The Pulse

Wyoming Air Ambulances
Wyoming wants to have Medicaid pay for all air ambulance transports in the state, but concerns mount the plan will chase the industry out altogether. Pages 12, 13

New Direction at FDA?
Confirmation hearings provide clues revealing how FDA nominee Stephen Hahn would modernize the drug approval process. Page 15

Keynes Enters Med School
The AMA wants tomorrow’s physicians to be well-versed in health care economics, but the proposed course focuses on current government payment models, not independent practice. Page 5

OH ‘Social Impact Bonds’
Ohio is considering implementing social impact bonds to encourage private organizations to help solve the opioid crisis and infant mortality in innovative ways. Page 3

Google Gets Medical Records
Blowback over a health records sharing partnership between Google and Ascension Health raises questions about whether government is keeping up with technology. Pages 16

Trump Administration Proposes New Health Care Transparency Rules

By Bonner Cohen
Vowing to help patients get accurate estimates of the costs of health care services before receiving treatment, the Trump administration issued regulations requiring hospitals and insurers to disclose hitherto hidden information on the prices they negotiate with one another.

The proposed Transparency in Coverage rule from Health and Human Services (HHS) and the Departments of Treasury and Labor would require most employer-based group health plans and health insurance issuers

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Congress Considers Bills to Address Doctor Residency Shortage

By AnneMarie Schieber
Lawmakers in Congress have introduced bills to add 1,000 new hospital residencies over the next five years to combat a national physician shortage intensified by the opioid crisis.

The bills, S. 2892 and H.R. 3414, have bipartisan support and would increase funding to Medicare to pay for residencies in addiction medicine, addiction psychiatry, and pain management.

The legislation is separate from the Resident Physician Shortage Reduction

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Policy Booklet

Tobacco Harm Reduction 101:
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Ohio Considers ‘Social Impact Bonds’ for Public Health Challenges

By Ashley Herzog

Ohio Treasurer Robert Sprague is proposing to turn to the private sector and local governments to help deal with two of the state’s most troubling health care challenges: infant mortality and opioid drug addiction.

Sprague proposes using so-called social impact bonds to encourage non-governmental organizations to create innovative solutions and reward them based on results.

Sprague calls the program ResultsOhio. The state legislature approved the first pilot program last year as part of its budget bill. Although the pilot program will deal with a criminal justice issue, recidivism, Sprague says ResultsOhio is a natural fit for treating problems such as drug addiction.

“The thing we struggle with is very low rates of recovery,” Sprague told the Tribune Chronicle in a November 26 article. “So, this ResultsOhio program was born out of that necessity.”

“We’ve tried hard and invested a lot of money in the treatment system in Ohio,” Sprague told the Associated Press on June 28. “But our recovery rates are stubbornly at 10 to 15%. So how do you have innovation occur in the system to increase those recovery rates?”

The legislature and governor would have to approve a specific application to addiction or other health challenges and set desired outcomes. Programs would have to find independent funding sources, and if they show results, the state would reimburse the costs and provide a small return on investment.

Beyond Government

The social bond concept makes good sense for treating drug addiction, says Jordan Roberts, a health policy analyst at the John Locke Foundation.

“While treatment for those addicted to opioids is an essential part of recovery, just focusing on treatment doesn’t address the core problems of why people turned to using the drugs in the first place,” Roberts said. “We need to focus on the root causes of why someone would choose to abuse opioids. This is where I see the private sector playing a more impactful role than the government, to stop people from abusing opioids in the first place.”

Government spending has done little to stem the tide of drug addiction and related public health crises, says Alita Eck, M.D., a practicing physician and proponent of private-sector responses to health challenges.

“Governments set up programs, hire people, and buy computers and printers, but until we can make a difference in the hearts and minds of those who are addicted, we will not have made a dent in the crisis,” Eck said.

Massive government health care programs have long had a monopoly on treating drug addiction, with little success, says Roberts.

“Medicaid and Medicare have intruded so far into the market that they cause more problems than they solve,” Roberts said. “I believe scaling back government overreach in the health care sector will create new opportunities for the private market and private actors to address these problems.”

Voice of Experience

Eck has personal experience demonstrating smaller programs are better at addressing problems like addiction. The book The Tragedy of American Compassion, by Marvin Olasky, inspired her to take action.

“Olasky outlined the failure of government to replace what church and civic groups used to do,” Eck said. “His book inspired my husband and me to start the Zarephath Health Center 17 years ago. Run by volunteers, we provide personalized care to those who are struggling. We can channel people into faith-based addiction support groups with a proven record of success.”

Workers in government programs can be overwhelmed by large-scale problems such as addiction, says Eck.

“The volunteers are motivated to help, as it is not just a job for them, and many former addicts have the experience and knowledge to empathize with those who are struggling,” Eck said. “Government programs tend to be impersonal. While good people may be employed by them, they are too often constrained by rigid rules that keep them from personalizing the intervention addicts need.”

‘All Solutions Are Local’

When it comes to tackling big health care problems such as addiction, a smaller-scale approach works better, says Eck.

“All solutions are local,” Eck said. “Local communities and churches need to see the mission and band together to tackle the tough issues.”

Ashley Herzog (aebristow85@gmail.com) writes from Avon Lake, Ohio.
Congress Considers Bills to Address Doctor Residency Shortage

Continued from page 1

tion Act of 2019, introduced earlier this year, which would fund 15,000 new resi-
dency positions over five years starting in 2021.

Government Controls Doctor Supply
The Association of American Medical Colleges (AAMC) projects the United States will be short 121,900 physicians by 2032. Medicare funds nearly all residency positions in the country, and the number allowed has not risen for more than two decades.

The residency cap is the main cause of the physician shortage, says Merrill Matthews, a resident scholar at the Institute for Policy Innovation. “The number is capped at 100,000 in legislation that passed in 1997,” Matthews said. “Government rations the spots. The funding demonstrates all the problems associated with the government running health care: rationing and political pressure.”

Although the bills to address the opioid crisis will increase the number of positions, they will have little effect on the overall problem, says Matthews.

“The expansion appears largely limited to residents focusing on addiction medicine and related fields,” Matthews said. “It’s the government responding to political pressure to address certain problems.”

Disconnect with Medical Schools
Although the number of residencies has remained stable, medical schools have been training more doctors, with enrollment rising by 31 percent since 2002. A July 2019 AAMC report states 44 percent of the nation’s medical schools have major to moderate concerns about their inability to place graduates in residency programs.

The shortage of residencies is disastrous for prospective doctors, says Jane Orient, M.D., president of the Association of American Physicians and Surgeons. “Reportedly, there are 8,000 medical school graduates every year who do not ‘match’ with a residency position,” Orient said. “This means they cannot work as a physician, despite having gone $200,000 into debt for their education.”

The shortage of residencies puts medical school graduates on the sidelines to wait for a chance at a residency. “Only Missouri has an ‘assistant physician’ license permitting practice in association with a licensed physician,” Orient said. “This does not yet have a path to licensure. These physicians must still try to match, with dwindling chances every year.”

Central Planning Problem
The mismatch between the numbers of medical school graduates and residencies is another example of government central planning going haywire, says Orient.

“We believe there were previously many privately funded residencies in private hospitals,” Orient said. “We need to find out what happened. Inability to get accredited to offer board certification? Disappearance of independent hospitals? Why should residency funding depend on the insolvent Medicare program?”

Like Matthews, Orient questions why Congress needs an opioid crisis before responding to the residency problem. “The government seems focused primarily on addiction specialists, but all kinds of physicians are needed,” Orient said. “And why do you have to have special certification to prescribe medication-assisted treatment for addiction? Other physicians could do the job but are not legally permitted to do so.”

AnneMarie Schieber (amschieber@heartland.org) is managing editor of Health Care News.
AMA Calls for Health Economics Classes in Medical Schools

By AnneMarie Schieber

In addition to promoting classes on climate change, the American Medical Association (AMA) now wants medical school curricula to include classes on “health economics.”

The AMA does not define the term in its press release on the announcement, but it said schools should “include information on fee-for-service, managed care and other payment structures.”

The policy was adopted by the AMA’s House of Delegates at its meeting in mid-November. The AMA says it has spent several years trying “to integrate health systems science” into the curriculum and it should be a “third pillar” in addition to basic and clinical science.

“Medical students and residents with a deeper understanding of cost, financing, and medical economics will be better equipped to provide more cost-effective care that will have a positive impact for patients and the health care system as a whole,” stated Barbara McAneny, M.D., spokesperson and past president of the AMA.

