Warren wielding political power rather than customers wielding purchasing power using their own money. Warren and her kind are like doctors who break our legs and then charge inflated prices for weak and ineffective drugs treatments to ease the pain they’ve created.”

No Free-Market Forces

Hudgins says government programs such as Medicare and Medicaid artificially raise drug prices and medical service costs.

“Through Medicare and Medicaid, government already manipulates drug prices in ways to keep them high,” Hudgins said. “For example, some regulations pay doctors a larger fee if they prescribe higher-costs medications to patients when lower-cost alternatives are available. Most individuals must secure health insurance through their employers since, if they purchase it on the open market, they cannot deduct the prices they pay. Thus, for most medical-related services like doctor visits and goods, like medications, there is a third-party payer rather than a direct customer. Drug pricing, thus, is not controlled by customer demand but opaque fees, discounts, and kickbacks.”

Better Ways

Hudgins says if Warren sincerely desires to make lower-cost drugs available via generics, she should eliminate the government intervention within the health care sector that keeps costs artificially high.

“If Warren is interested in high costs, she should acknowledge that Obamacare, which she championed, led to insurance premium hikes of more than 100 percent and deductibles hikes of more than 212 percent,” Hudgins said. “There is zero chance that a government manufacturer could produce medications efficiently. Even in heavily-regulated European countries, private companies lead the way. The government can’t run Amtrak without losing billions of dollars. The U.S. government’s Veteran’s Administration is a national disgrace. In the 2000-2002 period, more than 300,000 veterans were on waiting lists of six months or longer to receive proper care. Many died while waiting. The idea that the same sort of government bureaucracy can efficiently produce quality medications is farcical, at best.”

Leo Pusateri (psychmeistr@fastmail.fm) writes from St. Cloud, Minnesota.
Direct Primary Care Group Seeks Tax Incentives

By Sarah Lee

The Doctors 4 Patients Care Foundation (D4PCF) sent a letter to the Internal Revenue Service (IRS) asking that the agency “recognize dues paid to direct primary care (DPC) practices as tax-free medical expenses reimbursable by employers,” according to a statement.

The letter follows a recent Trump administration rule proposal titled “Health Reimbursement Arrangements and Other Account-Based Group Health Plans” that would allow for two new types of health reimbursement arrangements (HRA).

The two new arrangements include HRAs integrated with individual health insurance coverage and standalone excepted-benefit HRAs up to $1,800.

The first, integrated HRA allows employers of any size to reimburse employees for the cost of premiums for individual health insurance under certain conditions. The second, standalone excepted-benefit HRA allow the employers who offer traditional group plans the ability to also offer an excepted benefit plan that could reimburse up to $1,800 for qualified contributions.

The letter from D4PCF asks the IRS to also consider payments made to direct primary care physicians as tax-free medical expenses that can also be reimbursed by employers.

The foundation filed its letter as part of comment on the proposed rule.

Consistent Interpretation

The letter makes the case that the proposed rule is a step in the right direction, but that recognizing DPC payments as also reimbursable is a necessary step in supporting the direct primary care movement, which seeks to establish better one-on-one relationships between doctors and patients.

“Such an interpretation would bring consistency to the Departments’ interpretation of DPCs and expand the availability of affordable and quality healthcare options to working Americans,” the letter says, referring to the push to qualify DPC payments as tax-free and reimbursable. “DPCs involve a fixed-fee arrangement between providers and consumers, where the patient pays a periodic fee in exchange for a defined number of visits as well as office-based procedures and treatments. It generally includes all office-based professional services for the prevention and management of disease, including associated in-office testing, procedures, related supplies and office-administered medications. It also typically includes technology visits via email, texting or video. Despite the fact that such services fit within the definition of ‘medical care’ expenses pursuant to Section 213(d) of the Code, there is uncertainty as to whether Health Reimbursement Arrangement (HRA) funds can be used to pay the monthly fee that individuals incur as part of a membership in a DCP.”

Clearing Confusion

Dr. Lee Gross, president of D4PCF, said in a statement upon filing the letter that direct primary care physicians have been hampered by a lack of attention to the health savings account issue, primarily that DPC membership is insurance and that dues paid should be considered a legitimate medical expense.

