Maine Medicaid Expansion
With a new governor and voter-approved referendum, Maine becomes the 37th state to expand Medicaid. Despite enrollment rising at a “steady pace,” proponents claim there is plenty of money to pay for the costly expansion.

Newsom’s Agenda
Incoming California Gov. Gavin Newsom wants to expand Obamacare with mandates, increased insurance subsidies, and Medicaid coverage for all Californians, regardless of citizenship.

Virginia Telemedicine
Virginia lawmakers are trying to lead the nation in bringing down barriers to telemedicine by passing key bills to broaden access and expand markets to new technologies.

OR, WA Parental ‘Visits’
The term “nanny state” takes on a new meaning in the Pacific Northwest, as lawmakers consider sending government workers to look in on all new parents.

House Bills Propose Medicare Negotiate Prescription Drug Prices
By Kenneth Artz
Congressional Democrats and one Republican are proposing a package of bills they say will lower drug prices, including a measure giving Medicare more power to set drug prices.

The Pulse

Medicaid Expansion
Crowds Out Other Spending in Virginia
By Ashley Bateman
For most of the past decade, Medicaid has been overwhelming Virginia’s budget, to the point where the state is now expecting a $462.5 billion shortfall over the next two years, and lawmakers are torn over how to make up the difference.

In the fall of 2018, Virginia Secretary of Finance Aubrey Layne blamed unexpected costs on inaccurate cost projections and higher enrollment than the state government had forecasted.

Layne told the Richmond Times-Dispatch Medicaid expansion had nothing to do with

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Drug Prices, p. 4
FEBRUARY 27 - MARCH 2, 2019

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Congress, President Consider Multiple New Regulations to Lower RX Prices

By Kenneth Artz

The Trump administration and Congress are considering a variety of proposals to reduce the costs of pharmaceuticals, including legislation to permit personal importation of prescription drugs from Canada, matching drug prices to lower ones in other countries, and mandating drug makers state the prices of their products in TV ads.

‘No Master Price List’

Sally C. Pipes, president and chief executive officer of the Pacific Research Institute, says all these proposals are ill-advised, starting with the demand that drug companies include prices of prescription drugs in their television ads.

“There’s no master price list anywhere, and it would be harmful to patients if they see the price on TV and it’s not the price they’re paying,” Pipes said. “So many people already get lower prices through their pharmacy benefit manager.”

Matching Prices, Delaying Drugs

Independent Institute Senior Fellow John Goodman says setting price controls on what Medicare pays for drugs to match lower prices charged in other countries would deny patients drugs they urgently need.

“What we’ve discovered is in other countries, the lower the price they’re paying correlates to the longer they wait to make a deal,” said Goodman. “And what that means is in some cases they waited years, resulting in cases where people were denied access to lifesaving drugs.”

Goodman says those countries sometimes threaten to violate the patent of a drug and make their own generic version.

“I don’t know if they’ve ever done it, but they have threatened to do it,” Goodman said.

Tying drug prices to an international price index would stifle innovation, Pipes says.

“If we are going to keep developing new and beneficial drugs and biologics, then we have to allow the free market to work, and it doesn’t work when these countries are free-riding off our R&D,” Pipes said.

Trump Administration Proposes Rule Change on Prescription Drug Rebates

The U.S. Department of Health and Human Services is proposing a rule change that will essentially prohibit drug companies from giving rebates to pharmacy benefit managers (PBMs).

Drug companies offer rebates to PBMs as an incentive to include the companies’ in their formularies and have been protected from the Anti-Kickback Statute. The new rule gives that protection to fixed fees instead of rebates. HHS Secretary Alex Azar says without the rule change, drug companies have little restraint in lowering their prices.

“This proposal has the potential to be the most significant change in how Americans’ drugs are priced at the pharmacy counter, ever, and finally ease[s] the burden of the sticker shock that millions of Americans experience every month for the drugs they need,” said Azar in a news release.

Edward Hudgins, research director at The Heartland Institute, which publishes Health Care News, says although the new rule is a step in the right direction, the industry needs a more fundamental change in government policy.

“The reform is in the context of an insurance market highly distorted by government,” Hudgins said. “The reform could be like whack-a-mole. It bans rebates to PBMs, which normally pass some of the rebates along to insurance companies as an incentive to cover particular drugs, and instead allows rebates to customers at the pharmacy.

“This could mean lower drug costs for customers at the pharmacy but the insurance companies, no longer receiving rebates, could charge customers higher premiums,” Hudgins said.

—Staff Reports
House Bills Propose Medicare Negotiate Prescription Drug Prices

Continued from page 1

Rep. Peter Welch (D-VT) and nine other House Democrats, along with Republican Rep. Francis Rooney (FL), introduced the bill on January 8.

"Leveraging the federal government’s enormous purchasing power to cut drug prices for seniors is common sense and long overdue,” said Welch in a news release. “Paying retail prices for wholesale drug purchases is ridiculous and irresponsible. If the President is serious about lowering drug prices, he should demand that Congress send our bill to his desk.”

‘A Program on Steroids’

John Dunn, a physician, lawyer, and policy advisor for The Heartland Institute, which publishes Health Care News, says the bill draws a target on the back of the pharmaceutical industry.

“What they want is a program on steroids that can negotiate and drive down the prices of drugs and effectively price-fix costs instead of letting the market work its wonders,” said Dunn. “They want to make the pharmaceutical companies provide a public service and then run them like public utilities.”

Medicare will use the power of its market share to tell pharmaceutical companies what it is willing to pay, Dunn says.

“That’s not negotiation, that’s price-fixing at a level they think they can force the pharmaceutical companies into accepting, and if they can’t, then they will say they’re not making that drug available to the people insured by the program,” Dunn said. “The really expensive drugs you see advertised on TV will never be part of a program like Medicare because it restricts its formulary by lowering the price it will pay for certain drugs,” Dunn said.

Such a setup limits consumer choice, Dunn says.

“The program drives down the costs and reduces the access to drugs that might be expensive or more expensive but are worthwhile to use, on the theory that, ‘Well, we can’t afford to do that,’ but that’s the game played by socialists everywhere,” says Dunn.

“Where we wind up is with the market determining what drugs we have, not with the government picking winners and losers,” Dunn says. “The government interferes with the market by deciding what drugs we get to use and how much we pay for them. The government should not be in the business of picking winners and losers.”

The New Chicago Way

Lessons from Other Big Cities

Ed Bachrach and Austin Berg

“[Congressional Budget Office] has already studied this and concluded there’s not going to be much savings as long as Medicare buys every drug. The Veteran’s Administration system saves money because it walks away from the table and does not buy every drug, and therefore the VA is notorious for not having the best and most up-to-date drugs.”

DR. JOHN C. GOODMAN
SENIOR FELLOW, INDEPENDENT INSTITUTE

Government vs. Markets

Devon M. Herrick, a health economist and policy advisor to The Heartland Institute, says it is a myth that Medicare does not negotiate the price of drugs.

“The background is that under the non-interference clause. It created a drug benefit administered by private companies: private insurance plans and private drug companies.

“So when people say that Medicare does not negotiate the price of drugs sold in the United States, that’s false,” Herrick said. “It does, but the government doesn’t do it: very large drug plans, pharmacy benefit managers, insurance companies, and the like manage drug benefits for seniors, 100 million or more people.”

Not Expecting Much

Dr. John C. Goodman, a senior fellow at the Independent Institute and president of the Goodman Institute for Public Policy Research, says history tells us not to expect big savings from this change.

“While expanding the ability of Medicare to negotiate with drug providers is a good step toward bringing market forces into the drug industry, it is important for the federal government not to treat this as a first step toward price controls, which would be the death knell for drug innovation in the United States,” Glans said.

Kenneth Artz (kennethcharlesartz@gmx.com) writes from Dallas, Texas.
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“The Western is an anachronism. I know it’s fascist. I know it’s sexist. I know it’s evil and out of date. But, God help me, I love it so.”

— Sam Peckinpah
Medicaid Expansion Crowds Out Other Spending in Virginia

Continued from Page 1

the anticipated budget hole. Medicaid expansion went into effect in Virginia on January 1, 2019, and the state officials revealed the cost projections in a revised budget forecast on November 2, 2018, the day enrollment opened for the expanded program.

Virginia is one of 37 states to expand Medicaid. Under the Affordable Care Act, the federal government promises to cover 90 percent of the costs for the first five years, a much higher reimbursement rate than the states receive for the base Medicaid program for the neediest recipients.