Concerned About Bias

Teaching medical students about the highly regulated profession they are about to enter can be a positive step, says Beth Haynes, M.D., a board member of the Benjamin Rush Institute, a nonprofit organization that helps students learn more about free-market medicine.

“My concern is that medical schools will fail to be balanced in their presentation of economic theories,” Haynes said. “Schools may emphasize [the late economist John Maynard] Keynes and other supporters of significant government intervention while ignoring free-market, limited-government theories like [those of Milton] Friedman and [Ludwig] von Mises.”

Economics can be a touchy subject in medical school, says Chad Savage, M.D., owner of the Michigan-based direct primary care practice Your Choice Direct Care and a policy advisor to The Heartland Institute, which publishes Health Care News.

“There is an implicit understanding in medical schools that it is for some reason taboo that physicians should discuss or have any expectation of compensation,” Savage said. “It is somehow unseemly to expect compensation, and this engenders the belief that the only way to partake of medical care is via governmental transaction.”

Hoping for Balance

The AMA says it has published a study tool and developed several teaching models so medical educators can provide a better understanding of health care economics.

The AMA’s announcement is welcome news to third-year medical student Anthony Fappiano.

“I happen to love economics, so this is a topic I would have loved to learn about more, especially in school,” said Fappiano, who attends the University of New England College of Osteopathic Medicine.

Fappiano says he hopes the presentation will be balanced, but a recent conference he attended was not encouraging.

“It was a panel with a lobbyist for some single-payer company and two physicians who supported single-payer systems,” Fappiano said. “Not exactly a broad set of opinions.”

Calls for Consumer Emphasis

Fappiano says he would like to learn more about consumer-driven care models.

“I think it would be important to emphasize the ways that we as upcoming doctors can lower costs for patients more effectively. We need to stress the importance of inexpensive treatments like lifestyle changes, hands-on medicine like physical therapy and osteopathic manipulation, and generic drugs, rather than jumping to topline drugs or surgery. This is rarely emphasized in medical school, and the board exams reinforce the idea that expensive tests are a necessity, when that is not always the case.”

ANTHONY FAPPIANO, THIRD-YEAR MEDICAL STUDENT

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ANNOUNCED IT WANTS MEDICAL SCHOOLS TO INTRODUCE CLIMATE CHANGE INTO THE CURRICULUM, AND AN AMENDMENT TO STOP FORMALLY OPPOSING SINGLE-PAYER HEALTH CARE WAS DEFEATED BY THREE VOTES.

AnneMarie Schieber (amschieber@heartland.org) is managing editor of Health Care News.
Trump Admin Proposes New Health Care Transparency Rules

Continued from Page 1

offering group and individual coverage to disclose price and cost-sharing information to participants, beneficiaries, and enrollees up front.

The rule would require health plans to give consumers real-time, personal access to cost-sharing information. Insurers would have to provide estimates, online and in paper form, of how much policyholders will have to pay out of pocket for covered services. Insurers would also have to reveal the rates they negotiate with their in-network providers and what the allowed amounts are for out-of-network care.

The proposed rule was added to the Federal Register and will likely go into effect after the public comment period ends on January 14, 2020.

The administration’s action comes in the wake of President Trump’s June 24 executive order instructing HHS to develop rules promoting price transparency and competition among hospitals and insurers.

Biggest Change Yet

“Today’s transparency announcement may be a more significant change to American health care markets than any other single thing we’ve done, by shining a light on the costs of our shadowy system and finally putting the American patient in control,” HHS Secretary Alex Azar said in a statement announcing the new rule on November 15.

“Under the status quo, health care prices are about as clear as mud to patients,” said Centers for Medicare and Medicaid Services (CMS) Administrator Seema Verma in the statement.

“The goal is to give patients knowledge of costs before they make important health care decisions.

“With this information, patients will have accurate information on out-of-pocket costs they must pay to meet their plan’s deductible, co-pay, and co-insurance requirements. This will make previously unavailable price information available to patients and other stakeholders in a standardized way, allowing for easy comparisons.”

PRESS RELEASE
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President Donald Trump and Health and Human Services Secretary Alex Azar

administration at the U.S. District Court in Washington, D.C.

“The burden of compliance with the rule is enormous, and way out of line with any projected benefits associated with the rule,” the plaintiffs claimed in their filing.

“Hospitals should be ashamed that they aren’t willing to provide American patients the cost of a service before they purchase it,” said Caitlin Oakley, a spokesperson for HHS, in response to the suit.

‘A Baby Step’

The health care industry needs even bolder action, says Russ Carpel, CEO of LevelFunded Health, a national company that helps midsize companies find better-value plans for their self-insurance programs.

“This is a baby step in the right direction,” Carpel said. “The problem is consumers have very little skin in the game and have no power to shop. Health care is the only market where consumers and providers don’t set the price, a third party does.”

Carpel says Congress should address anti-consumer incentives created a decade ago.

“The Affordable Care Act capped profit margins on fully insured health insurance carriers,” Carpel said. “Both hospitals and insurance companies have an incentive to increase volume on claims and to push consumers to the highest-priced services. Networks have lost their original purpose, which was to save consumers money by offering patient volume for discounts. Now networks are a way for hospitals and insurers to look out for themselves.”

Calls for Fiduciary Rule

Government rules on brokers who sell insurance plans to employers also need reform, says Carpel.

“We need brokers who sell employers health insurance plans to work like fiduciaries, much like employer retirement plan providers now have to act in the best interest of employees,” Carpel said. “Health insurance brokers, because they work on commissions, have no incentive to offer employers plans that can save money and provide employees with the best value. Both the employer and the employee get stuck with higher bills.”

Bonner R. Cohen, Ph.D. (bcohen@nationalcenter.org) is a senior fellow at the National Center for Public Policy Research and a senior policy analyst with the Committee for a Constructive Tomorrow.
CMS Cracks Down on States’ Abuse of Supplemental Medicaid Payments

By Kelsey Hackem

The Trump administration and the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule on supplemental Medicaid payments to states, to improve monitoring and enforcement of Medicaid spending. The proposed Medicaid Fiscal Accountability Rule (MFAR) would end impermissible financing arrangements, to ensure Medicaid dollars are spent on the direct needs of beneficiaries.

“We have seen a proliferation of payment arrangements that mask or circumvent the rules where shady recycling schemes drive up taxpayer costs and pervert the system,” stated CMS Administrator Seema Verma in a news release. “Today’s rule proposal will shine a light on these practices, allowing CMS to better protect taxpayer dollars and ensure that Medicaid spending is directed toward high-value services that benefit patient needs.”

Hidden in Bulk Payments

The rule, issued on November 12, arrived on the heels of a report by the Senate Finance Committee Majority Staff on April 30 that reviewed base payments and supplemental payments made by the federal government to the states. Supplemental payments are lump sums paid to states not linked specifically to beneficiaries. The report, Greater Transparency of Supplemental Payments Needed, notes data on these payments is collected in the aggregate, which leaves Congress and the administration in the dark as to how states are distributing the money. The report says supplemental Medicaid payments totaled nearly $50 billion in 2016 alone.

The payment arrangements are typically seen in two situations: states making additional payments above normal reimbursement for billed services, and states using the funds to subsidize their portion of shared federal-state funding for Medicaid.

Schemes and Scams

Devon Herrick, a health care economist and policy adviser to The Heartland Institute, which publishes Health Care News, says the schemes can be complex. “[In one example] states have created an [illegal] arrangement where they tax Medicaid facilities coupled with an under-the-table agreement to return the funds back to the facilities,” Herrick said. “This allows the state to claim a larger state contribution for which the state gets a federal matching grant.”

Herrick says it has taken far too long for CMS to get around to addressing this issue. “It is long overdue for CMS to rein in abusive Medicaid schemes,” Herrick said. “For instance, some states tax hospitals and then return the funds to providers, earmarked as state spending that the federal government has to match despite no actual increase in state spending.

“These shenanigans are why many analysts call for block grants to force states to spend more prudently,” Herrick said. “It is sort of like playing whack-a-mole.”

Kelsey Hackem, J.D. (khackem@gmail.com) writes from Washington State.