“Patients should be allowed to submit their monthly membership costs—which range from $40 to $150 per person—to their employers for tax-free reimbursement, if their employers offer health reimbursement accounts (HRAs),” Gross said in a statement. “The direct primary care community has spent many years frustrated by the lack of progress in fixing the HSA issue that has hamstrung the DPC movement for so long. D4PCF recognized an opportunity to advance this initiative through our multiple meetings with the executive branch, while also working through our legislative priorities. D4PCF engaged the Washington, D.C. law firm of Foley Hoag to draft a legal basis for allowing HRAs to be used for DPC memberships. This legal argument was submitted as a formal comment to the Departments of Health and Human Services, Treasury and Labor during the public comment period for the proposed rule for overhauling the use of HRAs across the country. We look forward to continuing to work with the Trump administration and Congress to expand access to this affordable care model for all Americans.”

Positive Fixes

Arianna Wilkerson, government relations coordinator at The Heartland Institute, which publishes Health Care News, says that any regulatory change that frees up the direct primary care movement and reduces the financial burden on patients should be considered.

“There appears to be little reason not to make these payments to direct primary care physicians tax-free,” Wilkerson said. “If the Trump administration is trying to move in a direction where the patient is less encumbered by a confusing insurance regulatory regime and are able to pay out-of-pocket how they choose, this would be a good step.”

Sarah Lee (see theheartland.org) is the managing editor for Heath Care News.

Internet Info

New Poll Shows Parties are Divided on Whether Health Care System Is ‘in Crisis’

By Sarah Lee

A new Gallup poll shows 70 percent of those surveyed believe the U.S. health care system is beset by significant problems, while 30 percent said they believe it has no problems or only minor problems.

The poll, released January 14, reveals a partisan gap when it comes to viewing the health care system as problematic, with those who identify with the Democratic Party more consistently rating the system as having major problems. The Gallup poll found 84 percent of Democrats indicated they believe the system is in crisis, an increase from 76 percent a year ago and 63 percent in 2016.

Republicans were more optimistic about the state of the health care system, with 56 percent saying it had major problems, a decrease from the 71 percent who reported the same a year ago and 80 percent in 2016.

“The difference between the two major parties on this measure was just five percentage points in 2017, Trump’s first year, when 76% of Democrats and 71% of Republicans said healthcare had major problems or was in crisis,” the poll’s news release said. “This expanded to a 28-point gap in 2018, when 84% of Democrats and 56% of Republicans expressed these views—the largest partisan gap on this measure in Gallup’s trend since 2001.”

‘Manufactured Crisis’

Robert Graboyes, senior research fellow at George Mason University’s Mercatus Center, says the U.S. health care system has problems but is not in crisis and the idea of a crisis has been manufactured.

“We have problems, but not a crisis,” Graboyes said. “For a half-century, medical science has churned out an astonishing array of drugs, devices, and procedures—many of which are startlingly expensive to produce. In dollar terms, the potential demand for useful medical services is virtually limitless, and no society on Earth has limitless resources. Hence, in each country, some people fall through the cracks—an American priced out of buying a service, a Canadian waiting months or years for treatment, a British citizen denied treatment by a cash-strapped NHS. America can do better—as can other countries. But sad individual anecdotes, gut-wrenching though they may be, do not constitute a systemic crisis.”

“Americans believe we are in a crisis because journalists and politicians of all stripes tell them around the clock that we are,” Graboyes said. “Both left and right sound alarms and peddle purported cures. One should view both the alarms and the cures with skepticism.”

‘Superb Care’

Graboyes says the U.S. health care situation is actually better than many other countries, and that it’s influenced not only by the efficiency of the sector, but by individual behaviors.

“While it’s easy to cherry pick examples to the contrary, Americans generally get superb care—and they get it in timelier fashion than most. Our health metrics lag in some areas, but those shortcomings stem mostly from factors outside the health care system—individual behavior, social factors, our unique genetic pool, the physical environment.”

ROBERT GRABOYES
SENIOR RESEARCH FELLOW
MERCATUS CENTER

“While it’s easy to cherry pick examples to the contrary, Americans generally get superb care—and they get it in timelier fashion than most,” Graboyes said. “Our health metrics lag in some areas, but those shortcomings stem mostly from factors outside the health care system—individual behavior, social factors, our unique genetic pool, the physical environment. Medical care is a surprisingly modest contributor to overall health. As for costs, Americans spend loads on health care, but again, mostly for reasons outside the health care system.”

