Trump Administration Outlines Extensive Health Care Deregulation Agenda

By Sarah Lee

The U.S. Departments of Health and Human Services, Treasury, and Labor released a 114-page report detailing an agenda for health care deregulation meant to reduce prices and increase quality and access.

“One of the most important mechanisms available to enhance the value Americans receive for their health-care spending is increased competition,” states the report released on December 3. “Market competition should encourage healthcare providers to charge lower prices and provide higher-quality services. Although the traditional view among economists is that government should step in to correct so-called market failures, this report finds many cases where government regulation

Deregulation, p. 8

Land O’Lakes Is First to Offer Multistate AHP

By Chris Talgo

Land O’Lakes, a member-owned dairy industry cooperative based in Arden Hills, Minnesota, announced it will be the first company in the United States to launch a multistate group association health plan (AHP) under new rules put into place by the Trump administration in 2018.

The company’s multistate association health insurance plans were made possible by regulatory changes enacted by the administration of President Donald Trump earlier in 2018. “Land O’Lakes, Inc. is the first organization to sponsor a self-insured

Association Health Plans, p. 6

Medicare Opt-Out
Forty leaders of conservative organizations have sent President Donald Trump a letter asking him to revoke what they characterize as an unfair and illegal Medicare rule imposed by a previous administration.

Drug Price Controls

Maryland Individual Mandate
Lawmakers are considering making Maryland the fourth state to impose a state individual mandate that would penalize residents for being uninsured.

Obamacare Enrollment Drops
During the 2019 Obamacare open-enrollment period, between 400,000 and 500,000 fewer Americans enrolled in a health insurance plan via the federal health insurance exchange compared to a year ago.
Your Promise:
Work for the good of your patients.
Treat your patients according to the best of your ability and judgment.
Do no harm.

Your oath, your solemn obligation to your patients, is under constant assault by the government. Antiquated FDA rules prohibit you from using promising new drugs to treat your terminally and seriously ill patients.

There is a way to fight back. Free to Choose Medicine is a groundbreaking plan to reform the FDA and speed cures and therapies to patients.

It is time to re-empower physicians, protect patients and take government out of the doctor-patient relationship.

For more information on Free to Choose Medicine, go to freedochoosemedicine.com, where you can also order a copy of the third edition of Bartley Madden’s book, Free to Choose Medicine.

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Alaska Considers CON Law Repeal

By Cory Compton

Alaska lawmakers are expected to reintroduce a measure to repeal the state’s certificate of need (CON) laws, which limit the services health care providers can offer.

In 2017, Alaska state Sen. David Wilson (R-Wasilla) introduced a bill to repeal the state’s CON laws, which prevent health care providers from offering new services and facilities unless the government deems them necessary. The bill failed to pass, and its sponsors reportedly plan to revive it in the 2019 legislative session.

Alaska is one of 35 states with CON laws, which lead to higher health care costs, restrain innovation, and reduce access to care by imposing limits on the services individual providers can offer. CON laws can create premature deaths by limiting access to medical equipment and services that diagnose and treat illnesses.

‘Particularly Disruptive’ Laws

Thomas Stratmann, an economics professor for George Mason University and a senior research fellow at the Mercatus Center, testified in favor of the 2017 bill before the Alaska Senate’s Labor and Commerce Committee.

Alaska’s geographical isolation makes its CON laws particularly damaging, Stratmann said in his testimony.

“In the lower 48, patients can travel across state borders to access medical services not provided in their states,” Stratmann told the legislators. “For most Alaskans, such travel is cost-prohibitive, and they have to live with the harmful effects of CON.”

If Alaska did not have CON laws, the state would have 30 percent more hospitals overall, nearly 50 percent more rural hospitals, almost 50 percent more ambulatory surgical centers, one-third more MRI scans, and 30 percent more CT scans, Stratmann said during his testimony.

“Comparing states with CON laws versus those with no CON laws shows that states with CON laws have lower quality of service, as measured by their hospital mortality rates and hospital readmission rates,” Stratmann testified.

CON Costs

In addition to decreasing access to health care services, CON laws have driven up the average cost of health care by forcing providers to operate in outdated facilities with obsolete equipment. Nationwide, health care costs are 11 percent higher in states with CON laws, according to data compiled by the Kaiser Family Foundation. In fact, states requiring CON on 10 or more services averaged 8 percent higher health care costs per capita than those requiring CON for fewer than 10 services, the Kaiser study found.

Repeal of Alaska’s CON laws could reduce the average price of health care per consumer in the state by $294 per year, the Mercatus Center reported in 2017.

Stifling Competition

Matthew Glans, a senior policy analyst for The Heartland Institute, which publishes Health Care News, says CON laws are particularly harmful to low-income and geographically isolated people.

“CON laws can keep an enterprising physician who may have the desire to open a clinic to serve an underserved population from fulfilling that dream,” Glans said. “If they know this arbitrary regulation exists that will keep them tied up in red tape simply for trying to serve patients, they are likely to scrap the idea of striking out on their own. That means those underserved areas miss out on a chance for better, geographically closer health care services.”

‘More Choice,’ ‘Higher Quality’
The U.S. Federal Trade Commission and the Department of Justice’s Antitrust Division recommended Alaska repeal its CON laws during discussion of the bill in 2017. The Trump administration’s December 2018 report on “Reforming America’s Healthcare System Through Choice and Competition” calls for policies to encourage states to rid themselves of CON laws. (See story on page 1).

Repealing those laws would be the right choice for Alaska, Stratmann says.

“Removing certificate of need requirements to provide health care services in Alaska will benefit Alaskans because they will have more choice and experience higher-quality medical services,” Stratmann said.

Cory Compton (thecomptonjr@gmail.com) writes from Cheboygan, Michigan.
A plan by Minnesota-based Land O’Lakes, Inc. to begin selling association health insurance plans (AHP) across state lines in Nebraska (see story on page 1) meets the state insurance standards required to begin offering the plans, Nebraska Department of Insurance Director Bruce Ramge says.

President Donald Trump reduced AHP regulations in June 2018, making it easier for small businesses and other groups to offer health care plans to their members. AHPs are more affordable than the insurance plans made available through federal and state exchanges under the Affordable Care Act (ACA), because they allow AHP administrators to offer more options for their members and because these plans offer people to seek coverage as part of a larger group, rather than as individuals.

Under the new rule established by the Trump administration, AHPs can now be sold across state lines to members of the groups offering the plans.

**Worked with Regulators** Land O’Lakes made sure to design its plans in compliance with Nebraska’s state insurance standards and laws, which differ from the laws in Minnesota, where the company is located, Ramge says.

“If Land O’Lakes is in good standing with us,” Ramge said. “They’ve done everything they needed to do to make sure they’re certified to offer these plans in Nebraska under the rule set out by the Trump administration.”

The AHP plans offered by Land O’Lakes are far more affordable than plans offering similar coverage on the Obamacare exchange, and the Nebraska Department of Insurance is in favor of their sale, Ramge says.

“Land O’Lakes’ plans are running 25 to 30 percent lower than comparable plans on the exchange,” Ramge said. “We in this office are always in favor of making available other options to people looking for lower-cost insurance options.”