‘She Saw Dollar Signs’

Dr. Deane Waldman, a physician and distinguished senior fellow for health care policy at the Texas Public Policy Foundation, says Virginia is making the same mistakes as New Mexico did in expanding Medicaid. He reviewed an analysis of New Mexico’s Medicaid expansion plans by the state’s legislative budget commission and found serious problems with the state’s projections.

Although the revenue projections seemed accurate, the forecasters were wrong in ignoring the reduction of care that would result from a rapid increase in enrollment, Waldman said. Waldman says he concluded the supply would not meet the rapidly rising demand.

“The governor didn’t believe me,” Waldman said. “She looked at a minimum estimate of three billion additional dollars and all these people who would have coverage who didn’t have it now.

“So she implemented it just the way Virginia did, and probably for the same reason,” said Waldman. “She saw dollar signs and saw more people insured.”

More Enrollees, Less Access

Forecasting the effects of Medicaid expansion is like planning for any other major project, Waldman says.

“You never talk about revenue without talking about cost, and you better talk about net,” Waldman said.

“First, [New Mexico] underestimated the enrollment volume by several hundred thousand people, Waldman said. “By 2017, 42 percent of the state’s population was covered by Medicaid. Unfortunately, the costs of federal insurance mandates—both benefits and the expanded bureaucracy—exceeded contributions from Washington by $417 million.

“To deal with its shortfall, New Mexico Medicaid had to cut reimbursements to providers,” Waldman said. “In other words, the only way they could balance their state budget was to reduce access to care. End result of Medicaid expansion was more people with insurance and fewer people who could get in to see a doctor.”

Coverage, Not Care

Lawmakers commonly make the mistake of assuming coverage, such as health insurance, means the same as health care, and the current highly regulated model, which often uses managed care, saves money by not giving care, Waldman says.

“The same way the insurance companies use ‘3-D’ offense to delay, defer, and deny, the less they spend, the more profit they make,” Waldman said. “As long as insurance is a prepayment plan, we’re going to continue to be in this mess. I have been pushing to get third party [payment systems] out of health care and return it to where it needs to be: an exchange between doctor and patient.”

‘Tearing Down the Walls’

Virginia state Sen. Ryan McDougle (R-Hanover) introduced a bill in the current legislative session to move responsibility and oversight of Medicaid from the Department of Medical Assistance Services to a new state agency to be called the Office of Medicaid Fiscal Oversight.

“The purpose of my bill is to ensure what happened last year doesn’t ever happen again,” McDougle told Health Care News. “The nearly $500 million debacle that we are having to confront in the current budget is unacceptable. The Office of Medicaid Fiscal Oversight and Accountability will take politics out of the equation. The Office will have the ability and authority to prevent this from happening in the future, which is especially important as we are already learning about inaccurate projections and other fiscal dangers related to Obamacare’s Medicaid expansion.”

The proposed office would issue a cost forecast, provide monthly oversight of Medicaid expenditures, and review the impact policy changes might have. The office would employ actuaries who would determine projections for growth in managed care rates. It is expected that the office would employ five to seven full-time people, including an economist and a data information analyst.

“Current federal matching dollars would cover 50 percent of the new agency’s expenses. According to a fiscal statement on the bill, however, it is not clear whether an independent office would be eligible for federal reimbursement. The Department of Medical Assistance Services would still exist to maintain current activity, such as federal reporting and provider rate setting with the Centers for Medicare and Medicaid Services.”

Calls for Deregulation

Deregulation is the path to success in health care policy, says Ben Knotts, Virginia grassroots director for Americans for Prosperity.

“With an expanded population on Medicaid, we must be focused on lowering the cost of health care for everyone,” said Knotts.

“Lawmakers can only lower the cost of care by tearing down the walls between patients seeking care and the qualified providers who wish to give it. By removing these barriers, we increase the supply of health care for patients to access, and we can provide more accessible, affordable health care to Virginians across the board,” said Knotts.

Virginia is also seeking a work requirement waiver from CMS. That application is pending.

Ashley Bateman (bateaman.aae@googlemail.com) writes from Alexandria, Virginia.

INTERNET INFO
Virginia Senate Bill 1352, “Medicaid Fiscal Oversight and Accountability”
https://lis.virginia.gov/cgi-bin/legp604.exe?191+sum+SB1352
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REPRESENTATIVE ISAAC LATTERELL
SOUTH DAKOTA

The Heartland Institute is a national nonprofit organization based in Arlington Heights. Its mission is to discover, develop, and promote free-market solutions to social and economic problems. For more information, visit our website at heartland.org or call 312/377-4000.
U.S. Sens. Amy Klobuchar (D-MN) and Charles Grassley (R-IA) have introduced in the U.S Senate a bill that would prohibit companies producing name-brand drugs from paying other companies not to put generic versions of their drugs on the market.

These arrangements between drug companies, known as pay-for-delay or payoff agreements, can reduce competition and raise drug prices by delaying consumer access to more-affordable alternatives to branded drugs.

Such agreements cost U.S. consumers and taxpayers $3.5 billion in higher drug costs every year, according to the Federal Trade Commission. The Preserve Access to Affordable Generics and Biosimilars Act (PAAGBA) would prohibit drug companies from entering into such agreements.

Consumers Pay More

Pay-for-delay tactics limit consumer choice in the prescription drug market by postponing availability of generic drugs, and consumers end up paying higher prices for branded drugs because generic drugs are kept off the market, says Anna Wilkerson, a government relations coordinator at The Heartland Institute, which publishes Health Care News.

“Inevitably, when high-quality and effective generic and biosimilar drugs are artificially barred from the market, the price of existing drugs increases and, worse, patients suffer,” Wilkerson said. “Overwhelmingly, consumers prefer and purchase generic drugs, saving them hundreds of billions of dollars each year.”

Fostering competition would make prescription drugs more affordable and accessible, Grassley says.

“Competition among drug makers is critical to lowering the price of prescription medications,” Grassley stated in a press release. “Our bill will curb the anti-competitive pay-for-delay tactics that artificially inflate prices for patients and prevent access to more affordable alternatives.”

Ending pay-for-delay tactics would benefit consumers, Wilkerson says.

“PAAGBA would address this nation’s skyrocketing health care costs by halting the anti-consumer practice of large, established pharmaceutical companies paying off their small, generic competitors to not sell their pharmaceutical drugs for a number of years,” Wilkerson said.

“Only a Band-Aid”

Christina Herrin, campaign manager for Free to Choose Medicine at The Heartland Institute, says the bill is a first step that can help direct attention toward a much bigger problem.

“The bipartisan legislation introduced by Sen. Klobuchar and Sen. Grassley to address price-fixing loopholes used and abused by big pharmaceutical companies to keep generics out of the marketplace sheds light on a serious issue,” said Herrin.

PAAGBA narrowly addresses just one of many things that contribute to higher drug prices, and it leaves the biggest problem, government regulations, untouched, Herrin says.

“As this legislation addresses the issue of crony capitalism and the ability of a monopoly to use payoffs as a way to decrease competition, it is only a Band-Aid solution,” Herrin said. “Unfortunately, this problem, like many, is caused by overbearing regulations and red tape. The underlying solution to lowering prescription drug prices starts and ends with free enterprise.”

Calls for More Reforms

Wilkerson says the key to reducing drug prices is to reform the approval process of the Food and Drug Administration (FDA).

“Something else that federal legislators can do to bring down drug costs is to reduce regulations surrounding the approval process of generic versions of pricey brand medicines,” Wilkerson said.

Herrin says the slowness of the FDA drug approval system unnecessarily reduces the availability of pharmaceuticals and increases their cost.

“It takes an average of 12 years for a drug to hit the marketplace and costs billions,” Herrin said. “We need a government that works for, not against, the American people. And with the innovative nature of medicine, we need a system that will bring drugs to market sooner, not one that requires pharmaceutical companies to jump through hoops just to appease the FDA.”

Concern for Consumers

Klobuchar says excessive prices for lifesaving prescription drugs prevent many people from being able to buy the drugs they need.

“This bipartisan legislation offers a commonsense solution for lowering the costs of prescription drugs,” Klobuchar stated in a press release accompanying the announcement of the bill. “It’s long past time that Congress put patients before pharmaceutical companies and help Americans get the critical medications they need.”

Emma Kaden (ekaden.heartland@gmail.com) is an intern at The Heartland Institute. Chris Talgo (ctalgo@heartland.org) is an editor at The Heartland Institute.
Maine’s New Governor Expands Medicaid

By Nicole Staley

Maine’s newly elected chief executive, Gov. Janet Mills, has instructed the state’s Department of Health and Human Services to move forward with Medicaid expansion.