More Innovation, Less Regulation

Graboyes says the link between emerging technologies in the health care sector and the cost of care is worth examining because it can provide information on which regulatory burdens should be lifted on innovation.

“Twenty-first century technologies offer the possibility of better health for more people at lower cost,” Graboyes said. “Unfortunately, the U.S. has spent a century or more hamstringing the ability of innovators to turn that possibility to reality. Our laws, regulations, and professional norms stifle the innovative process by protecting established producers from competition and by discouraging patients and providers from taking calculated risks. In some areas, policy is changing for the better—greater openness to telemedicine, for example. But it’s certainly not changing fast enough.”

No Crisis, But Fix Needed

Justin Haskins, research fellow and executive editor at The Heartland Institute, which publishes Health Care News, says the health care crisis narrative was used to pass Obamacare, but despite things not being as bad as people were led to believe, free-market policies can make things better.

“One of the best policy pushes the Trump administration has made has surrounded transforming the health care sector into one that embraces the free market, choice, and competition,” Haskins said. “It’s certainly true that the American people were misled into thinking the health care sector, from insurance to quality of care, was broken beyond repair so they would be more amenable to accepting government-controlled health care such as Obamacare. But that doesn’t mean there were areas that needed improvement, and that was even more apparent once Obamacare was declared unconstitutional by the Texas federal court in December 2018.”

Haskins says the free-market reforms the Trump administration has implemented are all good, timely policy changes.

“The problems tackled by the reforms embraced by the Trump administration pre-existed Obamacare,” Haskins said.

Sarah Lee (slee@heartland.org) is managing editor of Health Care News.
New York City Introduces Plan for Comprehensive Health Care for All

New York Mayor Bill de Blasio has introduced a plan to guarantee comprehensive health care to all residents regardless of their ability to pay or their immigration status. De Blasio says the plan will cover more than half a million New Yorkers currently using emergency room resources as their primary health care facility.

A spokesman for the mayor, Eric Phillips, said via Twitter that the plan is not health insurance but is a plan to provide care.

“This is the city paying for direct comprehensive care (not just ERs) for people who can’t afford it, or can’t get comprehensive Medicaid — including 300,000 undocumented New Yorkers,” Phillips tweeted.

De Blasio clarified the plan in a press conference on January 8, saying it would provide primary and specialty care, including pediatrics and OB/GYN, and mental health services, to the 600,000 New Yorkers currently without insurance. The new program will issue patients a card that gives them access to a primary care physician. Those unable to afford a physician will receive care for free and others will be billed on a sliding scale, the mayor said.

“The programs will include customer-friendly call lines to help New Yorkers — regardless of their insurance — make appointments with general practitioners, cardiologists, pediatricians, gynecologists and a full spectrum of health care services,” de Blasio’s office said in a release about the program.

The new program will launch in the Bronx in 2019 and will be available in New York’s other four boroughs by 2021.

According to a report from USA Today, half of the 600,000 New Yorkers currently uninsured are undocumented immigrants. The cost of the program is estimated at $100 million annually.

—Staff Reports

Prescription for Better Healthcare Choices

A Better Choice
Healthcare Solutions for America
John C. Goodman

“John Goodman understands the real life effects of the Affordable Care Act and the proposed alternatives. John also writes extremely well, making complicated concepts clear. All this makes A Better Choice a highly recommended read for those who wish to understand the current health policy debate.”

—Bill Cassidy, M.D., U.S. Senator

Polls show that by a large margin Americans remain opposed to Obamacare and seek to “repeal and replace” it. However, the question is: Replace it with what? In A Better Choice, John C. Goodman clearly and concisely provides the compelling answer. For anyone who wants to learn about some of the boldest prescriptions designed to remedy our healthcare system, Goodman’s book is a must-read.

Priceless
Curing the Healthcare Crisis
John C. Goodman

“There’s no question that today’s healthcare system is littered with distorted incentives and what John Goodman calls dysfunctionality. Priceless is a call to arms to do something about it. . . . You should read this book if you want to be an informed participant in the debate over the future of healthcare in this country.”