**More Affordable Care** Land O’Lakes, a farmer-owned cooperative, is one of the first companies to take advantage of the Trump administration’s relaxation of restrictions on AHPs. Pamela Grove, senior director of benefits for Minnesota-based BuyPoint Insurance Solutions, the Land O’Lakes subsidiary offering the new AHP plan, says the two-state market area increases the affordability of the plans, as roughly 44,000 farmers will be eligible to apply for the insurance coverage in Minnesota and Nebraska, giving them an important new option.

“If there’s only one option out there for them right now, and it isn’t feasible, then this becomes their viable option,” Grove said. “And I like competition. It drives us to ensure that we continue to offer good coverage at affordable prices and offer good customer services and some tools and education for those employees, because a lot of them are not health care-savvy. They are looking for people they can trust, and luckily they trust Land O’Lakes.”

**Consumer Power** In several states, including Nebraska, Obamacare exchange insurance is unaffordable and providers are sparse, says Chris Condeluci, a health care policy consultant and attorney who worked with Land O’Lakes on its plan. Unfortunately, opponents of AHPs have managed to convince some people the plans offered under the new rule will be less robust than Obamacare plans, Condeluci says.

“Critics have done a very good job of messaging that association health plans are going to offer skimpy coverage, but the facts to date do not corroborate that claim. These are member-based organizations, and if they offer skimpy coverage, their members are going to leave and they’re certainly not going to attract new members.”

**Another Really Good Choice** Ramge says the Land O’Lakes AHP “will offer another really good choice for individuals who either don’t receive a subsidy and cannot afford coverage on the exchange or for some reason prefer not to purchase that coverage.”

The State of Nebraska “bent over backwards to help us get [the plan] out and approved as soon as possible,” Grove said.

Land O’Lakes is offering eight AHP plans in Nebraska: one Platinum Plan, one Gold Plan, three Silver Plans, and three Bronze Plans. They feature a range of deductibles and provide coverage for each category of health benefits deemed “essential” under the ACA, including prescription drugs, maternity care, mental health, and substance-abuse treatment.
Drug Price Controls Proposed in Congress

By Leo Pusateri

Sen. Bernie Sanders (I-VT) and Rep. Ro Khanna (D-CA) have introduced legislation to impose price controls on the pharmaceutical market.

The Prescription Drug Price Relief Act would require the Secretary of Health and Human Services to compare domestic drug prices to the median price in the United States.

The bill, proposed on November 20, would remove market exclusivity from drugmakers granted by the U.S. Food and Drug Administration when a drug is approved for use.

‘Unnecessary and Counterproductive’

Matthew Glans, a senior policy analyst at The Heartland Institute, which publishes Health Care News, says price controls suppress innovation.

“Placing price caps on prescription drugs is unnecessary and counterproductive,” Glans said. “In a 2016 study, Citizens Against Government Waste found price controls would be ineffective at reducing prescription drug costs and harmful to long-term research and development. The report concluded price controls would do enormous damage all around the world.”

Markup in the Middle

The Sanders plan does nothing to address the costly process of adding drugs to health care plan formularies, as “middlemen” often add a significant markup to prices paid by consumers directly or through increased insurance premiums, Glans says.

“Supporters of price controls also ignore the fact that middlemen such as pharmacy benefit managers, not just drug companies, determine the cost of drugs,” Glans said. “These PBMs negotiate which drugs will be added to their formulary and receive substantial rebates and discounts from drug manufacturers, and they then sell the drugs to consumers at their own listed price.”

Federal Briar Patch

Although pharmaceutical companies make for convenient political scapegoats, such complaints distract from the need to prune the costly government regulatory briar patch drug companies must navigate in bringing new drugs to market, Glans says.

“Blaming drug companies for high drug costs is easy,” Glans said. “It provides an unsympathetic villain for angry patients while moving attention away from the real culprit: government regulations. The high cost of regulatory compliance and the threat of lawsuits have created a disincentive to develop new drugs. Having the government threaten to take away patent protection will further stifle the creation of new, innovative drugs. Affordable drug prices won’t matter much if pharmaceutical companies stop producing new products.

“New and innovative prescription drugs have made a profound impact on the lives of millions, curing illnesses and lengthening and improving quality of life,” Glans said. “These advancements were made not through any government mandate but through the free market.”

Coercion vs. Competition

Edward Hudgins, research director at The Heartland Institute, contrasts Sanders’ plan with the approach the Trump administration has taken.

“Both President Donald Trump and Sen. Bernie Sanders have offered plans to reduce the costs of drugs,” Hudgins said. “The president’s ‘American Patients First’ blueprint was released in May 2018, and his efforts to deal with high drug prices have been a work in progress. Unlike Sanders’ plan, the president claims the best way to deal with high prices is ‘improved competition’ rather than more government planning, the preferred avenue for the socialist Sanders.

“Although the president’s plan attempts a more free-market approach, the reality is that the president faces a situation in this country where drug pricing is already a tangled mess of government regulations mixed with private-sector suppliers and insurance companies,” Hudgins said. “Price controls on drugs mandated from a federal level will never work as well as simply allowing the free market to price drugs through supply and demand. The best thing any plan to lower drug costs can do is get government completely out of the way.”

Different Endgames

The big difference between the two plans is their endgames, says Hudgins, with Sanders aiming to socialize health care and Trump trying to increase access to drugs within a framework of market competition. Hudgins expects dire outcomes should Sanders win the day.

“Perhaps the most striking difference between the Sanders and Trump approaches to drug pricing is seen in their endgame visions,” Hudgins said. “Trump generally favors more patient choice and competition, even if the particulars of some of his proposals are open to question from a pro-market standpoint. Sanders is a strong advocate of single-provider socialism. That approach has run into serious problems in the countries under such systems. Closer to home, the horrors exposed in recent years in the Veterans Administration, a single-provider system that does a grave disservice to those who have served and in so many cases have put their lives on the line for their country, show the problems with Sanders’ approach. Sadly, many people put their lives on the line again when they have no choice but to seek medical care through the VA. Many who survived the battlefield have not survived VA hospital bureaucrats.

“Sanders’ single-provider approach would put us all at risk,” Hudgins said. “Maybe we would get a diminishing number of drugs at less cost, or even for ‘free,’ but the prices would be cold comfort because our overall health care will suffer.”

Leo Pusateri (psycmeistr@fastmail.fm) writes from St. Cloud, Minnesota.
Land O’Lakes Is First to Offer Multistate Association Health Plans

Continued from Page 1

multistate group health plan under new Association Health Plan (AHP) regulations that were issued this past summer,” a press release issued by the company in November states. “This self-insured arrangement now offers coverage to farmers of participating co-ops and individual dairy farmers within the Land O’Lakes network in Minnesota and now, Nebraska.”

Rules ‘Level the Playing Field’
The new rules governing AHPs reverse Obama-era regulations that favored large companies, says Jordan Roberts, a health care policy analyst at the John Locke Foundation.

“The Affordable Care Act gave large businesses an unfair regulatory advantage at the expense of small businesses,” Roberts said. “Large-group plans are exempt from many of the requirements that are placed on small-group and individual plans. The new rule will level the playing field to allow small businesses and self-employed owners the advantages that come from banding together in a large group to spread risk.”