The expansion, approved by voters through a referendum in November 2017, had been blocked by previous Gov. Paul LePage, who argued the policy should not go into effect until the legislature found a way to fund it.

The expansion, declared on January 3 as Mills’ first executive order, will make MaineCare, the state’s version of Medicaid, available to at least 70,000 new applicants.

At the time of the referendum, 260,969 people were enrolled in MaineCare, according to the Kaiser Family Foundation. As of February 8, MaineCare enrollment numbers were rising at a “steady pace,” according to the Maine Department of Health and Human Services (DHHS), with 4,515 people receiving Medicaid-expansion coverage.

“Maine needs to dedicate a long-term funding source to Medicaid expansion,” said Posik. “Relying on surplus Medicaid funds will not work. There is simply not enough existing revenue to provide coverage to the estimated 70,000 Mainers eligible for expansion.”

‘Discourages Upward Mobility’

Another concern about expansion is workers intentionally settling for lower incomes or wages to qualify for MaineCare, Posik says.

“That happened between 2002 and 2006, when MaineCare was expanded under Gov. Angus King, because Medicaid benefits end abruptly instead of phasing out as a recipient’s income grows,” Posik said.

“Medicaid expansion discourages upward mobility because benefits are cut off for individuals who earn more than 138 percent of the federal poverty level, thus providing an incentive for individuals who earn just over this mark to limit or reduce their earnings in order to retain coverage,” said Posik.

Crowding Out the Neediest

The rules for Medicaid expansion give states a perverse incentive to shift resources away from the neediest people, Posik says.

“If a state finds itself in a position where it has to make cuts, it’s actually more fiscally sound to make cuts within traditional Medicaid than to make cuts within the expansion population,” Posik said. “For example, in Maine, we pay 36 cents on every dollar within the traditional Medicaid program. If we have to make cuts, we save an extra 26 cents on every dollar cut from traditional Medicaid vs. Medicaid expansion. This is what occurred in Arizona after an earlier Medicaid expansion cost the state about four times more than the original projections, forcing the state to eliminate coverage for heart, liver, lung, pancreas, and bone marrow transplants.”

Arianna Wilkerson, a state government relations manager with The Heartland Institute, which publishes Health Care News, says Medicaid expansion goes against the reasons the program exists.

“It has been a system designed to assure taxpayers’ hard-earned dollars go towards health care for certain low-income populations such as the disabled, the elderly, and pregnant women,” Wilkerson said. “Obamacare, however, allowed states to extend Medicaid coverage to able-bodied adults without children, effectively diverting public dollars from those who need it to those who do not. Maine should expect their traditional Medicaid recipients to experience longer waiting times for treatments and their non-Medicaid residents to experience increased taxes or cuts to government services in order to pay for the expansion.”

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

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INTERNET INFO

“The Expensive Empty Promises of Medicaid,” Maine Heritage Policy Center: https://mainepolicy.org/project/medicaidexpansion/
NYC Mayor de Blasio Proposes Another Health-Care-for-All Plan

By Jake Grant

New York City Mayor Bill de Blasio introduced a plan he says guarantees the “right to health care for everyone” in his city, though it falls short of the universal coverage plans promoted at the national and state levels.

De Blasio proposes a “safety net” that will dedicate city funds to pay for primary care for those who don’t have health insurance or can’t afford copays or deductibles. It will be the largest program of its kind for any city in the nation, serving some 600,000 New Yorkers. The city will offer care through its public hospitals and clinics on a sliding scale based on income.

De Blasio’s plan, called NYC Care, would provide access to primary care, prescriptions, and mental health and substance abuse services. In a news conference, the mayor acknowledged coverage would extend to undocumented immigrants by saying he rejects the idea they don’t deserve care.

The Same, But Different

John C. Goodman, a senior fellow at the Independent Institute and president of the Goodman Institute for Public Policy Research, says what Mayor de Blasio is doing is smoke and mirrors: moving money around and claiming the city has done something when it really hasn’t.

“The charity hospitals in New York City have a deficit of over $100 million, and de Blasio wants to put $100 million into his new plan,” Goodman said. “Something tells me this is just going to cover the deficit of the charity hospitals and nothing else is going to change.

“The uninsured will be still be going to the same places as they did before, the lines will be just as long, they’ll be getting the same treatment as they got before, and nothing will have changed,” Goodman said. “We’ll just put a different name on it.”

Doubts Access Will Improve

De Blasio’s plan won’t increase health care access but will add to the overall cost of health care in the city, says Michael Tanner, a senior fellow at the Cato Institute.

“It’s not necessarily a Medicaid or Medicare-for-all plan,” said Tanner. “The idea is to throw more money at the system to pay for additional medical services, but they won’t be truly increasing coverage for everyone,” Tanner said.

‘Scoring Political Points’

Tim Rice, deputy director of health care policy at the Manhattan Institute, says de Blasio’s plan will be both ineffective and inefficient.

“Motivated by the prospect of scoring political points, the mayor’s new health care plan ignores reality at its own peril,” said Rice. “The stated budget of $100 million a year shakes out to about $167 for each of the 600,000 uninsured New Yorkers the plan aims to serve—although the mayor has already indicated his willingness to cast this budget aside and pour money into the program as need be.

“This reckless spending, combined with the fact that this plan would provide a wide variety of services for little to no cost, will inevitably add to the already burdensome debt of the city’s public hospitals, and the mayor will be forced to turn to the taxpayers to keep his single-payer dream a reality,” said Rice.

Calls for Regulatory Rollback

The city’s public hospitals are facing a $6.1 billion shortfall through 2020, according to the New York City Independent Budget office, and the city has tried to shore up revenues by expanding enrollment in its public option, MetroPlus plan. Rice says it would be better if de Blasio were to use his political clout to press for deregulation, which increases competition and lowers costs to consumers.

“If the mayor really wanted to improve the health of all New Yorkers, his time might be better spent lobbying his perennial sparring partner, Gov. Andrew Cuomo, to lift the statewide ban on short-term health insurance and roll back other regulations which discourage competition among health care providers and keep premiums artificially inflated.”

Short-term insurance plans offer coverage for people in transition between jobs. They are less expensive than plans on the individual market because they are exempt from Obamacare regulations. Last year, the Trump administration lifted time limits on the plans, but New York is one of 11 states where short-term plans are either banned, unavailable, or limited to three months, according to a report by the Foundation for Government Accountability.

The NYC Care program will launch this summer, starting in the Bronx. De Blasio says he plans for it to be available to all residents in the five boroughs by 2021.

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

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“This reckless spending, combined with the fact that this plan would provide a wide variety of services for little to no cost, will inevitably add to the already burdensome debt of the city’s public hospitals, and the mayor will be forced to turn to the taxpayers to keep his single-payer dream a reality.”

TIM RICE
DEPUTY DIRECTOR OF HEALTH CARE POLICY
MANHATTAN INSTITUTE
New Health Care Agenda for California Bolsters Obamacare, Eyes Single-Payer

By Kenneth Artz

During his first weeks on the job, California’s new governor, Gavin Newsom, restated his intent to establish a single-payer health care system, provide “state-based support” for illegal immigrants ages 19 to 26, expand insurance subsidies and reimbursements to providers, create a mandate to purchase insurance, and create a single purchasing system for prescription drugs.

Newsom requested Transformational Cost and Universal Coverage Waivers from the Trump administration to reach his goals, stating in a letter to President Donald Trump and congressional leaders, he wants to “build on the successes of the Affordable Care Act (ACA)” and prevent changes that “erode” Obamacare.

The waivers would give California more control over how it spends federal health care money.

Says Plan Will Be Costly

Devon M. Herrick, a health economist and policy advisor to The Heartland Institute, which publishes Health Care News, says expanding Medicaid to illegal aliens is unlikely.

“I know Gov. Newsom would like to expand Medicaid in California, but with all the wildfires they’ve had, recovery takes priority, plus the state is out of money anyway,” Herrick said. “It would be a very difficult push because they would have to get a divided U.S. Congress to sign off on it.”

Current federal law precludes undocumented immigrants from getting Medicaid, except in emergencies, says Herrick. Medicaid is available to “qualified” immigrants who complete a five-year waiting period.

“If you showed up in labor at a hospital, they would deliver the baby,” said Herrick. “They’re not going to turn you away. Even if you show up at the ER for a heart attack, they’re going to treat you and stabilize you.