—Peter R. Orszag, former Director, Congressional Budget Office

Americans are trapped in a dysfunctional healthcare system fraught with perverse incentives that raise costs, reduce quality, and make care less accessible. Now Priceless cuts through the politics and proposes dozens of bold reforms to free patients and caregivers to be empowered to chart their own lives with low-cost, high-quality healthcare.
NH Latest State to Add Medicaid Work Requirements

By Leonard Robinson

New Hampshire will soon begin implementing work requirements for residents who receive Medicaid.

In November, the Centers for Medicare and Medicaid Services (CMS) approved New Hampshire’s request to add a work requirement for certain Medicaid recipients in the state. Arkansas, Indiana, and Kentucky have also been granted waivers by CMS to implement work requirements for Medicaid recipients.

In New Hampshire, Medicaid beneficiaries would be required to complete at least 100 hours of “community engagement” a month or risk losing their coverage.

New Hampshire Department of Health & Human Services Commissioner Jeffrey Meyers, whose department is tasked with enforcing the rule, is working to expand resources for enforcement. Meyers estimates that the rule could impact 15,000 to 20,000 New Hampshire residents, although he speculates that it would be much fewer after exemptions for volunteer work, drug treatment programs, and pregnancy are implemented.

The Benefits of Work

Arianna Wilkerson, government relations coordinator with The Heartland Institute, which publishes Health Care News, says the furor over requiring people to work, be looking for work, be engaged in the community through volunteerism, or be enrolled in school, in order to receive Medicaid is misplaced.

“It’s a matter of incentives,” Wilkerson said. “If people are going to be given government-subsidized health insurance through Medicaid, they should want to be looking ahead to a time when they won’t need that subsidy. Asking them to work or go to school as a trade-off for inexpensive health insurance keeps the incentive to better themselves through school or by finding a job that will offer them comprehensive health care at the forefront of their decision-making.”

Finalizing Plans

Meyers told New Hampshire Public Radio (NHPR) that his office is still finalizing the plan and will provide details through the state’s website as soon as they become available.

“We’re trying to publicize it as much as possible so that we can address the issue,” Meyers told NHPR. “So that we can answer people’s questions, we can educate them as to what the requirement is, what all the qualifying activities are, what the exemptions are, how they can file for exemptions, how they can document their hours and report them to us, without it being burdensome to them.”

Leonard Robinson (robinsoniiileonard@gmail.com) writes from Washington, DC.

New White House Report Seeks Health Care Choice and Competition

By Jake Grant


The report—a collaboration between the Departments of Health and Human Services, Labor, and Treasury—focuses on state-based reforms that will lower health care costs and increase quality. Among the reforms mentioned in the report, the administration cites repealing “certificate of need” (CON) laws as a major step to increase health care competition.

Nanny State

Matthew Glans, senior policy analyst with The Heartland Institute, which publishes Health Care News, says CON laws force health care providers to acquire permission from state boards to expand and build new facilities. Glans says this raises the cost of health care services and leads to monopolies by providers.

“CON laws are regulatory overreach that prevents competition in the health care marketplace,” Glans said. “Less competition means higher prices for patients. CON laws also exacerbate the problem of access to health care because they push physicians who might want to enter a market out of contention.”

Nanny No More

The White House report shows that CON laws harm consumers because they lead to higher health care prices and fewer choices. The report introduces dozens of policy proposals—including repealing CON laws—that would reduce the skyrocketing cost of health care.

According to the report, fifteen states have abolished CON laws altogether, while some are being scaled back. Others will be sunset over time.

In a statement on the report, White House officials described the portion dealing with CON laws as an attempt to reintroduce competition and choice back into the health care sector.

“This report makes several recommendations to promote choice and competition in provider markets, including state action to repeal or scale back Certificate of Need laws,” according to a Trump administration official. “Encouraging the development of value-based payment models that offer flexibility and risk-based incentives for providers, especially without unduly burdening small or rural practices.”

Jake Grant (jakeg42294@gmail.com) writes from Alexandria, Virginia.

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Virginia Seeks Comments on Medicaid Work Requirements

By Ashley Bateman

Virginia is considering implementing work requirements on Medicaid recipients after applying for a waiver from the Centers for Medicare and Medicaid Services (CMS) and opening the waiver for public comment while it awaits approval.

Earlier this year, Virginia expanded its Medicaid program with the caveat of implementing work requirements.