Allowing groups to offer health care plans tailored to the unique needs of their members will help decrease health insurance costs, says Roberts.

“When small businesses and individuals can band together and receive the same regulatory treatment as large-employer groups, they have the freedom to offer their members coverage that better aligns with their needs, making the coverage much more affordable,” Roberts said.

‘AHPs Are Excellent’
AHPs can transform the health care landscape, says Justin Haskins, a research fellow at The Heartland Institute, which publishes Health Care News.

“Association health plans have the potential to be the most important health insurance innovation in decades, but only if the government gets out of the way and lets private associations offer these types of health care plans,” Haskins said. “AHPs are excellent because they allow groups of people who might otherwise have to buy health insurance as individuals purchase plans as part of much larger groups. Groups have a lot more power when negotiating prices with health insurers, and the larger the group, the more negotiating power the group has.”

Praises Trump’s Moves
The Trump administration has rolled back many of the regulations put in place by the Affordable Care Act (ACA) that limited people’s options to purchase affordable health care coverage, Roberts says.

“The Trump administration has taken meaningful steps to increase choices for Americans when it comes to how they get their health care coverage,” Roberts said. “The Affordable Care Act has failed in many ways to provide affordable health coverage for people, and they want relief. Expanding access to association health plans is an easy way to increase the choices and decrease costs for Americans struggling to buy health care coverage.”

Sees Revolutionary Potential
Haskins says the Trump administration and Congress can do even more to provide Americans with better options.

“The Trump administration’s rule change allowing small businesses to group together to form AHPs was a tremendous first step toward improving health insurance,” Haskins said. “But if Congress were to extend this right to all associations, then groups like the National Rifle Association, AAA, and even local churches and community organizations could offer health insurance for their members, too.”

Expanding the breadth of AHPs would increase the size of risk pools available and drive down costs for all members, Haskins says.

“Can you imagine how much power an association with millions of people would have when negotiating premiums and deductibles?” Haskins said. “It would revolutionize the U.S. health insurance system. And even more importantly, associations offering AHPs are required to offer health insurance at the same rate for all members, regardless of preexisting conditions, helping those people gain access to more affordable health coverage.”

Cites Service Experience
These associations have a long history of providing services to their members in an efficient way Haskins says.

“Most of the associations that would offer these plans directly to their members have been established for years and provide many other services to their members,” Haskins said. “Adding health benefits to the list of services shouldn’t pose a problem for these organizations.”

Haskins says granting AHPs greater flexibility does not necessarily mean the plans will fail to offer comprehensive coverage.

“The Land O’Lakes plans are not going to provide ‘skimpy coverage,’ as some on the Left have feared,” Haskins said. “They will provide plans that offer all the essential health benefits that the ACA mandates, and they won’t reject people with preexisting conditions.”

More to Come?
Haskins says the Land O’Lakes announcement will likely be followed by more groups offering similar plans.

“It’s great that Land O’Lakes is leading the way in offering association health plans to its members,” Haskins said. “I applaud the company for providing the necessary protections for those who need it most, and I expect many more business associations will soon follow in Land O’Lakes’ footsteps.”

Chris Talgo (ctalgo@heartland.org) is an assistant editor at The Heartland Institute.
Forty organizations have sent President Donald Trump a letter asking him to revoke what they characterize as an unfair and illegal Medicare rule previously imposed by executive fiat.

In 1993 and again in 2002, the Social Security Administration (SSA) and the U.S. Department of Health and Human Services (HHS) made Medicare Part A enrollment a requirement for eligibility for Social Security benefits, resulting in a drastic loss of Social Security income for those who choose to opt out of Medicare.

The U.S. Constitution grants exclusive legislative power to Congress, which means SSA and HHS did not have the authority to impose the eligibility rule, the letter states.

The Citizens’ Council for Health Freedom (CCHF) published the letter in November.

“Your Authority”
The letter calls on Trump to restore the voluntary nature of Medicare.

“We write to you with a very specific request: to rescind, by executive action, the current administrative procedures that unlawfully condition seniors’ access to Social Security retirement benefits on Medicare enrollment,” wrote Twila Brase, the president of CCHF. “These procedures effectively trap seniors in Medicare, but you have the authority to liberate them. Congress has made clear, in the statutory text, its understanding and intention that the program is voluntary. But current administrative procedures effectively defeat this intention.”

Arianna Wilkerson, a government relations coordinator with The Heartland Institute, which publishes Health Care News, says the coalition is right in asking the president to revoke the rule.

“This letter sends the message that the country has had enough of being forced by the federal government to buy into health care programs that some do not want to be enrolled in,” Wilkerson said. “Giving seniors the option to choose a different insurance plan is the right move.”

Considers Origins Dubious
Brase says the current rules for Medicare are unique.

“In many other entitlement programs, such as Medicaid, even if you’re entitled to it, even if you qualify for it, even if your income is a qualifying factor, you are not required to take it,” Brase said. “My guess is [the rule is] part of something the Clintons wanted as part of their universal health care system. It would solidify the program’s grasp on the seniors in ‘Medicare for All.’”

Brase says the mandate has no basis in the law.

“In this case, the language states that you have to take Medicare if you want to get your Social Security benefits,” Brase said. “But there is no law, no rule mandating that. There are people who have private health insurance that they would like to keep as their insurance, but in order to get their lawful Social Security benefits, which were taken from them all of their working lives, they have to go into Medicare.

“They don’t want to be dependent on Congress for what is and isn’t covered and what is or isn’t paid for, but if they decide not to use Medicare, they have to pay back all Social Security benefits,” Brase said.

“The President to Do This’
Brase says the letter is a formal document following conversations the coalition has been having with the Trump administration.

“We have been in conversations with the Trump administration, trying to move the president toward removing this language,” Brase said. “It’s as simple as removing it. It’s not a law or rule. He can tell his administration to issue an executive order.

“I believe that President Trump is the president to do this,” Brase said. “I don’t know who the next president will be, but it’s hard for me to imagine any other president willing to strip it out of there just because it’s the right thing to do,” Brase said.

Ashley Bateman (bateman.ae@goolemail.com) writes from Alexandria, Virginia.
The Trump administration has already implemented several policy reforms to increase choice and competition in the health care marketplace. These include making it easier for consumers to buy short-term, limited-duration insurance plans and association health plans, both of which have been shown to be significantly more affordable than Obamacare exchange plans. The report, titled “Reforming America’s Healthcare System Through Choice and Competition,” outlines plans to build on this foundation.

The departments also consulted with the Federal Trade Commission and “several offices within the White House” in preparing the report, the study’s cover letter to President Donald Trump states.

‘Very Encouraging’ Agenda

The policy suggestions in the report include encouraging states to repeal certificate of need laws, which restrict market entry, and broadening scope-of-practice laws for clinicians such as physician assistants. Other proposed reforms include reimbursing providers for telehealth services, permitting interstate medical licensing, decreasing restrictions on physician-owned hospitals, and implementing site-neutral payment policies.