INTERNET INFO


Greater Transparency of Supplemental Payments Needed, U.S. Senate Committee Majority Staff Report, April 30, 2019: https://www.heartland.org/publications-resources/publications/greater-transparency-of-supplemental-payments-needed

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Louisiana Removes Thousands of Ineligible People from Medicaid Rolls

Louisiana removed Medicaid benefits from 46,000 people who failed to document their income eligibility in an annual information request to renew coverage.

The state’s health department had sent warning letters to 52,000 Medicaid recipients telling them they had until October 31 to submit the information. The November removal is a decrease from 2018, when the state dropped 71,000 enrollees who failed to document their eligibility.

Louisiana is not the only state where ineligible people are signing up for Medicaid. A report released on November 18 by the federal Centers for Medicare and Medicaid Services (CMS) shows improper payments due to “insufficient documentation” of eligibility amounted to $57.36 billion for fiscal year 2019.

Blind Eye Incentive

An analysis of the CMS data by Brian Blase of the Galen Institute and Aaron Yelowitz of the Cato Institute found improper payments have grown rapidly since Medicaid was expanded under Obamacare. Louisiana expanded its program in 2016.

In an op-ed published on November 18 in the Wall Street Journal, Blase and Yelowitz say improper spending in Medicaid more than tripled since Medicaid expansion and that the Obama administration stopped auditing Medicaid eligibility in order to get as many people as possible enrolled in the program. Audits resumed in 2018 under the Trump administration.

States have an incentive to turn a blind eye to eligibility determination because Medicaid is a “cash cow,” the authors write. A federal audit found more than half the people in California’s Medicaid program had eligibility red flags, Blase and Yelowitz write.

“Whether out of greed or incompetence, many states neglect to obtain proper documentation and fail to verify income eligibility and citizenship,” the authors wrote.

Blase and Yelowitz estimate 2.3 million to 3.3 million Medicaid recipients may exceed eligible income levels.

“Improper payments in Medicaid are a real problem for policymakers, and it is imperative that CMS finally take this problem seriously,” the authors wrote.

—Staff reports

Michigan Lawmaker to Offer CON Reforms

After successfully blocking the state’s Certificate of Need (CON) Commission from restricting access to a cutting-edge cancer treatment, Michigan lawmakers will soon consider further CON reforms.

Sen. Curtis VanderWall (R-Ludington) says he plans to introduce a set of bills that would create exemptions to CON review and a bill that would expand the CON Commission to include two additional members from the public.

VanderWall says he will offer CON reform bills in the new legislative session that begins in January.

“Since becoming chair of the Senate Health Policy and Human Services Committee, I’ve spent a great deal of time working to understand CON requirements in Michigan,” VanderWall told Health Care News. “I believe these reforms are commonsense reforms that will eliminate unnecessary red tape, reduce costs, and provide more access to Michigan residents.”

The package of bills would require psychiatric hospitals or units to set aside one-half of their beds for patients approved for care by community mental health programs.

Another bill in the package of legislation would eliminate CON review for critical access hospitals located more than 35 miles from an existing similar facility. The bill retains CON for initiation, replacement, or expansion of clinical services currently covered by CON.

The bills don’t repeal CON altogether but are a good first step, says VanderWall.

“One of my passions in health care is to make sure we have access to care, especially in rural areas,” VanderWall said. “I felt it would be best to start with these reforms, some of which I believe will help with access. Throughout the process, I want to have open discussions to make sure we don’t have unintended consequences.”

—Staff reports

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“Whether out of greed or incompetence, many states neglect to obtain proper documentation and fail to verify income eligibility and citizenship. Improper payments in Medicaid are a real problem for policymakers, and it is imperative that CMS finally take this problem seriously.”

BRIAN BLASE, GALEN INSTITUTE
AARON YELOWITZ, CATO INSTITUTE
South Carolina Physicians Call for Market-Based Reforms

By AnneMarie Schieber

The South Carolina Medical Association (SCMA) has approved resolutions to support three reforms that would expand the quantity and quality of health care in their state.

Member physicians are working to repeal the state’s Certificate of Need (CON) laws, develop ways to exempt physicians from having to sign “no compete” stipulations as a condition of employment, and amend the state’s tax code to allow a limited tax deduction for doctors who work with charities to provide free care to patients.

The CON repeal efforts have had the most success so far, says Marcelo Hochman, M.D., president of the Charleston County Medical Society and director of the Coalition to Repeal CON. In January 2019, lawmakers introduced H.B. 3823, which “eliminates references to CON requirements” and removes the language from the title of the existing State Certification of Need and Health Facility Licensure Act. The bill has 31 sponsors and is currently under consideration in a subcommittee.

“The South Carolina Legislature’s 2019-2020 session resumes on January 7 and ends in May.

Unusually Restrictive CON

South Carolina has the ninth-most restrictive CON rules in the nation, according to the Mercatus Center.

“The law doesn’t do what it was intended to do but does what you’d expect it to do, and that is the people with CON approvals block newcomers into the market by contesting new applications, and the things that were supposed to happen—decreased cost, increased access, increased alternatives, increased charity care—all those things don’t happen,” Hochman said.

Hochman says five physicians have testified in support of H.B. 3823 so far and the state’s largest health care system, the Medical University of South Carolina (MUSC), appears to be in favor of the bill. However, the South Carolina Hospital Association, which includes MUSC, is opposed to repeal and released another proposal that Hochman says “doesn’t really do anything.”

“Publicly, [all the hospitals] are taking this unified position against repeal,” Hochman said. “Privately, there are hospital systems that are not opposed to repealing. The state’s largest system—which has unmatched access to research dollars and benefits from the state’s strong credit rating, so it is unlikely to be impacted by CON repeal—has argued both sides.”

Hochman says physicians have met with Gov. Henry McMaster on CON repeal, but the governor has yet to take a position on the issue.

Getting the Public on Board

Hochman says it is important for the public to know CON reduces the quantity and quality of health care. His organization, the Coalition to Repeal CON, has set up a website explaining what CON is, how it affects people, and what can be done about it.

“South Carolina has an estimated 6,331 fewer hospital beds than needed, 10-19 fewer MRI facilities than needed and 33-44 fewer CT scanners than needed,” Hochman said. “This is not a bill, like CON, that we can repeal.”

Letting Doctors Compete

The SCMA is also backing an effort to exempt doctors from non-compete clauses as a condition of employment. Protecting physicians against non-competes is a tricky proposition in the state because the clauses are not upheld by statute but by case law, says Hochman.

“Hospitals are incentivized to do charity care and get all sorts of money for ‘charity care’ which is not true charity care. It would increase charity care, which used to be a big part of medicine.”

Hochman says he is optimistic a bill will be introduced soon, and there is model legislation based on a similar proposal at the federal level. The bill would include provisions to prevent abuse, such as limiting the amount that could be deducted and mandating that care is provided through a recognized charity.

In addition, the state would be required to do an analysis on how such a deduction would affect the state budget, says Hochman.

“Contrary to the customary use of restrictive covenants to protect trade secrets or key customer relationships, physician non-compete clauses appear to be intended to lock physicians into long-term employment,” Habig said.

Habig says his research shows some physicians have been prevented from even informing patients of their departure, let alone passing on future contact information.

Encouraging Charity Care

The other reform the SCMA supports is to give doctors a state tax deduction if they work with a charity organization to provide free care to the needy.

“It is a nonpartisan issue,” Hochman said. “Hospitals are incentivized to do charity care and get all sorts of money for ‘charity care’ which is not true charity care. It would increase charity care, which used to be a big part of medicine.”

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Non-compete clauses frequently prohibit doctors from seeing established patients at new places of employment, says Adam Habig, president and co-founder of Freedom Healthworks and a policy advisor to The Heartland Institute, which publishes Health Care News. Three states disallow them for all employees, and nine eliminate or curtail them for physicians.

“It is a relatively minor reform but faces resistance from entrenched interests,” Habig said.
Michigan Governor Calls for Delay of Medicaid Work Requirements

By Bonner R. Cohen

Saying it is the “most reasonable thing to do,” Michigan Gov. Gretchen Whitmer called for a delay of the state’s Medicaid work requirements, which are set to go into effect on New Year’s Day.

The move would require the approval of the Republican-controlled legislature, setting up a year-end confrontation over a hot-button political issue that has roiled other states and spilled over into the nation’s courts.

In 2018, the Republican-majority Michigan Legislature approved a Medicaid work requirement, which was signed into law by then-governor Rick Snyder. Under the waiver approved by the federal Centers for Medicare and Medicaid Services (CMS) in December of that year, able-bodied adults with annual incomes of up to 133 percent of the federal poverty level will have to work in order to receive Medicaid.