“But illegal immigrants don’t qualify for federal assistance until they’ve been in the United States for five years,” Herrick said. “I don’t think California could get matching funds from the feds to expand Medicaid for noncitizens. They could go it alone, but they could not get matching funds to cover undocumented workers or illegal aliens. I don’t think this is something Health and Human Services would approve, or else it would have already been done by President Obama.”

Questions Cost Estimates

The plan would cost far more than expected, Herrick says.

“Hispanics, more than any other ethnic group, tend to be the least insured across the United States,” Herrick said. “A lot of people buy into the notion that they don’t want to pay for a health care plan or health insurance because it’s something they think they don’t need or will ever use.”

As a result, if California offers “free” health care to the uninsured, the ones most likely to sign up will be those who have health problems, says Herrick.

“What this means is you would not be getting a lot of healthy people buying premiums to offset the cost of the unhealthy folks, but you would get a lot of new expenses coming in as the unhealthy folks signed up for Medicaid,” said Herrick. “It would not be cheap.”

Play, No Pay

Adding illegal aliens to Medicaid will further erode the viability and quality of already troubled government insurance programs, says John Dunn, a physician, lawyer, and policy advisor for The Heartland Institute.

“Right now, we have a situation where access to health care is compromised for people who are insured with Medicaid,” Dunn said. “This is also true for people insured through Medicare, which also has a reimbursement rate which, in some cases, is not very friendly to providers. So in effect a lot of people are getting taken out of Medicare because the reimbursement system is so unattractive, despite the demand being so high.”

Newsom’s plan makes the situation even worse by adding a new category of people who will use the system without paying into it.

“Part of California’s program is to ignore the fact that illegal aliens are coming in to take advantage of the benefits of being an American citizen without becoming citizens.

“There isn’t anything about Medicaid expansion that I can describe as being a good development,” Dunn said.

Driving Taxes Higher

Sally C. Pipes, president and chief executive officer of the Pacific Research Institute, a San Francisco-based think tank, says extending Medicaid benefits to the illegal alien population between the ages of 19 and 26 is a radical idea that will drive people out of the state.

“First of all, illegal immigrants aren’t even covered under the Affordable Care Act (ACA), so why should people who are here illegally receive support from people who are here legally and paying taxes for health care?” Pipes said.

“They will be getting health care through Medi-Cal, which is California’s version of Medicaid, and the cost is about $200 million to do this,” Pipes said. “More and more people are going to leave California if the income taxes are increased, because the incentive to stay in California will just not be there because our taxes are so high. Our state tax, with the millionaire’s tax, is at 13 percent.”

Pipes says many illegal immigrants are already seeking treatment at costly emergency rooms.

“This will increase as more and more come to California for free health care, but they won’t be able to find doctors, and this will further increase ER use,” Pipes said. “ER is the most expensive form of care.”

Kenneth Artz (kennethcharlesartz@gmx.com) writes from Dallas, Texas.

Official Connections:
California Gov. Gavin Newsom: https://govapps.gov.ca.gov/gov40mail/

INTERNET INFO

Oregon Studies In-Home Visits to All New Parents

By Brandon Best

Oregon is considering taking the idea of “nanny state” to a new level with a program that would send government-sanctioned health care workers to the homes of new parents to make sure newborns are getting proper care and screening.

The Oregon Senate Committee on Health is evaluating Senate Bill 526, which would direct the Oregon Health Authority (OHA) to study the effects of in-home care provided by licensed health care professionals. Oregon Sens. Elizabeth Steiner Hayward (D-Portland) and Bill Hansell (R-Athena) and Reps. Sheri Schouten (D-Beaverton) and Duane Stark (R-Grants Pass) are sponsoring the bill. The lawmakers gave the bill “emergency” status, requiring the OHA to submit findings and recommendations to an “interim” legislative health care committee by the end of the year.

Gov. Kate Brown made government-sanctioned home visits and supplemental health screenings a key initiative in her campaign in 2017. Brown says the policy will improve children’s school readiness and health outcomes. Brown’s proposal is included in the 2019-21 budget but does not have a designated amount of funding attached.

OHA Director Patrick Allen told The Beaverton Valley Times he favors the plan, which he says would probably consist of two or three visits to every new parent in the state by a licensed health care practitioner who would provide screenings, contacts for primary care physicians, and planning for preventative care.

Expects Public Pushback

John Charles, president of the Cascade Policy Institute, says a study of in-home visitation is a long way from launching a feasible program.

“It’s possible this bill was introduced to have a token hearing,” said Charles. “Lots of bills are introduced to satisfy someone’s curiosity or their constituents.”

Charles says he expects the public to express a strong, negative reaction to the bill.

“It will generate a lot of pushback, because I don’t think many parents would welcome someone investigating how things are going with their new-born without a warrant,” Charles said.

Oregon has other, higher priorities, says Charles.

“The state has no particular expertise in this area, and it’s unclear what, specifically, they are trying to solve when they have so many other problems going on,” said Charles. “Parenting is highly subjective, and people are suspicious of anyone coming in, telling them what to do with their kids,” he added.

Raises Constitutional Issues

The bill does not say what the state would do with the information it gathers from the visits. Government employees entering private residences raises Fourth Amendment issues, as was the case in Michigan in 2013 when tax assessors in Davidson Township attempted to enter homes to make sure properties had been assessed correctly. Residents could refuse, but that would have put them at risk of having an assessment rise because an assessor could claim there was a lack of information. Property owners balked, and the local government backed down.

Paula Bolyard, coauthor of Homeschooling: Fighting for My Children’s Future, sees similarities between newborn visits and problems she witnessed in her 20 years in the homeschooling movement.

“As a general rule, I don’t think the government ought to be involved in health care or social work unless there is evidence of abuse or neglect,” said Bolyard. “If they want to give names of providers to parents, fine. But I think parents know what’s best for their own children and can do a far better job of taking care of them than some government agency.”

“Still, I think the threat remains. Lawmakers may be a bit more cautious about making the home visits universal right now,” Bolyard said. “So lawmakers may be a bit more cautious about making the home visits universal right now.”

There is also concern about how the state would administer such a program, Bolyard says.

“The state may run into trouble providing contacts to new parents for primary care,” said Bolyard. “The state would have to determine what providers would be on that list.”

North Carolina’s Experience

In 2018, North Carolina conducted a pilot program for a similar service, targeting communities with poor access to pediatric care. The Oregon bill would establish a universal program throughout the state.

The State of Washington is also considering universal newborn home visits. In a news release, Gov. Jay Inslee says he wants to set aside $173 million for the next two years to “provide universal newborn screening assessments and home visiting services, expand and improve preschool opportunities, create a statewide referral system to connect families with early learning services and build more early learning facilities,” according to his office’s press release on the proposal.

Bolyard says there has been an enormous outcry over the idea nationwide.

“Still, I think the threat remains. Lawmakers and health authorities keep using the word ‘universal’ to describe the effort, so what else could that mean except that they want every newborn child to be enrolled in the program?”

Brandon Best (bbest@cedarville.edu) writes from Cedarville, Ohio.

INTERNET INFO

Oregon Senate Bill 526

“As a general rule, I don’t think the government ought to be involved in health care or social work unless there is evidence of abuse or neglect. If they want to give names of providers to parents, fine. But I think parents know what’s best for their own children and can do a far better job of taking care of them than some government agency.”

PAULA BOLYARD
COAUTHOR, HOMESCHOOLING: FIGHTING FOR MY CHILDREN’S FUTURE

Official Connections:

Oregon state Sen. Elizabeth Steiner Hayward: https://www.oregonlegislature.gov/steinerhayward


Oregon Gov. Kate Brown: https://www.oregonlegislature.gov/stark
Affordable Care Act Enrollment Continues to Decline

By Jake Grant

For a second straight year and the first year in which the federal government-imposed penalty for not having health insurance has been lifted, the number of people signing up for coverage on government exchanges has dropped.

Approximately 8.4 million people signed up for taxpayer-subsidized insurance on state and federal exchanges during the fall enrollment period for 2018, a 4 percent drop from 2017 and a bigger drop from 2016 when enrollment was 12,681,874, according to the Centers for Medicare and Medicaid Services. These enrollment declines predated the elimination of the individual mandate, which went into effect on January 1, 2019.

Enrollment in Obamacare consistently has consistently fallen far short of the Congressional Budget Office’s estimate that 25 million people would sign up. It its first year, in 2014, 8,019,763 people enrolled. Enrollment rose slightly the following year, and in 2016 it peaked at 12,681,874.

“Enrollment is falling primarily among those who do not receive subsidies and therefore are exposed to the full cost of the ACA’s onerous regulations, which is one more indication that those regulations are unpopular,” said Michael Cannon, director of health policy studies at the Cato Institute.