Justin Haskins, a research fellow for The Heartland Institute, which publishes Health Care News, says the new report is further proof the Trump administration is dedicated to freeing the health care marketplace from burdensome government regulations.

“All of the goals laid out in the report are necessary to inject life into our broken health care marketplace,” Haskins said. “Free markets control costs and increase quality better than a government program ever could.”

“This blueprint for competition is very encouraging,” Haskins said.

Sarah Lee (slee@heartland.org) is managing editor of Health Care News.

Twelve state attorneys general filed a lawsuit against several information technology companies and their subsidiaries, alleging poor business practices led directly to the theft of private health care data of 3.9 million people in a 2015 data breach.

The complaint, filed on December 3 in the U.S. District Court for the Northern District of Indiana, names four companies or their subsidiaries, including Fort Wayne, Indiana-based Medical Informatics Engineering and NoMoreClipboard, LLC. The 66-page filing states these companies did not take “adequate and reasonable measures” to ensure protection of patient data.

In the breach cited in the lawsuit, hackers stole and exposed the private health care data of 3.9 million individuals that was stored in the companies’ electronic medical record databases. The exposed information included patient names, addresses, and Social Security numbers, as well as health information, such as lab results, health insurance policy information, diagnoses, and medical conditions.

The lawsuit marks the first time state attorneys general jointly filed a multistate data breach case in federal court based on the federal Health Insurance Portability and Accountability Act. Attorneys general from Arizona, Arkansas, Florida, Indiana, Iowa, Kansas, Kentucky, Louisiana, Minnesota, Nebraska, North Carolina, and Wisconsin filed the suit.

— Staff reports
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Idaho Group Sues to Block State’s Medicaid Expansion

By Ashley Bateman

A
n Idaho think tank has filed a lawsuit asking the state’s Supreme Court to block a scheduled expansion of Medicaid.

The suit, brought by the Idaho Freedom Foundation, says the expansion—which was passed through a ballot initiative during the 2018 election—is unconstitutional and that the state would be required to expand the program without the legislature having appropriated any funding for it.

Contradiction of Federal Law?
Fred Birnbaum, vice president of the Idaho Freedom Foundation, says the language of the initiative is “legally dubious.”

“The ballot initiative language says a couple of major things that we believe are legally dubious and should be challenged in court,” Birnbaum said. “The sections of the [federal] Social Security Act are those that describe eligibility, and they could be changed by Congress, ... basically saying the state is going to raise the eligibility [while still] allowing the federal government to change the eligibility. ... So, if the federal government, through an act of Congress, changes that eligibility, then the state is on the hook, the way this ballot initiative is written. That’s one major issue.”

The second big flaw is the “unconstitutional” delegation of legislative authority to the Idaho Department of Health and Welfare, Birnbaum says.

“In another section of the ballot initiative, it says, ‘no later than 90 days ... the department is required and authorized to take all necessary actions,’” Birnbaum said. “By saying this, it requires and authorizes [the Idaho Department of Health and Welfare] to take all actions necessary to implement. There is no limitation.

“It doesn’t just say to initiate; it says to implement,” Birnbaum said. “Before there’s even money appropriated, the plan amendment could be written and implemented [regardless of whether the legislature funds it]. ... We believe that’s an unconstitutional delegation of legislative authority from that branch to the executive branch.”

Unexpectedly High Costs
In a July 2018 report on the potential impact of expansion, the Idaho Department of Health and Welfare determined the plan would initially cost the state $45 million per year. The state would pay 10 percent of the total costs of the expansion, with the federal government covering the other 90 percent, the report noted.

“More than 30 states have expanded [Medicaid],” Birnbaum said. “The cost, on average, has been more than double [what was] expected. We were concerned that expanding Medicaid to able-bodied people would have them competing for services with the truly needy, children, disabled, and those concerns have not gone away. We still have the financial concerns and crowd-out care for the truly needy.”

More Insurance, Less Care
Medicaid expansion reduces the availability of health care for those who really need it, says Dr. Deane Waldman, director of the Center for Health Care Policy at the Texas Public Policy Foundation.

“The experience from New Mexico proves what happens with expansion,” Waldman said. “Watch out, Idaho.”

In 2012, the Budget Oversight Committee of the New Mexico Legislature estimated the cost and enrollment effects of Medicaid expansion under the Affordable Care Act through 2020, and then the state expanded its Medicaid program in 2013. By 2016, New Mexico had already hit the cost and enrollment predictions for 2020, and analysts predict nearly 50 percent of the state’s population will soon be enrolled in Medicaid.

Unions, Hospitals Doubtful About Proposed New York Universal Health Care Plan

T
he New York City Council is supporting a proposal from Albany to take over the state’s health care system by creating a “Medicare for All” program, over the objections of hospitals and labor union leaders.

The New York Health Act would reduce payments to hospitals and require an estimated annual tax increase of $139 billion by 2022.

The single-payer, socialized medicine plan is being sold as a way to cover one million uninsured New Yorkers while eliminating copayments and deductibles that accompany traditional health insurance coverage. Its advocates are also saying the plan will help to keep costs down. Undocumented immigrants would be insured under the plan.

At a hearing on the legislation on December 6, the Greater New York Hospital Association, which represents 140 hospital and health systems, expressed opposition to the proposal because of the tax increase and reduction of payments to hospitals.

Union leaders at the hearing voiced reservations about the new proposal while also reasserting their support of a universal, government-managed health care system.

Henry Garrido, director of District Council 37 (DC 37), New York City’s largest municipal union, said his organization was concerned about more than one element of the proposal.

“DC 37 has always supported universal health care, but we have serious concerns about various aspects of the bill as currently drafted, and we have expressed those concerns to lawmakers,” Garrido said.

— Staff reports
Thirty-Eight States Join Obamacare Lawsuit

By Leo Pusateri

Thirty-seven states have joined Texas in a federal lawsuit challenging the constitutionality of the Affordable Care Act (ACA).

The suit maintains the ACA is no longer constitutional since Congress and President Donald Trump repealed the Obamacare “individual mandate” as part of the Tax Cuts and Jobs Act of 2017.

The defendant in the case is the Trump administration. The administration said in June 2018 it would not defend the ACA in court, though it said in its filing it did not fully agree with the plaintiffs’ argument in the case that the elimination of the penalty meant the entire law should be struck down.

“A Pretty Straightforward Argument”

Justin Haskins, a research fellow at The Heartland Institute, which publishes Health Care News, says the suit is based on simple logic.

“The states have a pretty straightforward argument,” Haskins said. “The U.S. Supreme Court ruled in 2012 the individual mandate in the Affordable Care Act is constitutional on the basis that the penalty for the mandate was a tax, rather than a fine. When Republicans passed the Tax Cuts and Jobs Act in December 2017, they reduced the individual mandate penalty to $0, effectively eliminating it. Because there is now no ‘tax’ in place, it can no longer be argued Congress has the authority to impose the individual mandate on the basis of it being a tax.”

If the individual mandate is unconstitutional, the entire bill is invalid, Haskins says.

“The Supreme Court has previously determined that legislation should be struck down when one provision has been ruled unconstitutional and it’s unlikely Congress wouldn’t have passed the bill in the first place absent that provision,” Haskins said. “Accordingly, states are arguing that most or all of the Affordable Care Act should be deemed unconstitutional.”