Whitmer, a Democrat, has made no secret of her dislike of Medicaid work requirements. In a February 8, 2019 letter to CMS Administrator Seema Verma, Whitmer, who had just taken office a few weeks earlier, called the pending work reporting requirements “onerous” and said the law provides no resources for “job training, job search- es, or job supports.”

In her letter to Verma, Whitmer said the Michigan law is even more stringent than the waiver granted to Arkansas, where 18,000 people were removed from the Medicaid rolls in the first year of that state’s work-requirement program.

‘Deeper into Dependency’

Reaction from the Republican leadership in Lansing to Whitmer’s December 2 call for a delay was swift and unfavorable.

“Able-bodied adults who want cash assistance and subsidized health care coverage should obviously be expected to either work part-time or at least prepare for a career in exchange for welfare benefits,” House Speaker Lee Chatfield (R-Levering) and Senate Majority Leader Mike Shirkey (R-Clarklake) said in a joint statement.

“That is simply common sense, and it is something taxpayers who foot the bill for these programs should expect. Out of respect for those taxpayers, we are not willing to accept a pause in our state’s new welfare work requirements.

“These work requirements are also the right thing to do for people who need short-term help,” the legislative leaders stated. “Getting a job is the best way to become self-sufficient for a lifetime and escape poverty. Pausing the program takes that away and pushes people deeper into dependency, unhealthy behaviors, and long-term poverty. All Michigan families deserve a path and a plan toward a better future.”

**Work Rules on Hold**

The Trump administration favors work requirements, and several states have enacted them, pending approval by CMS, though none have been implemented yet. Courts blocked the policies in Kentucky, then Arkansas, and a pending lawsuit persuaded Indiana state administrators to suspend the state’s plan. A similar lawsuit has been filed against the Michigan work requirements (see related article, this page).

Michigan’s GOP lawmakers don’t always go along with Whitmer’s initiatives. Earlier in 2019, she proposed raising the gas tax to the highest level of any state in the country. The plan went nowhere in the legislature.

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Michigan Medicaid Work Rules Stalled by Lawsuit

Michigan’s Medicaid work rules, set to begin in January 2020, are under attack as four enrollees filed a class-action lawsuit claiming the requirement violates the intent of the federal Medicaid Act of 1965, among other charges.

The National Health Law Program, the Michigan Poverty Law Program, and the Center for Civil Justice filed the suit on November 22 in federal district court in Washington, D.C. on behalf of the enrollees, naming U.S. Health and Human Services Secretary Alex Azar and Centers for Medicare and Medicaid Services (CMS) Administrator Seema Verma as defendants.

Lawsuits have stalled implementation of Medicaid work rules in eight other states, most recently in Indiana. A federal judge struck down rules in Arkansas and Kentucky, but the cases are on appeal.

Michigan’s rules require anyone aged 19 to 62 who is enrolled in the Healthy Michigan Plan to document 80 hours a month of work, job training, substance abuse treatment, volunteering, or job-seeking. There are 12 exemptions to the requirement, such as physical or mental disability and being a caregiver.

CMS has not commented on the lawsuits challenging the work rules.

In a January 29, 2019 op-ed in RealClear Health on the 17,000 Medicaid recipients in Arkansas who lost coverage because of failure to comply with work rules, health care policy analysts Grace-Marie Turner and Doug Badger write it may be as simple as “they didn’t consider the benefits worth it.” Of those who lost coverage, “all were eligible to reenroll on January 1 to try again. Fewer than 1,000 did,” Turner and Badger write.

Gov. Gretchen Whitmer, a Democrat, has publicly opposed the work rule, enacted by Republican lawmakers before she was sworn into office, but she does not have the authority to repeal or suspend it.

House Speaker Lee Chatfield (R-Levering) and Senate Majority Leader Mike Shirkey (R-Clarklake) introduced the work rule legislation in 2018, suggesting the governor will get little cooperation from the legislature on her proposed delay in implementation (see related article, this page).

—Staff reports

Official Connections:


Michigan Senate Majority Leader Mike Shirkey (R-Clarklake): https://www.senatormikeshirkey.com
Editor’s note: In response to public outcry over “surprise medical bills,” Congress is considering the Lower Health Care Costs Act, reported out of the House Energy and Commerce Subcommittee on Health and the Senate Health, Education, Labor, and Pensions Committee. The legislation would require providers to accept the median network rate set by insurers. Health Care News spoke to Carter Johnson, spokesperson for the Save Our Air Medical Resources Campaign, on how this legislation would affect access to this lifesaving service.

**Health Care News:** How much of a market is there for air ambulance services?

**Johnson:** Many rural communities face a severe lack of access to emergency medical care. Since 2010, more than 110 rural hospitals have closed throughout the country. Because of these closures, approximately 85 million Americans now live more than an hour away from their nearest Level 1 or Level 2 trauma center.

**Health Care News:** How much does an air ambulance trip cost?

**Johnson:** Billing is based on two metrics: lift fee and mileage.

It is important to note the difference between the cost and the charge. The median cost of an air medical mission is just over $11,000 if every transport is paid equally by all payers: government health care programs and private insurance. That is not what occurs, however, because 70 percent of air medical flights are reimbursed by Medicare, Medicaid, or people who are uninsured and pay out of pocket, and these payers only cover just over 30 percent of that median cost.

**Health Care News:** What percentage of the air ambulance service market do Medicare and Medicaid cover, and what are the reimbursement rates?

**Johnson:** More than 70 percent of emergency air medical transport patients are covered by Medicare, Medicaid, another form of government insurance, or are uninsured. This means that air medical transport providers are drastically under-reimbursed on more than seven out of 10 transports.

“More than 70 percent of emergency air medical transport patients are covered by Medicare, Medicaid, another form of government insurance, or are uninsured. This means that air medical transport providers are drastically under-reimbursed on more than seven out of 10 transports.”

**CARTER JOHNSON, SAVE OUR AIR MEDICAL RESOURCES CAMPAIGN**

**Health Care News:** Who covers these unmet costs?

**Johnson:** The 30 percent of remaining transports are for patients with private insurance. Because of the drastic under-reimbursement by government payers, the cost of those transports is borne by the rest of the market. Unfortunately, private insurers increasingly deny emergency air medical transports based on “medical necessity,” after the fact, in more than 40 percent of privately insured claims, even though 100 percent of all air medical flights are deployed by first responders or medical professionals.

In some cases, insurance providers deny claims based on network status, while intentionally keeping air medical providers out of network. Consumers buy insurance so they are covered in an emergency. That’s what insurance is for. According to a 2106 paper by Sierra Health Group, all air ambulance transports could be covered with a $1.70 a month premium.

**Health Care News:** How would benchmarking, setting out-of-network bills to a median price, affect air ambulance companies?

**Johnson:** Moving forward with legislation before understanding the full cost of these health care services will not solve the problem. In fact, setting any kind of arbitrary benchmark rates without insight into accurate data could further limit patient access to air ambulances.

There is a better way. Last year, Congress directed the U.S. Department of Transportation to collect data from the air medical industry, develop recommendations for protecting patients from balance billing, improve disclosure, and inform consumers of insurance options. In addition, Rep. Ben Ray Lujan (D-NM) rightly introduced an amendment to the bill that would require private insurers to disclose their claims and payment data.

That committee has just begun to tackle this task, and Congress must allow this important work to continue. Then Congress should address the chronic under-reimbursement by government payers and the failure of private insurers to do right by their customers. Only then can we protect and preserve access to these lifesaving services.

Moreover, this proposal does nothing to address the bad practices of private insurers. Some insurance providers have refused to allow any emergency air medical providers to go in-network, and others have only one in-network emergency air medical provider.
Wyoming Requests Medicaid Pay for All Air Ambulance Flights

By AnneMarie Schieber

Wyoming, a state with expansive plains and a sparse population, is working on a plan through the Section 1115 waiver process to have the federal government cover air ambulance transportation through Medicaid for all state residents, regardless of income.

The intent, according to the state’s public notice, is to eliminate surprise billing of patients, reduce the cost of service, and increase price transparency for consumers.

The proposal would have Wyoming treat the air ambulance industry like a managed public utility. The state would issue competitive bids on a network of air ambulance providers and support them through “periodic flat payments, similar to a gym membership,” the proposal states. Providers would then “recoup the revenue needed to fund the system from the insurance plans and individuals already paying for transports.”