Premiums Up, Enrollment Down

As enrollment declined, premiums have increased, with the average monthly benchmark premium rising from $273 in 2014 to $481 in 2018, according to a Kaiser Family Foundation analysis.

In addition to the elimination of the mandate, consumers now have more access to short-term and association health plans under initiatives by the Trump administration. Such plans tend to be less expensive than insurance from the government exchanges because they are not required to include coverage for all items mandated under the Affordable Care Act.

The Trump administration has also eliminated cost-sharing-reduction payments to health insurers on the exchanges to make the premiums more reflective of the actual cost. Cannon says it is not surprising ACA supporters have attacked those measures.

“When ACA supporters call these steps ‘sabotage,’ they are implicitly admitting that transparency is bad for the ACA’s political survival and that the ACA can only work by taking away consumers’ freedom to choose,” said Cannon.

Downward Spiral Beginning?

The ongoing decline in Obamacare enrollment could be the beginning of a downward spiral in which healthy people flee the government-managed system and costs to those who remain increase rapidly, says Cannon.

“Since the consumers who are dropping ACA coverage are generally healthier than average, their departure suggests premiums are likely to keep rising in the future,” said Cannon.

Sully Pipes, president and CEO of the Pacific Research Institute, says the enrollment decline reflects what people want.

“It’s because the cost of exchange coverage is unmanageable for many middle-class Americans,” Pipes said. “Spiking premiums, high deductibles, and smaller networks of doctors and hospitals are why enrollment is declining.”

The average premium for individual health insurance in the United States in 2013, before Obamacare went into effect, was $2,784, and under ACA, the average individual premium jumped to $5,712 by 2017, Pipes says.

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

IN Lawmaker Proposes Reinstating Certificate of Need

By AnneMarie Schieber

An Indiana lawmaker says he wants to bring back the state’s certificate of need process.

CON laws, which were repealed in Indiana 25 years ago, require health care systems, hospitals, and private practices to prove a demonstrated need in the community before they are allowed to expand their facilities or services.

State Sen. John Ruckelshaus (R-Indianapolis) told the Indianapolis Business Journal (IBJ) his interest was prompted by a group of residents who were worried about a new hospital in their neighborhood and argued it would ultimately drive up medical costs. Ruckelshaus did not respond to Health Care News’ request for comment.

Ruckelshaus told IBJ he expected to introduce a bill by mid-February, but as of February 14 he had not done so. Ruckelshaus did introduce Senate Bill 8, now in committee, to study hospital markets for a recommendation by November 2019. Indiana passed a law creating a CON process for comprehensive care beds, such as those in nursing homes, in 2015.

“Enrollment is falling primarily among those who do not receive subsides and therefore are exposed to the full cost of the ACA’s onerous regulations, which is one more indication that those regulations are unpopular,” said Michael Cannon.

“Dozens of studies have shown that CON laws actually increase costs for consumers by tamping down competition and forcing providers to use older facilities and equipment.”

MATT GLANS, SENIOR POLICY ANALYST, THE HEARTLAND INSTITUTE

Against the Tide

In contrast to Indiana, a growing number of states have rolled back their CON laws or are in the process of doing so.

Wisconsin and New Hampshire are the most recent states to take action, and Missouri and Tennessee are considering CON repeal. Currently, 15 states do not require health care providers to demonstrate a need for services before offering them to the public.

Matt Glans, a senior policy advisor at The Heartland Institute, which publishes Health Care News, says there is plenty of evidence CON laws raise health care costs rather than reducing them as defenders of the regulations claim.

“When CON laws are intended to slow the growth of health care prices, they are implicitly admitting that transparency is bad for the ACA’s political survival and that the ACA can only work by taking away consumers’ freedom to choose,” said Glans.

‘Should Reject These Efforts’

CON laws are harmful, unnecessary, and intrusive, Glans says.

“If a hospital has both the need and means to expand the services it offers, it should be allowed to do so,” said Glans. “Indiana should reject these efforts to reestablish CON laws. Restoring these unnecessary barriers to the health care market would discourage growth and innovation in Indiana’s health care market and push away new and innovative medical facilities that will more effectively allow demand for new and existing patient services to be met without inflating costs.”

AnneMarie Schieber (amschieber@heartland.org) is managing editor of Health Care News.
Missouri Legislature Considers Pro-Market Reforms

By Jeff Reynolds

The Missouri Legislature has taken up three bills offering free market reforms to the state’s health care industry by providing transparency, decreasing the burdens to entry into the market, and increasing freedom of choice for providers and patients.

House Bill 232, introduced by Rep. Steve Helms (R-Springfield), would require each health care provider to publish a price list for all products and services offered, a layperson’s explanation, and a cash price to be paid if insurance is not involved. House Bill 433, introduced by Rep. Jason Chipman (R-Jefferson City), would repeal the state’s certificate of need law. House Bill 233, also introduced by Helms, would establish a pilot program for implementing direct primary care in Missouri’s Medicaid program, MO HealthNet.

All the bills have been assigned to committees.

Cheering for Price Transparency

Requiring providers to publish price lists would help reduce health care costs, says Josh Archambault, a senior fellow for the Foundation for Government Accountability.

“When in a world of rising deductibles and high health care costs, patients need price information to have some certainty about their costs ahead of time,” Archambault said. “It allows them to find the highest-value providers and reduce their chance of unexpected bills. When patients have this kind of information, many end up picking lower-cost care and therefore reducing the amount spent on medical care, which means lower premiums the next year,” Archambault said.

Price transparency gives consumers much greater control over the market, Archambault says.

“When patients vote with their feet, the highest-cost providers feel some pressure to lower their prices,” said Archambault.

Price transparency is a critical component of true competition, says Patrick Ishmael, director of government accountability at the Show-Me Institute.

“Transparent pricing is essential to a functioning marketplace,” Ishmael said. “Consumers generally want to maximize their well-being, and when given an opportunity to compare prices for the same goods and services, they tend to gravitate to the least-expensive options. That puts downward pressure on the higher prices of other providers, giving consumers greater choices and generally lower costs.”

Removing Barriers to Entry

Certificate of need laws work against consumers and providers alike, hindering competition, Ishmael says.

“Certificate of need programs are government-administered bureaucracies that require government approval before a given service provider can open or expand their operations,” said Ishmael. “Such programs are subject not only to information problems, whereby ‘need’ is dubiously defined, but are also subject to issues of cronyism, as competitors can weigh in against proposals from new market entrants.”

“This would be like a new restaurant being forced to spend two years and hundreds of thousands of dollars to try to open a new location,” said Ishmael. “They just won’t. That is often what happens in health care.”

Chipman says he sponsored the bill because he believes certificate of need programs work against patients.

“Certificate of need programs stifle innovation and competition,” said Chipman. “They also drive up costs, lower quality, and limit the availability of needed services. While all participants admit that there are severe deficiencies in the program, none are willing to work toward reforms because they are just making too much money without any threat of competition.”

Piloting Direct Primary Care

The direct primary care pilot program would allow Medicaid patients in two counties to enroll in a DPC program, a model that charges a fixed fee each month for unlimited primary care.

“Direct primary care’s key innovation is its disintermediation of health insurers,” said Ishmael. “The more that people are able to distinguish between health maintenance products and health insurance products—and be able price them accordingly—the better off those patients will be and the healthier the market for health care will become.”

Direct primary care provides several direct benefits to consumers and providers, says Archambault.

“The positive outcomes under direct primary care models are that doctors burn out less often, patients receive excellent care, and for those with chronic conditions this level of care will prevent future medical costs and save money in the process,” Islama said.

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

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“In a world of rising deductibles and high health care costs, patients need price information to have some certainty about their costs ahead of time. It allows them to find the highest-value providers and reduce their chance of unexpected bills.”

JOSH ARCHAMBAULT
SENIOR FELLOW
FOUNDATION FOR GOVERNMENT ACCOUNTABILITY

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Official Connections:


Michigan has broadened its list of regulated controlled substances to include gabapentin, an anti-seizure drug that doctors have been using as an alternative to opioids for nerve pain and for pain caused by shingles.

Gabapentin, which is the generic name for Neurontin, is considered a safe drug, but it can become lethal when combined with opioid-based substances such as heroin and fentanyl. Combining gabapentin with other opioids provides users with a significantly more intense high at a much cheaper price. According to a 2018 report by the National Center for Biotechnology Information, Kentucky was the first state to classify gabapentin as a Schedule V controlled substance. The Kentucky Office of Drug Control Policy reported the drug contributed to nearly one-third of the state’s fatal overdoses in 2016.