Action Likely, Outcome Uncertain

Haskins says there is much uncertainty regarding what will happen if the case ultimately makes it to the U.S. Supreme Court.

“No matter what happens in lower courts, this case will be appealed to the Supreme Court,” Haskins said. “It’s unclear whether the Court will choose to hear the case, but if it does, it could strike down all or part of the Affordable Care Act. Interestingly, the Trump administration has already determined that it believes the ACA is unconstitutional and that it effectively won’t defend most of the law in court, but it says only some of the law should be struck down, not the entire legislation.

“If the Supreme Court were to rule the entire ACA unconstitutional, Congress would be forced to pass new health care legislation,” Haskins said. “It’s highly unlikely Congress would simply allow the ACA to collapse without replacing it with something else.”

Worried About Subsidies

On the other side of the debate, the 12 mostly Democratic-controlled states that have not joined the suit want the ACA to continue because of the massive federal subsidies they rely on, says Michael Cannon, director of health care policy at the Cato Institute.

“If the Courts do strike down ACA provisions that govern or overhaul private health insurance, a lot of federal money could disappear,” Cannon said. “On the private insurance side, federal money going to private insurance companies would disappear. On the Medicaid side, money that would have gone to the states would disappear.

“Even though money subsidizing private insurance only goes to the private insurers, states will still be upset because that will be less money coming into the state,” Cannon said. “Insurance companies need to offer ACA-compliant plans only for as long as they are receiving subsidies. Without the subsidies, those plans could disappear off the exchanges.”

Free-Market Alternatives

Cannon says striking down ACA would not reduce health care access.

“If states that want to keep Obamacare complain that their own ‘high risk’ pools would be inadequate, all they would be doing is confirming what we already know, which is that their policy preferences lack political support,” Cannon said. “That’s not an argument for keeping those preferences in place. That’s actually an argument for, ‘Okay, we shouldn’t do this at all.’”

There are several free-market reforms ready to reduce health care costs and increase access if the ACA is invalidated, says Cannon.

“We could be doing a better job of achieving the goal of making health care more widely accessible [through reforms] that just happen to move in the opposite direction of Obamacare,” Cannon said. “As David Hyman and Charlie Silver explain in the Cato Institute’s new book, Overcharged, these reforms would give consumers control over the $3 trillion we spend on health care every year.

“This is because consumers would do a better job of spending that money and will demand lower prices and higher quality in a way they just don’t do when they’re spending their employer’s money or the government’s money,” Cannon said. “And we will then see prices falling while quality improves in health care, just like we expect to see in every other sector of the economy. Making consumers cost-conscious has been shown to make prices fall by over 20 percent on average over two years—even up to 30 percent on procedures such as hip and knee replacements.”

Leo Pusateri (psyecmeister@fastmail.fm) writes from St. Cloud, Minnesota.
Emergency Room Costs Increased by Nearly One-Third in Four Years

By Sarah Lee

The number of patient visits to U.S. emergency rooms increased by 31 percent from 2012 to 2016, a new study reports.

The study from the Health Care Cost Institute arrives on the heels of a study in Spring 2018 that found the cost for an emergency room visit reached a 10-year high in 2015.

Patients with non-urgent health problems are increasingly relying on doctors, staff, and facilities that are supposed to be devoted to critical and unexpected health emergencies, the study reports. Federal law requires all hospitals that receive Medicare to pay. Much of the emergency care in the United States is performed without compensation to the provider, according to the Centers for Medicare and Medicaid Services.

‘Alarming’ Rise in Costs

The increase in the cost of emergency room visits is a huge red flag, says Jordan Roberts, a health care policy analyst at the John Locke Foundation.

“Emergency room visit costs have been rising at an alarming rate over the past several years,” Roberts said. “This is concerning because not only does the cost of providing health care continue to rise, emergency room care in hospitals is some of the most expensive care you can get.”

Regulatory Obstacles

Charlie Katebi, a state government relations manager with The Heartland Institute, which publishes Health Care News, says government regulations limiting who can provide health care are partly to blame for emergency room overuse and the high costs related to many people’s reliance on emergency health care.

“Many patients, very often in rural or low-income areas, don’t have access to an affordable doctor or clinic in their region,” Katebi said. “Loosening regulations on nurses, dental therapists, physician assistants, and even certificates of need laws—which can keep doctors from entering the market—would help by potentially allowing access to those health care professionals who might find ways to practice in those areas where they couldn’t before.

“Many people head to the emergency room because they don’t see anywhere else they can go for help,” Katebi said. “Giving more options to patients seeking care, especially those in government programs such as Medicaid, would relieve much of the strain on emergency staff and facilities.”

Those and other improvements in access to primary care could reduce the need for emergency room visits, Roberts says.

“Better, more thorough primary care will not only help patients avoid emergency room care because of medical reasons, but also it is necessary for the ‘health education’ aspect of care,” Roberts said. “I think Americans have a difficult time choosing the correct facility to receive care from, depending on the situation, mostly because of how complex and tangled the entire health care system is in America, and partly because with insurance, most consumers don’t care to take the time to figure out costs and shop for the best value.”

New Options Through Technology

Embrace of innovative health care options can break down some barriers to timely primary care, if legislators and regulators allow the health care system to evolve, Roberts says.

“Many of these problems could be solved with increased access to tele-medicine,” Roberts said. “Ailments that people seek care for in the emergency room could often have been treated via telemedicine, which can help to avoid the expenses associated with a trip to the emergency room while still getting the same level of care.”

Charlie Katebi
Manager
The Heartland Institute

Sarah Lee (slee@heartland.org) is the managing editor of Health Care News.

“Loosening regulations on nurses, dental therapists, physician assistants, and even certificate of need laws—which can keep doctors from entering the market—would help by potentially allowing access to those health care professionals who might find ways to practice in those areas where they couldn’t before.”

CHARLIE KATEBI
State Government Relations Manager
The Heartland Institute

INTERNET INFO

Maryland Considers Imposing State Individual Health Care Mandate

By Nicole Staley

The Maryland General Assembly is considering a bill that would establish a “health insurance down payment plan” requiring residents to purchase health insurance or else pay a state tax penalty for being uninsured.

The legislation, introduced by state Sen. Brian J. Feldman (D-Montgomery County) and Del. Joseline A. Peña-Melnyk (D-Prince George’s County) on November 20, is a response to the reduction of the Affordable Care Act’s (ACA) individual mandate penalty to $0, which Congress and President Donald Trump implemented as part of their Tax Cuts and Jobs Act in 2017.

The proposed Maryland bill would differ slightly from the federal mandate in that it would allow the uninsured to use the penalty as a down payment for insurance bought on the state’s Obamacare exchange.

The legislation would make Maryland the fifth state or district to adopt an individual mandate law. Massachusetts, New Jersey, Vermont, and the District of Columbia have already passed individual mandate laws.

A New Penalty

Legislation establishing an individual mandate was defeated in the 2018 Maryland legislative session. The new proposal would require those who do not have health insurance to pay a fee of $700 or 2.5 percent of their household income, whichever is higher, each year they are uninsured.