The Centers for Medicare and Medicaid Services (CMS) accepted the application on November 13. The 30-day comment period ends on December 13.

Unique Challenges

The Wyoming Medicaid Air Ambulance Waiver plan is an attempt to address one of the state’s unique health care challenges. Wyoming is the tenth-largest state geographically, but its population, at 577,737, is smaller than those of 31 of the nation’s biggest cities.

“This [air ambulance] system is broken,” wrote Gov. Mark Gordon in the application. “My constituents are routinely hit with absurdly high surprise bills, and employers are consistently asked to cover escalating costs.”

“No one ‘has any say over how much air ambulance service we need, or how much we are expected to pay for it,’” the application states.

By implementing an “all-payer” system through Medicaid, the state can “regulate supply so air ambulance service can be provided efficiently and effectively,” and the bidding process will be “free market,” Wyoming’s website states.

Medicaid coverage for air ambulance trips will be retroactive, meaning a patient does not have to be enrolled in the program beforehand. The state estimates there will be 3,500 air ambulance transports a year, costing Medicaid an additional $45.6 million annually. Currently, 54,982 Wyoming residents are enrolled in Medicaid.

Deep Doubts

Allowing the air ambulance market more freedom would be a better solution, says Seth Myers, president of Air Evac, which provides air ambulance service in Wyoming.

“First, we wouldn’t need a ‘flat fee’ system if insurance companies would negotiate with us in good faith,” Myers said. “We need to cover our costs. Under this waiver request, taxpayers will end up paying an expense that insurance companies should be covering. We don’t need another government program. This is something the state’s insurance commissioner could address.”

The proposal raises red flags, says Myers. “Wyoming says it wants to create more of a free-market system but wants to regulate the supply,” Myers said. “When government does that, it is anything but free-market. If there is a government-controlled market, private companies will lose money and won’t want to participate. Service and access will suffer.”

Wyoming state senator Dave Kinsky (R-Sheridan) opposes the state’s waiver request for similar reasons.

“It costs $3,000 just to walk through the door of an emergency room,” Kinsky told Health Care News. “It makes sense that air ambulance service would cost more.”

Kinsky says Wyoming is a small, rural state struggling to sustain basic hospital service.

“High-level trauma care is out of the question in all but the largest communities in Wyoming,” Kinsky said. “If we as Wyoming citizens are to have access to high-level trauma care, it must come through air ambulance service. Let’s not forget that nor jeopardize the access.”

Myers says the waiver idea fails to address interstate transport, which is not uncommon for air ambulances in Wyoming.

“The interstate flights of air ambulances are why Congress continues to assert federal jurisdiction over air medical services,” Myers said.

Concern Over Surprise Bills

Air ambulances have been singled out in the recent debate over surprise medical bills.

Consumers may receive a “balance bill” if the air ambulance company falls outside their insurance network and the expense is not covered. The federal Government Accountability Office states the median price for an air ambulance trip is $36,400.

Air ambulance companies say they are compelled by law to send consumers a bill and it is more important to look at amounts actually collected. Data posted on the Wyoming Department of Health’s public notice website shows most of those who use an air ambulance service pay no more than $300 out of pocket because they are covered by a government health care program, and of the 10 percent who do pay out of pocket, the average amount paid is $2,250, with a median payment of $1,200.

“Wyoming is creating a new, state-wide government program for a problem that only affects a very limited number of people,” Myers said. “This is the worst type of policymaking: using a few anecdotes to justify an entirely new government program that will cause more harm than good.”

Wrong Kind of Flight?

Another concern about the proposed air ambulance waiver is the loss of critical access to care if providers leave the state or opt out of Medicaid because of low payment rates. Medicaid reimbursement is substantially below the costs of an air ambulance flight, and if payment for every transport were paid at the Medicaid rate or a similarly low rate, providers would no longer be able to operate in the state because they would be forced to take significant losses on each flight.

Providers participate in Medicaid currently and cover their unreimbursed expenses through other payers, particularly private commercial health plans. The proposed system would eliminate this revenue stream by paying for everybody through Medicaid.

“If providers are unable to cover Medicaid losses, you could see providers opt out of the Medicaid program and leave the state altogether,” Myers said.

AnneMarie Schieber (amschieber@heartland.org) is managing editor of Health Care News.
FDA Faces Challenges When Recruiting Scientists, Analysts

By Madeline Peltzer

U.S. Food and Drug Administration (FDA) commissioner nominee Stephen Hahn alluded to hiring challenges at the agency, saying the FDA must put “the right people in place” to modernize the federal drug approval process because “science is moving so quickly.”

Hahn made the comments at his U.S. Senate confirmation hearing on November 20.

Janet Woodcock, director of the FDA’s Center for Drug Evaluation and Research, expressed concern in October the FDA is rapidly losing medical experts to the private sector.

“The ACs [advisory committees] just have so many rules and lawyers,” Biopharma Dive quoted Woodcock as saying. “It’s really difficult to get people with the greatest expertise.”

That wasn’t the first time Woodcock mentioned the obstacles the FDA’s bureaucracy poses to pharmaceutical innovation and access.

“It’s not working, and it won’t work in the future,” she stated at a “Breakthroughs in Medicine” conference in September. “We need the whole system to evolve and change if we’re going to do what we set out to do: help every patient feel better and live longer.”

**Expert Shortage**

The FDA is having trouble competing for a limited pool of talent, the administrators say.

“Sometimes, [the biopharmaceutical companies] are competing to actually pick people from our agency,” said Peter Marks, director of the FDA’s Center for Biologics Evaluation and Review, at the Biopharma Congress in October. “That’s always fun.”

The staffing challenge is another reason for the FDA to modernize its approval process, says Ed Hudgins, research director at The Heartland Institute, which publishes *Health Care News*.

“The fact that the FDA has 15,000 employees but finds itself unequal to the task of expediting certification of medications to meet patient demands points to the fact that its regulatory system is woefully out of date,” Hudgins said.

If the FDA is to remain relevant, it must modernize its treatment certification process to foster the innovations of entrepreneurs and researchers in the private sector, instead of being an impediment, says Hudgins.

“The FDA can best speed innovation and allow the efficacy of experimental treatments to be determined by backing the creation of a Free to Choose Medicine (FTCM) track,” Hudgins said.

FTCM would allow drug sponsors to offer treatments deemed to be safe but still being tested for efficacy. Data from early use could be put into a Tradedef Evaluation Drug Database, which would speed up the drug approval process and provide much more information for regulators and health care providers alike.

Madeline Peltzer (mpeltzer@hillsdale.edu) writes from Hillsdale, Michigan.
FDA Nominee Grilled about Agency’s Drug Approval Process

By Bonner Cohen

At his initial confirmation hearing before the Senate Health, Education, Labor, and Pensions Committee, Stephen Hahn, President Donald Trump’s nominee to head the Food and Drug Administration (FDA), was told senators want him to speed up the agency’s drug approval process.

Sen. Mike Braun (R-IN) asked Hahn how open he was to reform.

“I think it’s important to expedite and reach patients as quickly as possible,” Hahn said. “I do want to ensure these approaches are validated, to avoid huge mistakes that hurt patients, but I am open to a conversation about that.”

Braun responded, “Rest assured, before confirmation I’ll be getting with you on that.”

Sen. Johnny Isakson (R-GA) told the nominee he wants the FDA to speed up approvals.

“I share your enthusiasm for modernizing the approval process,” Hahn said. “As a physician, I rely on the FDA for protecting patients, and the standards cannot be compromised. However, I believe in a new era, when the science is moving so quickly, the agency should be more efficient, and we should have more agility with those approvals.

“Part of that is, in fact, getting the right people in place to make the assessments that are needed to uphold the gold standard,” Hahn told the committee.

The Senate committee approved Hahn’s nomination in an 18-5 vote. A vote by the full Senate is expected in December. Hahn would replace Scott Gottlieb, who served as FDA commissioner for the past two years.

Systemic Problems

Ed Hudgins, research director at The Heartland Institute, which publishes Health Care News, says it is notable “the gold standard” came up again in the hearing, this time by Sen. Patty Murray (D-WA), who defined it as placing science before politics.

“The gold standard is turning to rust, and patients are suffering and dying while waiting for promising medications delayed for years by the increasingly antiquated system,” Hudgins said. “Even worse, proposals to actually put patients first and revamp the system are falsely portrayed as ‘loosening’ science standards.”