Taking Advantage of ACA

Charlie Katebi, a state government relations manager with The Heartland Institute, which publishes Health Care News, says states are taking advantage of the provision of the Affordable Care Act (ACA) that grants waivers for work requirements.

"Eighty hours a month is pretty much the standard that states have been requesting from the administration for work requirements," Katebi said. "Kentucky was the first, New Hampshire was the latest one granted. The ACA says when a state, whether through a governor’s decision, or the legislature wants to expand Medicaid, that option will be there for them under law."

Avoiding Kentucky's Mistake

Katebi says Virginia is wise to work closely with federal health officials to ensure a successful implementation is made.

"When a state applies for these work requirements it sends a full application about the details of the work requirements and especially how these work requirements fulfill the goals of the Medicaid program," Katebi said.

When Kentucky submitted a Medicaid work requirements application, the administration approved it, but "a judge stepped in and said there was very little discussion on how these requirements fulfilled the role of Medicaid, which is, people can receive improved health care access and improved health outcomes. The judge initially struck down the first iteration of these work requirements because Kentucky didn’t make a good enough case," Katebi said.

Work Requirements Work

This month, The Buckeye Institute’s Economic Research Center published a new report, "Healthy and Working: Benefits of Work Requirements for Medicaid Recipients," which shows that work requirements are a net benefit for Medicaid enrollees.

The report finds that work requirements are, "A means to economic prosperity," finding both women’s and men’s earnings over the course of their careers likely increased by $312,000 and $323,000, respectively, if remaining on Medicaid with work requirements.

"Buckeye’s new study looks at lifetime earning gains to Medicaid recipients who increase their hours of work to comply with work and community engagement waivers. Work requirements provide needed incentives to work toward economic prosperity, which can lead to better jobs and better quality private insurance for many Medicaid enrollees."

"Work and community engagement requirements can keep healthy, single Medicaid recipients connected to an ever-changing labor market, allowing them opportunities for skill and career development, oriented toward achieving economic prosperity," said Andrew Kidd, an economist at The Buckeye Institute.

"If the work requirements succeed, once they make enough money to move off the program, they start collecting employer-based insurance which is far better than Medicaid coverage," Katebi said.

HHS Secretary Alex Azar Calls for Expansion of Health Savings Accounts

By Ashley Bateman

Department of Health and Human Services (HHS) Secretary Alex Azar requested President Trump consider rule changes that would allow Americans to more fully utilize Health Savings Accounts (HSA).

The HHS report recommended policy changes such as incentivizing employers to offer plans with higher deductibles and copayments, increased contribution maximums, allowing Americans who choose fixed-rate consumer-driven care providers to contribute to HSAs, and allowing contributions by those in Medicare Advantage Plans.

Although free-market groups called for a Medicare opt-out option for Americans decades ago, HSAs are making headlines as an alternative solution.

No More Medicare

Under President George W. Bush, Congress passed the Medicare Modernization Act, a massive expansion including Medicare Advantage plans and prescription drug plans, says Rob Klein, a retirement health care advisor with INERTIA/Advisor Services Group.

“No one reads the fine print,” Klein said. “Congress knew what they were doing, and not in a good way. They didn’t just base it on income, but modified adjusted gross income; all of that is considered income, taxable, so you’re going to pay more for Medicare.”

“The general public doesn’t know about this and financial advisors don’t either,” Klein said. “They don’t realize they’ve been giving people advice for decades that will cause their retirement to go up, leading to higher taxes and less income.”

Combining Plans

Klein says HSAs function like a modern 401(k) savings account.

“The HSA is a modern 401(k) because it’s an above-the-line deduction,” Klein said. “HSAs are a great tool. President Trump has two fantastic people in his administration in Secretary Azar and Centers for Medicare and Medicaid Services head Seema Verma; those two are fantastic. And because our president is an insider and has his own money and doesn’t need lobbyists’ money, he’s trying to force drug prices down, along with the help of Verma and Azar.”

As a practicing medical doctor, McElroy does see patients on Medicare.

“It’s illegal for me to take cash payments from a patient unless Medicare has been billed first,” McElroy said. “The government restricts their access to me and my access to them. It’s a complete fiasco.”