Proponents of the individual mandate proposal say they fear the mandate will create a reduction in the number of residents with health insurance, particularly young and healthy individuals, which would cause health care prices to rise for all Marylanders, including those with employer-sponsored health coverage. This increase, they say, would stem from the cost transfer of hospital care for the uninsured to those with coverage.

Proponents of the bill claim requiring residents to purchase health insurance would prevent the need for this subsidy increase and thus lower overall health care costs.

Conflicting Claims

In 2018, the number of Maryland residents with health insurance increased by 150,000. Although proponents of the bill say the individual mandate would continue to increase the number of insured, Twila Brase, president of the Citizens’ Council for Health Freedom and a policy advisor to The Heartland Institute, which publishes Health Care News, says the proposed individual mandate would not help people gain access to health care.

“Just because everyone is covered does not mean they can access care. Especially under sky-high deductibles coupled with sky-high premiums.”

TWILA BRASE
PRESIDENT, CITIZENS’ COUNCIL FOR HEALTH FREEDOM

Governor Remains Skeptical

Maryland Gov. Larry Hogan opposed the Obamacare mandate and says he’s against a state-level mandate, too.

“The governor favors incentives over penalties” and would oppose an individual mandate in Maryland, Hogan spokeswoman Amelia Chassé said.

Hogan signed into law the reinsurance program Maryland lawmakers passed in the 2018 legislative session in April 2018. That legislation provides backup insurance for insurance companies to help cover the costs of high-risk patients.

Although Maryland lawmakers say the individual mandate bill is intended to decrease health care costs, a state-level individual mandate would have the opposite effect, says Brase.

“Requiring residents to purchase health insurance not only violates personal freedom but also increases health care costs for all,” Brase said.

“Nothing justifies an unconstitutional mandate.”

Nicole Staley (Nicole.staley24@gmail.com) writes from Pensacola, Florida.

Incentives for States to Reform Health Care Laws Under Consideration in Congress

The U.S. Congress is considering legislation to promote competition among health care providers by encouraging states to remove laws that restrict facilities and services and providing more federal money for investigation of potentially anti-competitive mergers.

Rep. Jim Banks (R-IN) introduced the Hospital Competition Act of 2018 in late October with a statement citing spiraling health care costs and exorbitant insurance premiums.

Among other reforms, the bill would give states strong incentives to liberalize their health care regulations, by providing “Grants for Hospital Infrastructure Improvement” to states that do not have certificate of need laws restricting health care facilities and that “allow advanced practice providers (such as nurse practitioners, advanced practice registered nurses, clinical nurse specialists, and physician assistants) to evaluate patients; diagnose, order, and interpret diagnostic tests; and initiate and manage treatments,” have laws ensuring “the only justification for limiting the scope of practice of a health care provider is safety to the public,” and do not require managed care plans to accept all providers, the bill states.

Banks’ legislation would also authorize a 400 percent increase in Federal Trade Commission staff to investigate suspected anti-competitive mergers and practices, to help ensure hospital mergers do not increase costs for patients.

“The consolidation of hospital markets through mergers is one of the biggest drivers of health care costs, with hospitals charging as much as 44 percent more for the same services in consolidated regions,” Banks said in his statement. “With costs soaring and uncertainty continuing to loom over the future of Obamacare, my proposal would aggressively combat the rising cost of health care. This bill should be the starting point in the conversation about how we can help lower health care costs for families in Indiana and across the country.”

— Staff reports
Sen. Grassley to Change Chairmanships, Focus on Health Care

By Ashley Bateman

Pending confirmation by the 116th Congress, Sen. Charles Grassley (R-IA) says he will fill the seat of retiring Senate Finance Committee Chairman Orrin Hatch (R-UT) and address health care affordability and high drug prices in his new role.

Grassley’s chairmanship of the Senate Judiciary Committee, which he was appointed to lead in 2015, is set to expire at the end of the current session.

Grassley called for “improving the affordability, quality, and accessibility of health care, including in rural America,” in a press statement announcing his intentions.

Third-Party Problem

The prevalence of third-party payment models—instead of models that encourage direct payment by patients—is pushing prices up in all areas of health care and is what lawmakers must address to slow cost increases, says Wayne Winegarden, a senior fellow at the Pacific Research Institute.

“Drug costs are often the most visible part [of health care costs], so consumers feel it more, but the lack of affordability is a problem that plagues the entire system, and those costs are rising,” Winegarden said. “There are all sorts of things we don’t know the cost of because we don’t see them. Even if you squeeze pharmaceutical prices, you’re not going to solve the problem people really care about, which is rising health care costs and declining health care quality. We don’t have proper competition and patients in charge of their own health care.”

Identifying the Real Concerns

Grassley knows the primary issue for most consumers is out-of-pocket drug costs, says Peter Pitts, president and co-founder of the Center for Medicine in the Public Interest.

“Sen. Grassley is a thoughtful guy, and I think he understands that the issue isn’t the price of drugs from a list-price perspective; the issue is the out-of-pocket cost of drugs for patients.”

PETER PITTS, CENTER FOR MEDICINE IN THE PUBLIC INTEREST

Optimistic About New Leader

Grassley’s reputation makes him a good fit for the job, says Pitts.

“Sen. Grassley and the staff are bright people, and he’s not known for grandstanding, so I think he has the opportunity to do it right,” Pitts said.

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

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Vermont’s ‘OneCare’ All-Payer System Beset by Problems

By Ashley Bateman

OneCare Vermont—the state’s all-payer health care network that works in tandem with Medicare, Vermont Medicaid, commercial, and self-funded insurance programs for residents of Vermont—is coming under increased scrutiny, as administrators failed to release data on the program’s financial status and patient outcomes.

On November 9, Vermont Legal Aid’s Office of the Health Care Advocate sent a letter to members of the Green Mountain Care Board, the organization charged with overseeing health care administration in the state, expressing concerns over the program and a lack of transparency on the part of OneCare’s administrators.

“OneCare has not provided the Board with adequate information to exercise meaningful oversight,” the letter said.

The concerns are related to the agreement between Vermont’s OneCare program and the federal Centers for Medicare and Medicaid Services. The pact runs from 2017 to 2022 and was characterized as a way to provide better-quality, lower-cost health care.

Failure of Oversight Claimed

In 2011, the Green Mountain Care Board was created to run as an independent oversight entity responsible for supervising the development and implementation of the state’s all-payer model, evaluating its effectiveness, and regulating the health care payment and delivery system changes it would implement. The board’s regulatory authority gives it oversight of payment and delivery system reforms, provider rate-setting, approval of health information technology and workforce plans, hospital and accountable care organization budget approval, insurer rate approval, certificate of need issuance, and oversight of the state’s all-payer claims database.

Four insurance programs—Medicare, Medicaid, Blue Cross and Blue Shield of Vermont, and the University of Vermont Medical Center’s self-funded employee insurance plan—are slated to be part of OneCare in 2019. Critics of the program have said the all-payer system has failed to meet target growth goals and the Green Mountain Care Board has failed to produce accurate data about the program.