Hahn told the committee he agreed with Murray and pledged to put patients first. Hudgins says the FDA’s requirements for certifying the safety and efficacy of new medicines and treatments, established by Congress in 1962, stand in the way of that promise.

“The standard is behind the times and hampering medical innovations based on scientific advances and exponential technology,” Hudgins said.

Hudgins says it would have been more encouraging if Hahn had acknowledged that problem.

“Rather than giving more power to the FDA bureaucracy, Hahn should expose how the current system stifles innovation and takes away patient choice, if he wants to put patients first,” Hudgins said.

Open to Analytics

While discussing potential reforms at the hearing, Hahn said he was open to new ways of using data.

“Data analytics [could] help us come to more accurate and precise conclusions about products,” Hahn said. “Those are two things I’d like to see, if confirmed, pushed forward at the agency.”

Problems with the FDA’s drug approval process have existed for decades. Currently, it takes 12 years and $2.9 billion to bring a drug to market in the United States. Although the FDA commissioner has limited jurisdiction over the prices patients pay at the pharmacy, high drug prices reflect the extraordinary time and expense involved in getting new drugs approved by the agency.

Focused on Drug Prices

The high cost of prescription drugs was another important subject of inquiry at the hearing. Hahn told the committee he wants to encourage competition in the market, but he could not commit to supporting a policy of importing drugs from other countries.

Asked by Sen. Tammy Baldwin (D-WI) about his views on lowering drug prices, Hahn said, “I don’t spend a lot of time on the price side. But rarely a day goes by that this isn’t an issue addressed by patients. It’s an urgent issue, and the American people want us to act on this. Ultimately, this is an access issue.”

Asked about the safety of lower-cost generic drugs, Hahn said he would encourage adherence to manufacturing standards and improvements in manufacturing practices.

Several senators said they wanted the FDA to focus on the development of biosimilars and other generic drugs while tackling “patent gaming,” the practice of pharmaceutical companies blocking generic drug makers’ access to product samples needed to create generic drugs, and the use of legal loopholes to extend patents.

“I am very much in favor of transparency, and anti-competitive practices should be eliminated,” Hahn told the committee.

Hahn, a radiation and medical oncologist, has served as chief medical officer at the University of Texas MD Anderson Cancer Center in Houston since May 2018. In that capacity, he oversees 20,300 employees and administers an annual operating budget of $5.2 billion.

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Medicare for All Would Reduce Household Income by 11 Percent, Study Finds

By Ashley Bateman

Most Americans will pay much higher taxes and earn less income if Medicare for All becomes law, a new study by The Heritage Foundation states.

“Our analysis finds that in order to fund such a program, it would be necessary for the federal government to impose substantial, broad-based taxes equal to 21.2 percent of all wage and salary income.”

EDMUND HAISLMAIER, JAMIE HALL
AUTHORS OF THE STUDY
THE HERITAGE FOUNDATION

People would pay 21.2 percent more in federal payroll taxes, bringing the rate to 36.5 percent for most workers. Average annual disposable income for U.S. households would decrease by an average of $5,671.

In addition to income taxes, most American workers pay 15.3 percent in payroll tax, 12.4 percentage points of which funds Social Security and 2.9 percentage points goes to Medicare. The new payroll tax of 36.5 percent would apply to every dollar earned, from the lowest-paid worker to the highest, the study states.

People who receive health insurance from their employer would be hit with an even bigger decrease in household income. Their disposable income loss would be $10,554 because they would lose the tax advantages from their employer insurance, which is currently untaxed. The study, released on November 19, finds 87.2 percent of households with employer-sponsored health insurance would be financially worse off.

All Income Groups Lose

Proponents of Medicare for All argue a government-run system will benefit consumers by costing less than what they have been paying for private insurance or health care services paid for out of pocket. That assumption is false, the study states.

“Our analysis finds that in order to fund such a program, it would be necessary for the federal government to impose substantial, broad-based taxes equal to 21.2 percent of all wage and salary income,” study authors Edmund Haislmaier and Jamie Hall wrote.

The 21.2 percent tax on workers would be necessary to fund a program that not only replaces employer-paid insurance but also insurance for workers with no health plans and the “additional spending that would result from the program stimulating increased use of medical care.”

In addition, the Medicare for All proposals offered by contenders for the Democrat presidential nomination would cover many services currently not covered by Medicare, such as long-term care, the study states.

Lower-income working families that currently get their health care through Medicaid or the Children’s Health Insurance Program would also lose, because they too would be subjected to higher taxes, the study finds. Haislmaier and Hall calculate these families’ average household income would decrease by $5,592 a year.

The authors used data from the 2016 Medical Expenditure Panel Survey of 12,704 households in making their calculations.

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

Google Data Partnership with Insurer Raises Patient Privacy Concerns

Under fire from consumers, privacy experts, and regulators, Google is defending its data-sharing partnership with insurer Ascension Health, saying it will treat private patient data “with the respect that it deserves.”

The Wall Street Journal reported on December 2 Ascension Health has been sharing private patient data with the tech giant in an effort called Project Nightingale. The data involves patients from 21 states and was shared without their knowledge or specific permission.

Ascension is one of the largest health care systems in the country, with 2,600 hospitals, offices, and other facilities, the Journal reported. Google is not charging for the work yet, the report states.

The goal of the project is to develop “an intelligent suite of tools for clinicians, including a tool that aims to make health records more useful, more accessible and more searchable by pulling them into a single, easy-to-use interface for doctors,” stated David Feinberg, M.D., head of Google Health, in a blog post and video in response to public concerns.

Ethical, Legal Concerns

The criticisms of the deal are based on ethical and legal grounds. On November 18, the U.S. House of Representatives Energy and Commerce Committee demanded briefings from the companies on Project Nightingale.

“This initiative raises serious privacy concerns,” committee leaders stated in their letter to the companies. “[This] raises serious concerns whether Google can be a good steward of patients’ personal health information.”

The Citizens Council for Health Freedom calls the partnership “troubling” (see page 17).

Feinberg said the partnership is a “business associate agreement,” and although some Google staffers will have access to patients’ medical records, “these staff undergo HIPAA and medical ethics training, and are individually and explicitly approved by Ascension for a limited time.”

Google Cloud President Tariq Shaukat, on a video on the blog post, said the company’s goal is “ultimately improving outcomes, reducing costs, and saving lives.”

Consent Issue

Although such research can be considered to be under blanket permission from patients, it is important for the business parties to have safeguards in place, says Roger Klein, M.D., J.D., who specializes in health care regulation and compliance and is a policy advisor to The Heartland Institute, which publishes Health Care News.

“It sounds like Google and Ascension could be considered to be doing research without specific consent—which may fall under a general research consent—which seems appropriate for a project of this magnitude,” Klein said. “I find it interesting that there has been no mention of institutional review board involvement.”

Although the partnership can be defended as valid research leading to general knowledge, the Google project does not appear to be purely scientific in intent, says Klein.

“While I think that [generalized knowledge] applies here, it is more in the nature of applied commercial-product research than pure medical investigation,” Klein said. “In a sense, it is reflective of newer modes of service provision enabled by ‘big data’ capabilities with which our regulatory efforts may not have kept pace.”

—Staff reports
Poll: Millions Know People Who Died Because Health Care Was Unaffordable

By AnneMarie Schieber

A new poll shows more than 13 percent of American adults believe someone they know died because they did not receive needed medical treatment or could not pay for it.

The poll says 34 million U.S. adults know someone who died after not getting treatment because they could not afford it, and 58 million adults report an inability to pay for needed drugs.

When asked whether there was a time in the last five years when a friend or family member passed away after not receiving treatment because they had “an inability to pay for it,” the highest rate of yes answers came from nonwhites (20.3 percent), those with household incomes under $40,000 (18.5 percent), and those aged 18-44 (16.9 percent). Independents and Democrats had the highest rates (21.6 percent and 27.8 percent), and those aged 18-44 (16.9 percent) and who earned household incomes under $40,000 (18.5 percent) were most likely to answer yes.

The survey was released while Congress considers bills to control prescription drug prices. In its news release, Gallup stated, “drug prices directly affect consumers, and with the U.S. one year away from the 2020 election, presidential candidates will increasingly be asked to explain and defend their policy positions on rising drug costs.”