The Michigan Department of Licensing and Regulatory Affairs (LARA) issued new guidelines, to begin in January, for prescribing and dispensing gabapentin. These include training physicians and providers on alternative pain treatments and counseling of patients on the effects and risks of controlled substances, state and federal controlled substance dispensing laws, and use of the state’s automated prescription system.

Restricting Treatment Options

Chad Savage, M.D., a Michigan-based internist and policy advisor to The Heartland Institute, which publishes Health Care News, posted on his Facebook page a critical comment about the new guidelines.

“They tell doctors not to use narcotics, which I get, but then go out of their way to make it hard to use anything that could be an alternative to narcotics. Additionally, my practice gets an incredible price on narcotics,” Savage said. “Additionally, my practice gets an incredible price on these as a DPC [direct primary care] practice but will now no longer be able to carry them as they are going to be controlled substances. Thus, this again undermines our attempts to make medical care cost-effective.”

Last year, a Michigan bill that would have effectively exempted gabapentin from controlled-substance rules failed to make it out of a House committee before the end of the legislative session.

States Determine Regulation Level

LARA says the new classification of gabapentin will not add to physicians’ costs.

“It is unlikely that the reclassification of gabapentin will have any direct added costs to physicians,” said Pard-eep Toor, a spokesperson for LARA. “With the reclassification, when prescribing gabapentin, physicians will be required to comply with the recent laws on schedule 2-5 substances, which are outlined on the state’s website.”

Physicians in the state now must apply for a controlled-substance license if they don’t have one and want to prescribe gabapentin. The federal government classifies drugs as controlled substances, and the states determine the level of regulation.

Michigan’s regulations on gabapentin may be the toughest in the nation. Kentucky’s rules bar physician assistants but not physicians from prescribing the drug, and prescriptions cover a longer period of time before becoming invalid. In 2016, the year Kentucky’s rules were put into place, deaths from overdoses involving gabapentin dropped to 363 from 456 in 2014. In 2010, before gabapentin started getting attention and no rules were in place, they were at 121.

Calls for More Study

Savage says he will be hesitant to prescribe gabapentin because of the additional time, hoops, and legal risk the new regulation imposes. In his 20 years of practicing medicine, he has never seen anyone abuse gabapentin or die from an overdose from it, and he is not aware of a street market for the drug in his community, Savage says.

“Whatever level of abuse there is, to me it doesn’t justify restricting a drug that can be used instead of the much more dangerous narcotics,” said Savage.

The best way to confront abuse is to foster a system where patients can have a strong face-to-face relationship with one doctor, Savage says.

“I’m not sure that’s possible by expanding Medicaid, where patients have a hard time getting appointments with primary doctors,” said Savage. “Few are accepting new patients because of the low reimbursement rates.

“A better solution might be to study the distribution of a particular drug and see why it is being abused,” Savage said.

Rocco Cimino (rocco.j.cimino@gmail.com) writes from Washington, DC.

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U.S. Cancer Death Rates Decline, But Gap Exists Between Low- and High-Income Counties

By AnneMarie Schieber

Over the past 25 years, death rates from cancer in the United States have declined by 27 percent, but the gap between low-income and high-income counties is growing, the American Cancer Society (ACS) reports.

The gap between low-income and high-income U.S. counties is almost nonexistent for cancers where prevention actions—such as lifestyle changes and early detection—have less effect, the annual ACS report on cancer rates and trends states. This indicates improving health care access would reduce cancer death rates, conclude the authors of the report, titled “Cancer Statistics, 2019.”

The death rate from cervical cancer in low-income counties is twice that for women in high-income counties, the report states. For lung and liver cancer, the gap is 40 percent. Colorectal cancer deaths have decreased by 53 percent since 1970, while the gap between high-income and low-income counties increased from 20 percentage points to 35 percentage points.

Concentrating on Low Incomes

Low-income counties are “low-hanging fruit” in the war against cancer, the report’s authors write.

“A broader application of existing cancer control knowledge with an emphasis on disadvantaged groups would undoubtedly accelerate progress against cancer,” the report states.

Nina Schaefer, a senior research fellow at The Heritage Foundation, says the report is right to direct attention to health care access in low-income areas.

“The ACS release reveals that there are probably underlying factors and challenges in some of these counties with accessing care that should be looked at carefully,” she said.

The report, released in January, covers the years 2006 to 2013, when Medicaid enrollment grew from 42.6 million to 55 million people.

Cites Medicaid Failures

Naomi Lopez Bauman, director of health care policy at the Goldwater Institute, says the trends point to an access problem.

“The recent and continuing good news about the progress being made in the battle against cancer is great news, disparities remain,” said Bauman. “Unfortunately, the poor and vulnerable have not been as fortunate.

“The Medicaid program, which serves as the nation’s health care safety net for the indigent, was already facing access issues, such as long waiting times for appointments and many doctors who do not participate in the program, before the [Affordable Care Act] expanded the program to millions more,” said Bauman.

A better system would be more patient-centered, Bauman says.

“Reforms where the program’s resources ‘follow the patient,’ allowing them to seek coverage that better meets their needs and preferences, is an important first step toward getting the patient the right care at the right time,” Bauman said.

Recommends DPC

Phillip Eskew, a physician, attorney, and founder of DPC Frontier, a direct primary care organization, says the report shows coverage does not equal care.

“The fastest way to solve an access problem is to make policy changes so that the price for a service falls,” said Eskew. “Medicaid patients in many locations might struggle to find a physician willing to see them under Medicaid’s inefficient and uncertain fee-for-service terms.”

A better way to improve access is to offer more-affordable options, such as direct primary care, in which members pay a low-cost, flat fee for unlimited primary care, Eskew says. DPC providers can offer lower fees because they work outside the insurance system and are free of the administrative costs of coding and filing claims.

“The irony is that direct primary care physicians would see Medicaid patients for a price that the patient could afford,” said Eskew. “DPC physicians solve the access problem by providing chronic and preventive care at a transparent, predictable, and affordable price.

“Medicaid departments should embrace DPC physicians for their decision to provide care to Medicaid patients without charging a dime to Medicaid,” Eskew said.

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Short-Term Health Insurance Can Help Millions, Study Finds

By Chris Talgo

A new study reports the Trump administration’s decision to allow short-term health insurance plans could help millions of Americans gain access to affordable health care services.

Short-term plans can provide much-needed insurance for the millions of Americans who cannot afford coverage through the Obamacare individual market established by the Affordable Care Act (2010), reports “Short Term Plans: Affordable Options for America’s Uninsured,” published by the Foundation for Government Accountability (FGA).

“Short-term plans are affordable, temporary insurance plans that offer an alternative solution for individuals and families looking for more affordable options,” FGA stated when releasing the report in January. “Short-term plans can be purchased at any time, unlike most plans on the individual market, and offer more flexibility in plan options.”

Problem: Obamacare Price Spiral

Premium payments for Obamacare have increased substantially in recent years, the report notes. From 2013 to 2017, the average yearly premium has more than doubled, from $2,800 to nearly $6,000.

In addition, many of those seeking health insurance on the Obamacare exchanges are left with few choices, the report notes.

“Individuals who have not been priced out of the market altogether are left with few affordable options,” the report states. “In 2018, consumers in 56 percent of counties had just one insurer to choose from in the individual market.”

Justin Haskins, a research fellow at The Heartland Institute, which publishes Health Care News, says short-term plans allow people to escape the rapid price increases of Obamacare.

“Allowing a greater number of people to benefit from short-term health plans is a huge win for consumers,” Haskins said. “The Affordable Care Act has been a total disaster. Premiums have doubled since the ACA went into effect. More importantly, deductibles and out-of-pocket costs are through the roof. Many people can’t even afford to use their Obamacare plans because these costs are so high.

“What’s the point of health insurance if you can’t afford to use it?” Haskins said.

Problem: Millions Still Uninsured

Obamacare, passed by Congress in 2010 without a single yes vote from any Republican, was supposed to provide affordable health insurance for the millions of Americans who do not receive employer-based insurance and do not qualify for Medicaid or Medicare. Eight years later, millions of Americans remain without health insurance, says Greg George, an FGA senior research fellow and coauthor of the report.

“Nearly 30 million people are uninsured today, and millions more are paying expensive out-of-pocket costs for limited choices,” said George.