‘Not Actually Doing Anything’

Meg Hansen, executive director of Vermonters for Health Care Freedom, says the state administrators in charge of OneCare have not released records on the program’s performance.

“We've submitted requests to the Department of Vermont Health Access and the Green Mountain Board, and no one has records,” Hansen said. “The next legislative session, in 2019, we are going to ally with legislators in the House to force them to reveal the data.

“If the login reports show that no one's actually using [the program], it means this model doesn't work and we should just end it,” Hansen said. “It's like a small hedge fund with an incrementally increasing budget, but it's not actually doing anything in terms of improving patient care and saving money.”

Government Dominance

Robert Roper, president of the Ethan Allen Institute, says Vermont is suffering from a lack of health care innovation because the market is under-mined by one-size-fits-all government programs.

“OneCare and all-payer have a future in Vermont because there are no other ideas on the table at this point—at least none that would be politically acceptable to our moderate Republican governor and our very liberal legislature,” Roper said. “So far, I have not seen enough public interest in or dissatisfaction with the issue to cause a political shift. I don’t think many people outside of the ‘Montpelier bubble’ even know what this is enough to be dissatisfied with it at this point.

“If Green Mountain Care Board members go ahead and vote [in favor of] OneCare, I don't see why the federal government should continue to honor this agreement, because it was meant to be a mutual agreement,” Roper said. “They should cancel it.”

Single-Payer to All-Payer

Hansen says the state turned to OneCare after lawmakers failed to find a way to fund the state’s planned single-payer system.

“Vermont tried to do the single-payer model ... under Democrat Gov. Peter Shumlin,” Hansen said. “He made it the hallmark of his administration. In 2011, the Green Mountain Care Board—in five bureaucrats that now determine all regulations for Vermont—was created to oversee and regulate the entire process. But the whole thing collapsed. It failed. They ran the numbers: There was a 150 percent increase in income tax on Vermonters and it still wasn’t enough [money].”

Meg Hansen

EXECUTIVE DIRECTOR
VERMONTERS FOR HEALTH CARE FREEDOM

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Roper says Vermont’s large elderly population makes expensive programs like all-payer easier to sell.

“Vermont has the second-oldest demographic out of all the states in the nation,” Roper said. “Only Maine has an older population. The older you get, generally the more health care you need.”

High-Demand Demographic

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“Vermont has the second-oldest demographic out of all the states in the nation,” Roper said. “Only Maine has an older population. The older you get, generally the more health care you need.”

Ashley Bateman (bateman.ae@googlemail.com) writes from Alexandria, Virginia.
Missouri Activist Files Medicaid Expansion Ballot Initiative

By Rocco Cimino

A retired trucker has filed paperwork to put Medicaid expansion on Missouri’s 2020 election ballot.

Having failed to achieve ballot access in 2018, political activist Gary Peterson of Raytown, Missouri says he is encouraged by voters’ approval of similar initiatives in Idaho, Nebraska, and Utah during the 2018 midterms. Thirty-seven states have now passed Medicaid expansion.

“I really think that I’m going to have a good chance of getting it going this time,” Peterson told the Kansas City Star in late November 2018.

‘Expect Higher Costs’

Matthew Glans, a senior policy analyst with The Heartland Institute, which publishes Health Care News, says Missouri is lucky Peterson could not get the measure on the ballot in 2018.

“The states who passed expansion can expect higher health care costs for all residents in their state, because that’s what Medicaid expansion leads to,” Glans said. “Expansion was sold as a way to pay for the program, but all it really does is give people who are young and healthy a way to use a program that was never designed for them. Those people will be using resources at the expense of the elderly and sick, who were the original patients Medicaid was supposed to help.

“And because more people have signed up for the program than anyone ever anticipated in states that have expanded Medicaid, the cost of Medicaid has gotten out of control,” Glans said. “That means states have to siphon money from other areas of the budget to help pay for it.”

‘Missouri Dodged That Bullet’

For his 2018 effort, Peterson expected help from the Missouri Democratic Party and its allies in collecting the required 100,000 signatures from each congressional district. The assistance never materialized.

The ballot measure Peterson has filed to propose for 2020 would extend Medicaid to those with a household income up to 138 percent of the federal poverty level, which is currently $34,638 per year for a family of four. That would qualify an additional 293,000 families for Medicaid in the state.

“The GOP-led legislature in Missouri made the right decision in saying that Medicaid expansion in their state was too expensive,” Glans said.

“The states that recently passed [Medicaid expansion] through ballot initiatives will be interesting to watch as they attempt to find ways of taxing their population or shuffling federal subsidies around in order to pay for a program that many of the newly enrolled no longer need because of the options recently made available under President Donald Trump, such as short-term health insurance plans and association health plans,” Glans said.

Rocco Cimino (rocco.j.cimino@gmail.com) writes from Washington, DC.
Nebraska’s Expanded Medicaid Program Faces Shortfall

By Kenneth Artz

Nebraska’s Medicaid expansion is creating a budget crisis that will likely force cuts to other government programs.

Moody’s Investors Service released a report in November detailing the future fiscal situation for Nebraska after its Medicaid expansion goes into effect in 2019. Earlier in 2018, Nebraska voters approved the expansion, but the state has not yet announced how it will pay for its share of the costs. Under Obamacare, states that expand Medicaid receive partial funding from the federal government. States are responsible for covering the remaining costs.

Republican Gov. Pete Ricketts, who opposed the expansion, says the costs will have to be paid for using existing tax revenue, even if it means less money for K–12 schools, higher education, and roads.

Dueling Estimates

Nebraska’s Legislative Fiscal Office estimates the state’s initial share of the cost of Medicaid expansion will amount to $39 million per year, slightly less than 1 percent of the state’s general revenue fund.

State Medicaid officials disagreed, estimating the cost will be $57 million per year, roughly 1.3 percent of annual revenues. The federal government pays 93 percent of the expansion costs in 2019 and 90 percent in 2020 and thereafter.

Moody’s reports Medicaid expansion will mean there will be less money available for other state spending priorities if funded with existing revenue.

Moving Money Around

Sarah Curry, policy director at the Platte Institute, says Medicaid expansion is going to cost more than the state projects, although it might not “be felt in the first year.”

“I don’t know what number they are using, so I don’t know if the impact will be felt in the first year, but it might be felt in the second and third years, when we get some cost expectations back and see a shortfall in the amount which has been allocated for Medicaid expansion,” Curry said.

Although education in Nebraska, as in most states, is primarily funded through local property taxes, lawmakers will want to avoid offending powerful special interests by cutting the state-level allocation, Curry says.

“I believe the governor said they would have to cut the budget for K–12 education to bring home the message Medicaid expansion costs money,” Curry said. “I don’t think it’s going to be K–12, because the education lobby is really strong in Nebraska, and I just don’t think they would let that happen. Even when we had the big budget shortfall, they did not cut education like they cut other areas of the budget.

“Nebraska has six to seven different funds which it uses to fund state government,” Curry said. “A very large fund is federal grants, so I could see them drawing down more federal grants to offset state appropriations. They could also move things outside the general fund into cash funds or revolving funds to free up money in the state’s general fund.”