Block Government Patient I.D.s, Organizations Ask Senate

Twenty-two organizations signed a letter urging U.S. Sen. Richard Shelby (R-AL), chairman of the Senate Appropriations Committee, to block funding for a national patient identification system known as the Unique Patient Identifier (UPI).

In June, the U.S. House of Representatives removed a prohibition on funding put into place in 1997 by former Congressman Ron Paul of Texas. A UPI is a number the federal government would assign patients so their medical information could be tracked in a national medical records system.

Such a system would undermine patient privacy, says Twila Brase, president of the Citizens Council for Health Freedom (CCHF), which organized the letter campaign.

“In an attempt to unify and control patient data, Congress threatens to put Americans and our national security at risk to hackers and others wishing to steal and leverage private medical and financial details,” Brase said in a statement.

The letter cites the Google-Ascension data-sharing agreement (see page 16), which it calls “troubling” because it did not require obtaining explicit individual consent from patients. The letter also says a UPI is another step toward creating a national health care system.

“Therefore, Mr. Chairman, we are asking you to use your considerable power to stop the National Patient ID,” the letter stated.

In September, Sen. Rand Paul (R-KY) introduced S. 2538, which would deauthorize the UPI.

“As a physician, I know firsthand how the doctor-patient relationship relies on trust and privacy, which will be thrown into jeopardy by the National Patient ID,” Paul stated in a press release. “Considering how unfortunately familiar our world has become with devastating security breaches and the dangers of the growing surveillance state, it is simply unacceptable for government to centralize some of Americans’ most personal information.”

—Staff reports

Preserving the Literature of Liberty

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The Michael Parry Mazur Memorial Library is one of the country’s best libraries devoted to freedom and limited government, with hard-to-find books on free-market environmentalism, economics, health care, and much more. Censors can’t hide or delete physical books on physical shelves in a building open to the public, free of charge, and conveniently located.

The library is located at The Heartland Institute, 3939 North Wilke Road, Arlington Heights, Illinois. Call 312/377-4000 to schedule an appointment or to donate books. Visit heartland.org/library for more information and an online book catalog.
Hospital Supply Chain Inefficiencies Are Wasting Billions of Dollars, Study Finds

By Ashley Bateman

Hospitals across the United States are wasting money through poor supply chain management, with the total amount increasing by nearly 12 percent over the most recent year to $25.7 billion, a study by the consulting firm Navigant found.

Researchers analyzed data from 2,127 acute care hospitals and found an individual hospital can save on average $12.1 million per year by identifying which services, products, and procedures are truly necessary, efficient, and based on clinical evidence. Hospitals can also save money by increasing standardization and employing physicians as executives, the study says.

The annual study breaks down the potential savings based on geographic region, urban or rural setting, ownership type, whether the hospital is academic-based, and size measured by bed capacity.

Perverse Incentives

The study is much-needed but could do more, says Marilyn Singleton, M.D., J.D., anesthesiologist and president of the Association of American Physicians and Surgeons.

“It is heartening that the ‘thought leaders’ are addressing the facility supply chain as a source of cost savings in medical care,” Singleton said. “Missing from the conversation is a discussion of the role of group purchasing organizations (GPOs).”

GPOs negotiate contracts in the health care market. Hospitals depend on GPOs to act as cost-saving intermediaries with vendors, distributors, and other suppliers by making large purchases and providing better deals on products for medical facilities. Unfortunately, GPOs have an incentive to keep costs high, says Singleton.

“GPOs are supposed to reduce supply costs through volume purchasing, but the current system of payment encourages higher prices,” Singleton said. “The GPOs are paid by a percentage of the cost of the product, so the higher the cost, the higher the fee.”

“This conflict of interest must be taken into consideration when looking for remedies for high supply-chain costs,” Singleton says. “GPOs do not always choose the products that are best for their customers, patients, or the taxpayers.”

Singleton says GPOs also pad their income by charging vendors “contract administration fees.”

Ripe for Disruption

Consolidation in recent years has given four GPOs—HealthTrust, Intalere, Premier, and Vizient—control over 90 percent of the market, says Singleton.

Big tech companies have seen an opportunity to bring down costs. Services such as Amazon B2B, Amazon’s business-to-business marketplace, remove intermediaries from the purchasing process to allow vendors to sell directly to buyers.

Singleton says the idea has been slow to catch on in the health-care industry.

“It remains to be seen if Amazon’s B2B service will disrupt the status quo by providing price transparency and comparison shopping,” Singleton said.

Ashley Bateman (bateman.aa@googlemail.com) writes from Alexandria, Virginia.
It Takes a Village to Restore and Protect Market Freedom

Editor’s note: Each month, Health Care News will profile a national and a state-based public policy organization working to advance freedom in the health care market so that consumers and providers can all be winners. The Heartland Institute, which publishes Health Care News, is a national research and educational policy organization focused on free-market solutions in all 50 states. Because worthy causes are never achieved single-handedly, we devote this space to share the good work of our allies in this effort.

Galen Institute Takes on Socialized Medicine, Promotes Health Care Choices

Wherever there is a robust debate about socialized medicine, such as the congressional hearings on Medicare for All proposals, chances are the Galen Institute is front and center.

Galen is a national public policy research organization devoted to creating a vibrant, patient-centered health care sector. Founded 25 years ago by Grace-Marie Turner, Galen facilitates public debate and educates policymakers and the public about ways to support individual freedom, consumer choice, competition, and innovation in health care.

The Galen team has worked tirelessly to promote market-liberating health care policies on Capitol Hill and in the public square. The organization is actively involved in the current debates over surprise medical bills, prescription drug prices, price transparency, and repairing the damage the Affordable Care Act has done to our health care sector and overall economy. Senior Fellows Doug Badger and Brian Blase, both of whom have served as top presidential advisers on health care policy, have written extensively about these and other issues in recent papers for the organization.

Galen’s recent reports include a look at how health insurance premiums have dropped in states that have received permission to shed Obamacare mandates, and an examination of how international drug pricing policies affect prices and access. Another report (see story on page 8) shows Medicaid expansion has led to an increase in ineligible enrollees.

Turner testified before Congress four times in 2019, arguing forcefully against Medicare for All. She and her colleagues speak around the country on a range of health care policy issues, appear regularly as commentators on television, and are widely published in The Wall Street Journal, New York Times, National Review, and dozens of other media outlets.

In 2020, the Galen Institute will continue to address the great threat of socialized medicine by promoting its market-driven policy ideas and expanding its influence and outreach in the health care arena. As the 2020 presidential election goes into full swing and health care takes the spotlight, the Galen Institute will be a prominent contributor to the debate.

Pelican Institute Serves as a Louisiana Health Care Public Policy Watchdog

When Louisiana expanded its Medicaid program in 2016, the Pelican Institute for Public Policy found another target for its vigilance: becoming the watchdog over a program tarnished by reports of waste, fraud, and abuse.

The work has paid off. The organization received national recognition for demanding a full accounting of records when the state claimed the expanded program had a positive impact on the Louisiana economy.

The Pelican Institute believed the state was underreporting “crowd-outs,” people leaving private insurance plans to sign up for free care under Medicaid. When Pelican pushed for better accounting, the state took action that indicated the organization was on to something: It stopped compiling data that would have shed more light on crowd-outs.

Health Care Priority

The Pelican Institute is a Louisiana-focused policy organization that provides research and education on free-market principles and liberty-oriented policy solutions.

Health care is a top priority for the organization, says its vice president for government relations, Renee Amar.

“Citizens need private-sector solutions to their ever-increasing health care costs, and the government definitely needs help due to its poor management of health programs,” Amar said. “The cost of health insurance is a major issue for every citizen, business, and government. We need real solutions to truly lower costs for everyone.”

Amar says the organization’s work has transformed the health care policy debate in the state.

“The biggest change is now Medicaid is a major part of the conversation,” Amar said. “In highlighting the issues with Medicaid expansion, we have received national attention, so now more people are paying attention to waste, fraud, and abuse.”

In addition to Medicaid reform, the organization supports simplifying the state’s tax code and changing the relationship between local and state government as other ways to improve health care.

Spotlighting Reform

Turner testified before Congress four times in 2019, arguing forcefully against Medicare for All. She and her colleagues speak around the country on a range of health care policy issues, appear regularly as commentators on television, and are widely published in The Wall Street Journal, New York Times, National Review, and dozens of other media outlets.