A ‘Distorted Market’

Tommy McElroy, a sports and family medicine physician who practices concierge medicine in Florida, says HSAs are very useful as a supplement to Medicare, but believes they should be on par with other options outside of the Medicare system.

“My feeling on the subject is HSAs are more useful for Medicare,” McElroy said. “They’re a good idea, but outside of Medicare I think they should run parallel to another delivery system. In the majority of Medicare practices, you’re going to be taken to the cleaners using an HSA card.”

“Medicare necessarily price distorts the market,” McElroy continued. “You can have HSAs, that would be great; they’re still going to be playing in a distorted market. They may lead a little bit to more free-market price orientation but in reality, as long as Medicare is still dictating through their program what the majority of older Americans spend on health care, [cost] is always going to be inflated so HSAs are going to be chasing a price that is not true.”

Medicare Is the Problem

McElroy says the problem is Medicare and politicians are simply not bold enough to vocalize that fact.

“There’s no constitutional reason for Medicare or Social Security,” McEl-
BOOK REVIEW

Author Offers Revolutionary New Approach to Drug Approval Process

By Jack Reardon

Technology is rapidly changing how we produce and consume resources and how we provision. No longer is the world neatly divided into consumer and producer, buyer and seller, markets and commons; but each is morphing into something quite different, requiring a new lens and a new vision to understand our changing world.

This new modus operandi is already emerging in energy, education, and medicine, giving us fruitful pause (but certainly not long-lasting) to reconceptualize the firm, the industry, the role of the government, and how we adequately provision for all.

Enter Bart Madden’s wonderfully pithy, cogent, thoughtful, and revolutionary book.

Excuse the excessive modifiers, but each necessarily describes this must-read book, which is rich in depth, cogent in analysis, yet only 89 pages (including 11 pages of notes and references) in length. Madden, a former financial entrepreneur turned independent (and pluralist) thinker, is passionate to make the world a better place. He draws from a broad background of economics, finance, management, and psychology; and writes with an easy flair, every word efficiently utilized, easily accessible to the novice, yet resonating to the specialist.

Simple and Revolutionary

His thesis is narrowly simple, but pregnant with revolutionary overtones: Technology is changing how we practice medicine, disrupting and toppling traditional monopolies while bringing doctor and patient closer together in a nexus of decentralized decision-making.

The U.S. Food and Drug Administration (FDA), however, is stuck in an earlier mindset, excessively and myopically focused on the risk of adverse publicity while ignoring the invisible graveyard of people silently suffering without access to lifesaving drugs. If we as a society demand effective drugs, quickly, timely, and at lower cost, why does a new drug take 12 years for FDA testing and approval at an average cost of $2.5 billion dollars? Should not we be outraged? Absolutely, argues Madden.

Pinpointing the Problems

The book is divided into six chapters. The first two introduce us to the invisible graveyard and to systems thinking (which, by the way, is intrinsically pluralist), allowing us to see the big picture while pinpointing problems and bottlenecks.

The preponderant bottleneck preventing our society from producing drugs quickly and cheaply is the FDA, with its unnecessarily long testing process and its excessive focus on attenuating potential negative publicity while neglecting the urgency to get cheaper drugs to those who need them most.

Madden has done his homework, peppering his text with numerous quotes from doctors, professors, and former and current FDA officials, letting the actors speak for themselves. He is not proposing the abolition of the FDA, only its demise as a monopoly. He proposes an alternative, secondary track in which patients and their doctors can obtain a drug in half the time (and at half the cost). Madden explains the nuts and bolts of Free to Choose (FTC) in the book’s second two chapters, and specifically:

“The way to solve the FDA bottleneck is to preserve the current conventional track for new drug approval which includes sequentially phased clinical trials, [and] create a second new track, called Free to Choose, that patients and their doctors could use to access a drug that has successfully passed both Phase I safety trials and one or more Phase II efficacy trials. Instead of the current one-size fits-all regulatory straightjacket that assumes everyone is equally risk-averse, patients could express their own unique preferences for risk versus the opportunity for health improvement” (pp. 44–45).

Bypassing RCT

The FTC bypasses the randomized control trial (RCT), which perhaps more than any other factor has significantly increased the time for bringing a new drug to market by 40 percent since the mid-1960s. Wait a second, you might ask, is not the clinical trial the bedrock of science, in which we select volunteers who, not knowingly, are either given the drug itself or a placebo? And is not the RCT the only way to protect the health of future users, who might otherwise suffer a calamity? How does science progress if not by the RCT?