Solution: Short-Term Plans

Short-term plans offer flexible health insurance that meets individuals’ unique needs, Haskins says. The plans do not include the costly comprehensive benefits required by Obamacare, making them attractive to those who are seeking basic coverage for a limited period of time, Haskins says.

In 2018, the Trump administration eliminated the time limitations the Obama administration had placed on these plans in 2016. Consumers can now keep these plans for 364 days instead of 90 days and can renew them for up to three years. They can be purchased any time during the year instead of a restricted enrollment period, and coverage begins within a few days instead of weeks. The plans are not subject to the same regulations as plans in the exchanges, so insurers can offer more plan options with different price points. The FGA report says there are 160 plans available as a short-term option, compared to 20 plans on the individual market.

“Short-term health insurance plans aren’t for everyone, but for younger, healthy individuals and those who are between jobs or who are enrolled in a direct primary care plan, it’s a fantastic option,” Haskins said. “They don’t offer many of the same benefits of Obamacare plans, but they are significantly more affordable, allowing people to save money for when a medical emergency does arise.”

States should take advantage of the Trump administration’s decision to make these plans available, George says.

“The Trump administration gave states the flexibility to provide their citizens with access to more affordable health insurance options through short-term plans, and states need to take advantage of these plans,” George said.

Chris Talgo (ctalgo@heartland.org) is an editor at The Heartland Institute.
Virginia Opens Way for Nurse Practitioners to Address Primary Care Shortage

By Ashley Bateman

In an effort to broaden access to primary care, Virginia has enacted a law that allows nurse practitioners (NPs) more autonomy to run their own practices and receive better reimbursement for their services.

The new law, House Bill 793, allows nurse practitioners to apply for independent practice authority licenses. Previously, each nurse practitioner had to sign a practice agreement with a patient-care team physician in order to operate autonomously. Under the new law, which took effect on January 7, nurse practitioners can operate independently if they have completed at least five years of full-time clinical experience and are licensed by the state’s Board of Medicine and Nursing.

Lauds Insurance Component

The payment reimbursement component is the biggest improvement in the law, says Joyce Knestrick, a certified nurse practitioner and president of the American Association of Nurse Practitioners.

“The language in this new law guarantees nurse practitioners receive insurance reimbursement as far as the scope of their practice,” said Knestrick. “This will help improve patients’ choice to choose a nurse practitioner and expand care across Virginia. The trend of insurance companies to contract and directly reimburse for nurse practitioner care is growing.”

The law requires NPs to serve a minimum number of clinical hours in a team model in which a physician is in charge.

“Five years, about 9,000 hours of clinical practice under a written agreement with a physician, we would still consider restricted,” said Knestrick. “The period of time is an issue. Five years is a long time.

“In general, Virginia is moving in the right direction by making nurse practitioners more accessible to patients,” Knestrick said. “Removing regulations that restrict NP’s ability to practice autonomously and expanding timely access to care throughout the state is really important.”

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

Federal Appeals Court Supports Texas’ Authority to Choose Medicaid Providers

By Katie Zehnder

A federal appeals court rejected a lower court’s decision that had prevented Texas from cutting off Medicaid funding for Planned Parenthood.

In 2016, the inspector general of the Texas Department of Health and Human Services terminated the state’s Medicaid agreements with the organization for failing to meet the definition of a “qualified” provider under the state’s Medicaid Act. The inspector general said Planned Parenthood was proven to have acted unethically and violated state and federal laws when an undercover video showed Planned Parenthood agents discussing modifying abortion procedures to preserve body parts of aborted fetuses for the research market.

Planned Parenthood sued the state in federal court to restore the funding, and in 2017 U.S. District Judge Sam Sparks of Austin issued a preliminary injunction blocking Texas from terminating the organization’s Medicaid funding, calling Texas’ action “arbitrary and capricious.”

States Determine Qualification

The Texas Health and Human Services Commission appealed the ruling, and in January 2019 the federal appeals court panel vacated the injunction and sent the case back to the district court for review, saying the state’s Office of Inspector General had acted within its power. The court must allow the agency’s action unless it was “arbitrary and capricious” and “fails to satisfy minimum standards of rationality,” the appeals court ruled.

“OIG is the agency that the state of Texas has empowered to investigate and penalize Medicaid program violations,” the U.S. Fifth Circuit Court of Appeals panel wrote. “The agency is in the business of saying when providers are qualified and when they are not.”

The federal Medicaid Act allows states to set reasonable standards for qualifications and gives them discretion in managing Medicaid provider agreements, the court noted. According to the Kaiser Family Foundation, Texas’ Medicaid program pays for abortions only in cases involving life endangerment, rape, and incest.

States’ Authority Affirmed

The decision upholds states’ authority to determine what is best for their residents in need of public care, said David Balat, director of the Right on Healthcare initiative at the Texas Public Policy Foundation.

“Noncompliance with medical and ethical standards from medical providers is never acceptable, regardless of who is violating those standards,” Balat said. “The Medicaid patients who require Planned Parenthood need qualified medical professionals for their everyday care.

“The state is right to protect any patient, Medicaid or otherwise, from providers found to commit numerous violations of generally accepted standards of medical practice,” Balat said. “Patients who benefit from Medicaid are Texas’ most vulnerable, hard-working patients and need accessible, affordable, and safe care.”

“Planned Parenthood’s shocking and repugnant conduct, captured in raw video footage, proves that it is not a ‘qualified’ provider under the Medicaid Act,” said Paxton. “An organization that is willing to subject women to abortion procedure modifications that can put their health at risk without their consent does not deserve a dime of Texas taxpayers’ money.”

Planned Parenthood receives approximately $3.1 million a year in Texas Medicaid funding, according to Paxton’s office.

Thirty-three states fund abortion under Medicaid, following the federal Hyde Amendment which bans federal Medicaid dollars for abortions except in cases of life endangerment, rape, or incest, according to the Kaiser Family Foundation. Fifteen states provide Medicaid dollars for abortions.

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INTERNET INFO

Virginia Bills Would Open Market for Telemedicine

By Ashley Bateman

Virginia lawmakers passed a set of bills that would open the door for greater use of telemedicine.

Telemedicine is the use of information technology such as telephone consultations, internet communications, and web-connected diagnostic devices in providing health care. Providers, for example, can monitor a patient’s weight, blood pressure, pulse, and glucose levels through devices linked to the internet, and doctors can perform consultations through video conferencing. By opening the door for more service, telemedicine can increase access to health care and cut costs through increased competition and elimination of transportation for patients who live in remote areas.

The legislation, introduced with bipartisan support in both state chambers in January, will insurance companies to cover telemedicine services if the governor signs it.

“These proposals are a positive first step that will allow millions of Virginians access to high-quality, convenient, and affordable telehealth services,” said Matt Glans, a senior policy analyst at The Heartland Institute, which publishes Health Care News. “Telemedicine allows increased access to care for the unserved while dramatically reducing health care costs.”

Filling Doctor Shortages

More than 84 million people are in primary care Health Professional Shortage Areas as defined by the federal government based on the percentage of health care professionals among the population. In Virginia, according to data listed by the Kaiser Family Foundation, there are 110 such areas, where 1.5 million people live.

Outdated laws are an important cause of the shortages, Glans says.

“The stringent licensing process has made it difficult for entrepreneurs to enter the market with new services, slowing the competitive process,” Glans said. “The new proposals directly address the licensing issue by allowing any doctor who is licensed and in good standing with the relevant regulatory agency in their home state to provide telehealth services to Virginians.”

Supply-Side Solution

Telehealth helps tackle problems with the nation’s overregulated health care system by improving the supply side, says Benjamin Knotts, a grassroots director for Americans for Prosperity.

“For years, we’ve been arguing the demand side of health care and who’s going to pay the bill,” Knotts said. “The patient? The government? Insurance companies? No one can afford it, because the cost is so high. We need a more unifying focus and to start thinking of ways to increase the supply. If we increase the supply, we can decrease the cost while meeting the demand.”

Glans says health care has been unduly slow in incorporating commonplace innovations in communications technology.

“The health care industry is one of the last sectors of the economy to fully embrace the potential of modern communication networks. Look at the innovation and reduced costs we’ve seen in sectors like retail and transportation,” said Glans.

Weeding Out Regulations

Technology is changing so rapidly that the best thing states like Virginia can do is remove legislative barriers to expansion of health care services, especially occupational licensing, which restricts who can practice and where, Knotts says.

“If you are licensed to provide care, you should be able to leverage cutting-edge technology to expand your service,” Knotts said. “And it is the patient’s decision. Currently, many are driving across state lines to get care, so why should they not be able to do that from the comfort of their own home?”