In 2020, the Galen Institute will continue to address the great threat of socialized medicine by promoting its market-driven policy ideas and expanding its influence and outreach in the health care arena. As the 2020 presidential election goes into full swing and health care takes the spotlight, the Galen Institute will be a prominent contributor to the debate.
The necessary cure for what ails the U.S. healthcare system?

**Patients who are passionate advocates for their own medical care!**

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“In my view, the best possible medical and mental care outcomes happen when a medical professional and a patient work together to ask the right questions and then find the answers, and when the patient exercises control of his or her own care.” – Lee Beecher, MD, author of *Passion for Patients.*

**Explore the book at** [http://leebeecher.com/home.html](http://leebeecher.com/home.html)

Dr. Beecher’s career as a psychiatrist spanned parts of six decades. He served patients in all manner of practice settings. There is a better path to choose than those imposed by third party payers and government regulators, or dictated by heartless Big Data. The book concludes with practical reforms – physicians and patients having skin in the game.

“I am concerned that modern medical practice is moving from a physician-patient relationship to a patient-Electronic Health Record (EHR) relationship, from the tender hands of a physician touching the heart of an individual patient, to the calloused hands of a data entry clerk ensuring that all the boxes required by regulators and third party payers have been checked.”

**Available online at** alethospress.com or Amazon.com

As an eBook or in Hardcover
Health Insurance Tax Break Increases National Debt, Stifles Economy

By Robert Berry, M.D.

A cartoon featured in some eastern Tennessee newspapers on Father’s Day was both sad and sobering. A young girl was shown graciously offering Uncle Sam a gift, exclaiming, “Happy Father’s Day! I got you something,” to which Uncle Sam reciprocated by saying, “I got you something too,” and handing her a gigantic ball and chain with the words “$21 TRILLION NATIONAL DEBT.”

No one knows for sure exactly what will happen if our government continues to accumulate more debt. Since “the borrower is slave to the lender,” the liberties we have been blessed to inherit will most likely be threatened for future generations if we don’t start doing something about it now.

Many people probably have various insights from their own experience about ways to reduce this debt. As a direct primary care (DPC) physician in Greeneville, Tennessee who has not accepted health insurance in more than 18 years, I have been in a unique position to see not only how insurance for nonemergency outpatient medical care increases our country’s debt but also how it stifles our overall economy and thus reduces tax revenues from which to pay off this debt.

Untaxed Benefit

Americans carry insurance for unexpected catastrophes such as car accidents, burned houses, and inpatient hospital care. We don’t purchase it for routine care or home maintenance, so why do we have it for everyday medical care? The reason is, unlike other insurance, it is a pretax expense enjoyed primarily by large and medium-sized corporations wielding great political influence.

Most people don’t know this tax exemption for employer-provided health insurance adds about $350 billion to our national debt each year while discriminating against the self-employed and employees of small businesses, many of whom can’t afford health insurance yet were cruelly forced to pay Obamacare penalties until Congress and President Donald Trump ended them in 2017.

The increasing number of families choosing membership in Christian health care sharing ministries don’t benefit from this tax exemption. As a matter of justice both to future generations who will be responsible for this debt and to the many uninsured, Congress should eliminate this tax favor. While they are at it, Congress should remove the tangle of insurance regulations so companies will have to compete by offering consumers the opportunity to buy policies that make sense for them.

Magic of Price Transparency

When Americans pay directly for outpatient medical care at facilities that make their pricing transparent, they pay much less than they would at facilities that don’t. I have observed that patients and health care providers today don’t seem to know what—or even if—insurance will pay for elective outpatient care. My DPC patients who pay me directly are not confused by such uncertainty. They make me cost-justify diagnostic strategies and therapeutic interventions before they are undertaken. As a result, lab tests purchased at my clinic and MRI scans, and several thousand dollars on colonoscopies. One patient traveled 900 miles to save more than $10,000 on outpatient surgery at the Surgery Center of Oklahoma, which posts all-inclusive prices on its website and offers patients a way to pay for such procedures on credit.

These examples show that when Americans pay directly for outpatient medical care at facilities that make their pricing transparent, they pay much less than they would at facilities that don’t.

Diverting Needed Workers

Since DPC practices such as mine don’t bill insurance, we require three fewer employees per physician than those that do. That means with roughly 350,000 primary care physicians in this country, health insurance drains approximately one million dependable, hardworking people from our labor force today, when there is less than 4 percent unemployment. Many jobs that are unfilled as a result are arguably of greater service to our fellow citizens than the settling of small medical claims that require a ridiculous and onerous level of documentation in electronic medical records.

From my perspective, simply eliminating the tax exemption for employer-provided health insurance would bolster the economy by reducing health care costs and supplying much-needed labor to our nation’s employers while leveling the taxation playing field for all Americans. Most important, eliminating this tax break would help to reduce our national debt and preserve our legacy of freedom for generations to come.

Robert Berry, M.D.
OWNER, DIRECTMD GREENVILLE

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OWNER, DIRECTMD GREENVILLE
FDR Deserves Abundant Blame for America’s Health Care Headaches

By Chris Talgo

Have you ever wondered why your health insurance is inexplicably tied to your job?

Well, the answer is quite simple.

On October 2, 1942—as World War II raged across the globe—President Franklin D. Roosevelt signed the Stabilization Act of 1942, which allowed the commander-in-chief to set price and wage controls. The logic behind the law was to keep price inflation and the cost of labor low so the government could afford the massive number of weapons and other goods necessary to win the war.

In short, this supposedly temporary government intervention—during a time of desperation—produced a host of unintended consequences that continue to haunt us long after the Allies defeated the Axis powers in 1945.

After Roosevelt issued his price and wage controls, employers could not offer employees higher salaries to attract and retain top talent. So, they did the next best thing. They offered “fringe benefits,” such as health care packages (and pensions), to employees to increase their compensation.

So began the sordid chapter of employer-provided health care that has caused all sorts of problems—lack of policy choices, resistance or reluctance to change one’s job for fear of “losing” health insurance coverage, a less dynamic job-creation environment—and continues to wreak havoc more than seven decades after the Second World War ended.

Employees Get Tax Break

In 1943, the employer-health care knot was tightened when the Internal Revenue Service determined employees were not required to pay taxes on health care premiums funded by their employer.

Later that year, the National War Labor Board upheld the exemption of fringe benefits, including employer-provided health care, from FDR’s wage freeze. These seemingly innocuous actions further cemented the connection between your job and your health insurance.

To put this in historical context, consider this: In 1940, one year before the United States entered World War II, less than 10 percent of Americans had what we now call health insurance. By 1946, just one year after the Nazis and Japanese were defeated, 30 percent of Americans were receiving health care insurance via their employer.

Today, that number has swollen to about half the U.S. population (49 percent). In case you are curious, the other 51 percent of Americans receive health insurance most commonly from Medicaid (21 percent), Medicare (14 percent), and non-group plans (7 percent). The remaining 9 percent have chosen to forgo health insurance for one reason or another.

In other words, the fact that roughly half of Americans receive health care benefits directly from their employer is an artifact from an era long ago. Perhaps now is the time to rethink this situation and reform how most Americans receive their health care benefits.

This would unbridle the chokehold of employer-provided (and government-provided) health insurance. Allowing large groups of people outside the strict bounds of employment to buy health plans would launch a much-needed wrench into the arbitrary employer-health care contraption.

Another obvious reform that has the potential to vastly improve the health care system would be expansion of health savings accounts (HSAs). Similar to 401(k) accounts, HSA funds are portable, meaning individuals own the funds in them. HSA funds are pretax dollars that can be used to purchase a vast array of medical expenses. Even better, HSAs can be coupled with complementary health insurance plans to avoid catastrophic costs in a health care emergency.

HSAs put consumers, as opposed to third-party payers, in charge of purchase decisions, which will likely drive down costs and improve health care quality.

Stuck in the Past

Unfortunately, a well-intended public policy meant to help ensure victory in a world war has remained intact for decades and devolved into a sclerotic shell of its former self. As is the case with most government interventions, we are stuck with the remnants of an antiquated and draconian measure that has relatively limited bearing today.

The real question is this: When will Americans wake up and realize FDR’s price controls were wrong in the first place? After all, FDR’s other misguided economic policies during the war, such as strict rationing allowances for consumer goods, were abandoned after the defeat of the Third Reich and the Rising Sun.

Maybe it is about time we did the same for the hopelessly outdated and obsolete employer-health care debacle.

Chris Talgo (ctalgo@heartland.org) is an editor at The Heartland Institute.
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