The RCT itself, argues Madden, has several ethical problems, or dilemmas, if you will. The unnecessarily long testing process ignores the demands

“His thesis is narrowly simple, but pregnant with revolutionary overtones: Technology is changing how we practice medicine, disrupting and toppling traditional monopolies while bringing doctor and patient closer together in a nexus of decentralized decision-making.”

of the living who could immediately benefit. Why should a segmented sample receive a placebo when they could knowingly have received the drug itself? In order to randomize, the FTC homogenizes the sample of patients receiving the new drug, ignoring groups at the fringe, the very population that needs access.

**Confronting Ethical Problems**

But no matter the system used to distribute drugs to the public, ethical decisions abound, and Madden’s book puts them squarely on the table.

The FTC will reduce escalating health care costs. At just 3 percent of GDP in 1965 (just prior to passage of Medicaid and Medicare), health care costs will approximate 19 percent of GDP—the highest of any nation—by 2026, according to *Health Affairs* (“National health expenditure projections, 2017–2026: despite uncertainty, fundamentals primarily drive spending growth,” March 2018). Madden’s FTC can reduce health care costs by reducing the cost of drugs and the length of hospitalization.

Another FTC benefit is the rapid development of a national database on which drugs work and which drugs do not, exhibiting economies of scale as more people use the information.

**Empowering Patients and Doctors**

But like the provision of big data elsewhere, democratic institutions need to be established to guarantee that the data is readily available for all and does not become monopolized. Is it ethical to offer drugs to ready and eager patients? Are they being exploited? Are they guinea pigs, sacrificed for the future benefit? No: Denying all patients access. Are they receiving a placebo when they could benefit. Why should a segmented sample receive a placebo when they could knowingly have received the drug itself? In order to randomize, the FTC homogenizes the sample of patients receiving the new drug, ignoring groups at the fringe, the very population that needs access.

The penultimate chapter recognizes the myriad obstacles intrinsic to a steadfast bureaucracy set in its ways; after delineating them, Madden proffers effective solutions. The last chapter is a call to action. This is a book about empowerment and democracy. Madden ends with the clarion call to the reader, ‘it really is in your hands.’”
Medicare will begin requiring hospitals to post prices online, as well as making electronic records more available to patients. The program will grade hospitals on how well they comply, which will become part of the formula used to determine reimbursement rates.

The new requirements, which begin January 1, 2019, aim to create more pricing transparency and competition. The motivation, according to Seema Verma, administrator of the Centers for Medicare and Medicaid Services (CMS), is to empower patients in their health care purchasing choices.

There is a debate among free-market analysts about the usefulness of publishing prices online, with some sold on the idea that more transparency of costs will produce incentives that encourage people to price shop, creating competition and lower costs.

Other scholars believe too much focus is being put on price transparency and more interest should be paid to other efforts already being undertaken by the Trump administration to reform Medicare.

“Price transparency is great in concept,” Benedict Ippolito, a research fellow in economic policy studies at the American Enterprise Institute, expressed skepticism that this move would help drive down health care costs in the long run and says the Trump administration should focus on other concepts to help control costs by reforming Medicare.

“Price transparency is great in concept,” Ippolito said. “But this is a rare case where it is likely to have little value. Price transparency benefits consumers when it provides relevant information that can inform choices. Unfortunately, hospital list prices are neither relevant, nor useful, for the majority of patients. Most consumers pay much lower rates that have been negotiated or set by their insurer. List prices provide little information about what a typical patient will end up owing — as such, they are effectively impossible to use for shopping around.”

“Frankly,” said Ippolito, “they could cause more confusion than anything. This is unlikely to lower what typical patients pay.”

Ippolito says there are other ways Medicare can control costs.

“The administration should continue to push in other areas where they have made progress,” Ippolito said. “For example, working to establish more ‘site-neutral’ payments by Medicare. Or changing payment models to reduce the incentive for physicians to prescribe more expensive medication. These kinds of changes are all working to incrementally lower program costs.”

Jeff Reynolds (jefferyreynolds@comcast.net) writes from Portland, Oregon.
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