Awaiting Signature

Both house of the legislature passed two of three components of the bills on February 4 and sent them to Gov. Ralph Northam for signature. Knotts attributes the success to bipartisan support.

“Both Republicans and Democrats like the idea of disrupting the status quo and telemedicine does exactly that because it increases access,” said Knotts.

The chambers passed measures on remote monitoring and reimbursement but deferred on the licensing component of the bill until further study. Knotts says the focus now turns to North Carolina, where a telemedicine bill failed two years ago.

“This time there will be a completely new bill, one based on our success in Virginia and tailor-made for North Carolina, and it will have bipartisan support,” he said.

Virginia is the first state to consider telemedicine involving input and support at the grassroots level, Knotts says, adding he is hopeful professional groups will see the licensing issue not as a threat but as a new way to expand their reach.

Ashley Bateman (bateman.ae@googlemail.com) writes from Alexandria, Virginia.
Telemedicine Offers Solution to Psychiatrist Shortage

By AnneMarie Schieber

The District of Columbia is the latest to join the Interstate Medical Licensure Compact, a move expected to address the nation’s shortage of psychiatrists and other medical professionals.

State governments, led by their medical boards, began working together in 2017 to form the Interstate Medical Licensure Compact, an agreement establishing an expedited way for experienced physicians to practice beyond their state borders. The compact became effective in 2017 once seven states adopted it. A state, district, or territory can join by enacting a law doing so. The compact now includes 26 members.

Telemedicine can increase access to mental health diagnosis and treatment for adults and children in places with shortages of psychiatrists, especially rural areas, says Peter Yellowlees, M.D., of the University of California, Davis and past president of the American Telemedicine Association.

“We currently have 25,000 to 50,000 licensed psychiatrists in the country and need about 5,000 to 10,000 more,” said Yellowlees. “There is a particular shortage of psychiatrists not just in rural areas but in all regions of the country when it comes to adolescent and geriatric psychiatric care.”

Decreasing Availability

Seventy percent of practicing psychiatrists in the United States are age 50 or older. A majority of psychiatrists are in cash-only practices and work independently of health care teams. Many don’t accept Medicaid patients or treat people with severe mental illness, the National Council for Behavioral Health (NCBH) reported in a 2017 paper, The Psychiatric Shortage: Causes and Solutions.

Burnout is a common problem, the report states. Psychiatrists complain of insufficient time with patients to do proper assessments, regulatory restrictions on information sharing, and increased time spent on entering required data into patients’ electronic medical records. Another problem is patients not showing up for appointments scheduled months in advance.

Although there is better access to mental health counselors, generally those who are not physicians cannot write prescriptions. Yellowlees says it is critical to have specialists for the geriatric population.

“One of the biggest problems is overmedication of patients in nursing homes,” said Yellowlees. “Many are being treated by doctors who have little training in psychiatry and drugs and may be more inclined to write prescriptions to sedate patients who are exhibiting behavioral problems.”

In adolescent and pediatric care, there is a severe shortage in all but six states, NCBH reports: Connecticut, Maine, Massachusetts, Rhode Island, New York, and Vermont.

Telepsychiatry’s Track Record

The concept of remote psychiatric treatment is not new. Yellowlees says he has used it in California on thousands of patients since 1991. The American Psychiatric Association (APA) issued a statement approving of telepsychiatry in 2018:

“Telemedicine in psychiatry, using video conferencing, is a validated and effective practice of medicine that increases access to care,” the statement read in part. “The American Psychiatric Association supports the use of telemedicine as a legitimate component of a mental health delivery system to the extent that its use is for the benefit of the patient, protects patient autonomy, confidentiality, and privacy; and when used consistent with APA policies on medical ethics and applicable governing law.”

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Medicaid and Work: Is There a Crisis in Arkansas?

Arkansas is in crisis. At least that’s what several advocacy groups and mainstream publications say.

Kevin De Liban of Arkansas Legal Aid calls the state’s new requirement that able-bodied Medicaid recipients work or seek work “disastrous.” The Medicaid and CHIP Payment Advisory Commission, a group that advises Congress on Medicaid issues, pronounced itself “highly concerned” about the program and urged the HHS Secretary to “pause” the disenrollment of recipients who fail to meet the work requirements. The left-leaning Center on Budget and Policy Priorities charged that the program was causing “harm to beneficiaries.”

What produced this horror? Beginning last June, the state required non-disabled, childless adults aged 30-49 to engage in 80 hours of work-related activity each month. Those who failed to do so for three consecutive months were dropped from the program through the end of 2018.

Nearly 17,000 recipients lost their benefits between September and December. All became eligible to reenroll in Medicaid on January 1. Fewer than 1,000 did. Crisis indeed.

Looking at the Numbers

The “social experiment,” contrary to press reports, isn’t entirely without precedent. Arkansas is one of seven states that have obtained permission from the Trump administration to establish work requirements in its Medicaid program. The administration is currently reviewing similar waiver applications from an additional nine states. Nor are these requirements unique to Medicaid. They are similar to those in other public assistance programs.

Of the nearly 65,000 Medicaid recipients subject to Arkansas’s work requirements in November, most did not have to report their work activities, because they were meeting requirements in other welfare programs. Thousands more were exempt because they had a dependent child or medical issues. In all, nearly 55,000 recipients were not obliged to report.

A total of just over 8,400 recipients who were required to report their work activities in November fell short. Of those, more than 8,308 (98 percent) reported no work activity at all—they neither had a job, sought one, nor endeavored to develop the skills to get one. November marked the third consecutive month that more than 4,600 of these recipients failed to meet the requirements. They were removed from the rolls. That brought the total number of Arkansans who lost Medicaid coverage for failing to meet the work requirements in 2018 to just under 17,000.

All were eligible to rejoin the program on January 1, 2019. Only 966 did, according to the most recent statistics released by the state’s Department of Human Services.

That may not be as counterintuitive as it may at first seem. Since they didn’t value the benefits enough to comply with its work requirements—or, in the overwhelming majority of cases, report any work activities at all—it is hardly surprising that most didn’t bother to reenroll.

Medicaid Not Worth It

Health care policy analysts have long been puzzled that millions of uninsured people snub the government’s offer of free health benefits. The Kaiser Family Foundation estimates seven million of the 27.5 million nonelderly people who were uninsured in 2016 were eligible for Medicaid. That’s more than one-fourth of the uninsured population. Another eight million were eligible for Obamacare premium subsidies, meaning more than half the nonelderly uninsured didn’t avail themselves of government-subsidized health coverage.

Academic research suggests one possible reason: Medicaid recipients aren’t the primary beneficiaries of the program’s spending. A study of the Oregon Health Insurance Experiment, which provided Medicaid coverage to expansion adults on a randomized basis, found the program’s “welfare benefit to recipients per dollar of government spending range[s] from about $0.2 to $0.4.” In other words, $1 of Medicaid spending provides around 20 to 40 cents of benefits to recipients. The rest—an estimated 60 cents of every Medicaid dollar—benefits “external parties,” most likely hospitals that use the money to cover uncompensated medical costs.

The reason so many Medicaid recipients failed to comply with the Arkansas work requirement may be as simple as this: They didn’t consider the benefits worth the effort.

Work Requirements Benefit Recipients

A study by the Buckeye Institute, an Ohio-based free market think tank, found people who respond favorably to work requirements will earn far more—in some cases nearly $1 million more—over the course of a lifetime than those who remain on Medicaid and don’t increase their work efforts. Work requirements benefit recipients.

The program has put liberals and conservatives alike in uncomfortable positions. The Left strongly supports Medicaid expansion but regards work requirements as an act of state-sponsored cruelty. The Right supports work requirements but opposes Medicaid expansion. Many conservatives fear that work requirements will make expansion more palatable in the 14 states that have so far resisted it.

Arkansas is caught in this political conundrum. Gov. Asa Hutchinson, a Republican, supports the Medicaid expansion he inherited from his predecessor. But he also says able-bodied recipients should work or at least pursue the training and skills they need to hold a steady job.

Each year, three-fourths votes are required in the state’s House and Senate to approve funding for the expansion. That leads to “almost annual cliffhanger votes” over whether to repeal the expansion, according to Politico.

If Arkansas’s overwhelmingly Republican legislature votes again to fund an expansion that conservatives detest, it will be at least partly because of work requirements liberals abhor.

Doug Badger (think@heartland.org) is a senior fellow and Grace-Marie Turner is president of the Galen Institute. An earlier version of the article was published in RealClearHealth on January 29, 2019. Reprinted with permission.
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