Curry says there’s a possibility higher-education money may be targeted to help pay for the expansion.

“In 2017, [most funding] was cut 2 percent across the board, but the universities only got a 1 percent cut, so I could see universities getting cut a little bit more since they were spared the last time,” Curry said.

Expects Huge Cost Overrun

Curry says estimates projecting Medicaid expansion will cost $30 million and be covered by a new internet sales tax are unrealistic.

“I think the cost is going to be closer to $90 million,” Curry said. “If they say it’s only going to cost $30 million and the Legislative Fiscal Office says it’s going to cost $30 million and they put that into our budget, then they’re not going to need to cut any money from K–12 education until next year, when there’s a massive budget shortfall because it costs $60 million more than they thought and they’re going to have to fill the hole.”

Adding Medicaid expansion to Nebraska’s already very tight budget will reduce the state’s ability to help the neediest people, Curry says.

“I think Nebraska’s Medicaid benefit is very generous in the services it provides, so in order to expand coverage to more people, they’re going to have to limit the services they currently offer in Medicaid, and, unfortunately, those who are the most vulnerable who need these programs are probably going to have to do without so the state can balance its checkbook,” Curry said.

Expansion Realities

Matthew Glans, a senior policy analyst with The Heartland Institute, which publishes Health Care News, says Medicaid expansion puts other government programs at risk and harms those most in need of assistance.

“Medicaid expansion is expensive and insures the young and healthy instead of concentrating on the disabled and elderly,” Glans said. “It’s no surprise to learn that states may have to use funding for other projects they may consider priorities to pay for expansion. Taxpayers will ultimately be footing the bill for those projects if their funding is diverted away to pay for Medicaid expansion.

“Medicaid expansion doesn’t improve the quality of health care, so states shouldn’t choose to expand a program with that kind of history and take federal funding away from other important programs like infrastructure or schools, especially when there are better free-market options for improving the health insurance system,” Glans said.

Kenneth Artz (kennethcharlesartz@gmx.com) writes from Dallas, Texas.
Enrollment in Obamacare Through Federal Exchange Declines

By Cory Compton

During the 2019 open-enrollment period for health insurance coverage, fewer Americans signed-up for health insurance through Obamacare exchanges than in the previous year.

At press time (December 14, 2018), enrollment in Obamacare health insurance plans had dropped by 20 percent compared to the same period in 2017, according to a report by the Associated Press. Between 400,000 and 500,000 fewer people are believed to have enrolled through an Obamacare exchange in 2018 than in the previous year.

The enrollment numbers do not include totals from states that operate their own exchanges or from consumers automatically enrolled in plans during the last week of open enrollment, which ended on December 15 for most states.

Attractive Alternatives

Charlie Katebi, a state government relations manager for The Heartland Institute, which publishes Health Care News, says the drop in Obamacare enrollment indicates health insurance options recently made available by the Trump administration, as well as a decrease in unemployment numbers, are at least partially responsible for the enrollment drop.

“The new health insurance alternatives—such as association health plans and short-term, limited-duration insurance—give people the option of making their own decisions about what best suits their individual needs,” Katebi said. “It would appear, if those numbers hold, that people are taking the Trump administration up on their offer of taking a more proactive role in those decisions. The administration also made decisions through tax reform that helped the economy flourish and created jobs, which, in turn, gave more people the opportunity to find coverage through their employer.

“Introducing choice in a market and making administrative decisions that move health care away from government control have contributed to consumers taking advantage of alternative forms of health insurance,” Katebi said.

Cory Compton (theecomptonjr@gmail.com) writes from Cheboygan, Michigan.

Despite Medicaid Expansion Defeat, Mont. Governor Includes It in 2020–21 Budget

By Sarah Lee

Montana’s governor is attempting to continue the state’s Medicaid expansion program, even though voters in the 2018 election rejected a ballot initiative to continue it.

A sunset provision for the state’s Medicaid expansion program is set for mid-2019.


The expansion extended Medicaid eligibility to those earning less than 138 percent of the Federal Poverty Level, which amounts to $16,643 for a single person and $33,948 for a family of four.

Ballot initiative 185 would have preserved the program via tax hikes on tobacco and related products, including an additional $2 per pack tax on cigarettes, a tax on other tobacco products, and a tax on e-cigarettes, which have thus far only been subjected to regular sales taxes in Montana. The proposal was defeated in the November midterms.

“Medicaid expansion would be a huge drain on the state’s treasury. It simply costs too much. It would ultimately cost Montana nearly $60 million a year, much of that coming from [the state’s] taxpayers, since the federal share of the costs will drop to 90 percent by 2020.”

DAVID HERBST
MONTANA STATE DIRECTOR
AMERICANS FOR PROSPERITY

Learning from Others’ Mistakes

David Herbst, Montana state director of Americans for Prosperity, spent the months leading up to the November midterms warning voters of the problems with Medicaid expansion and pointing out the deleterious effects the program has had on other states’ budgets.

“Medicaid expansion would be a huge drain on the state’s treasury,” Herbst said. “It simply costs too much. It would ultimately cost Montana nearly $60 million a year, much of that coming from [the state’s] taxpayers, since the federal share of the costs will drop to 90 percent by 2020.

Proponents of expansion like to tout how many people are covered under the program, but we have research showing a large number of the adults in the expansion program are working-age adults, and over half have no dependents. Able-bodied adults are crowding out the truly needy the program is supposed to cover.

“Additionally, we have examples from other states that have borne the costs of Medicaid,” Herbst said. “New Mexico expanded the program in 2013 and wound up with a $417 million Medicaid shortfall. By mid-2019, nearly half the state’s population is expected to be covered, and that makes Medicaid the second-largest item in the state’s general fund, leaving lawmakers with little option but to raise taxes to pay for it. Montana shouldn’t repeat the mistakes of her neighbors.”

“The Opposite of Free’

Matthew Glans, a senior policy analyst for The Heartland Institute, which publishes Health Care News, says Montana should not make the mistake many other states are making by assuming federal Medicaid funding that comes with expanding the program is “free” money.

“Expanding Medicaid always leads to a dramatically increased costs and new restrictions,” Glans said. “A report from the U.S. Department of Health and Human Services found the average cost of a Medicaid expansion enrollee was almost 50 percent higher in fiscal year 2015 than what HHS had previously projected.

“Medicaid expansion is the opposite of free,” Glans said. “It’s costly, burdensome, and takes resources away from those who need it in favor of those who can and should be embracing the new health care alternatives offered to them through short-term and association health plans.”

Expansion Politics

Herbst said the move to include Medicaid expansion in the budget is little more than a political ploy the governor has attempted in the past only to be defeated by the state’s Republican-majority legislature—and now directly by the state’s voters.

“The midterm results voting the expansion down should really be seen as a referendum on Medicaid expansion in the State of Montana,” Herbst said. “The legislature may take up the issue again if it can strike a deal between moderate Republicans and Democrats and if expansion continues to contain a sunset clause, as it has in the past. But whatever gets passed will not be what the governor is proposing.”

Sarah Lee (slee@heartland.org) is the managing editor of Health Care News.
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REPRESENTATIVE ISAAC LATTERELL
SOUTH DAKOTA