THE MONTHLY NEWSPAPER FOR HEALTH CARE REFORM

Making Medicaid Work
With the Centers for Medicare and Medicaid Services saying no to “partial” Medicaid expansion, Utah tries to add a work requirement.

Freeing Medical Records
The federal government is increasing enforcement of patients’ right to access to their medical records.

Sprint to Coordinated Care
HHS Deputy Director Eric Hargan says his department wants to eliminate unnecessary regulatory hurdles standing in the way of effective care.

Generic Drug Hurdles
FDA is approving generic versions of drugs at a record pace, but few are reaching the U.S. market.

Wyoming Plan Grounded
The Centers for Medicare and Medicaid Services rejected Wyoming’s request to have Medicaid pay for all air ambulance flights in the state.

Congress Considers Expanding Health Savings Accounts
By Bonner R. Cohen
Congress is considering bills to expand the allowable uses of tax-saving health savings accounts (HSAs).

KS Governor, Senate Agree to Expand Medicaid
By Ashley Bateman
Kansas Gov. Laura Kelly, a Democrat, and Republican State Senate Majority Leader Jim Denning (District 8) announced a compromise proposal that would expand Medicaid eligibility in the historically red state.

Expanding Health Care
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HEALTH SAVINGS ACCOUNTS, p. 6

Sen. Ted Cruz (R-TX), sponsor of the Personalized Care Act

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CMS Approves Utah’s Medicaid Work Rules After Rejecting Partial Expansion

By Jesse Hathaway

The federal Centers for Medicare and Medicaid Services (CMS) approved a work requirement for enrollees in Utah’s expanded Medicaid program.

The approval arrives several months after CMS rejected Utah’s request for a “partial expansion” program that called for full expansion funding while limiting enrollment to able-bodied adults below 100 percent of the poverty level, not 138 percent as required by the Affordable Care Act. Utah voters approved full expansion in November 2018.

Utah is now enrolling in Medicaid able-bodied adults whose annual income is up to 138 percent of the poverty level. The Utah Department of Health estimates 120,000 people will be eligible for the expanded program.

Utah had requested permission for partial expansion and its proposed Medicaid work rule under Section 1115, a provision of the Social Security Act of 1935 authorizing CMS to approve state-led reforms such as cost-reduction programs and eligibility changes.

Few Recipients Affected

Utah state Sen. Allen Christensen (R-North Ogden) says the state’s Medicaid work rule is similar to its rules for another federal program it administers: the Supplemental Nutrition Assistance Program (SNAP). As with SNAP, the Medicaid work requirement is very limited, says Christensen.

“An estimated 80 percent of the newly eligible people on Medicaid will be excluded from it,” Christenson told Health Care News. “If there’s a health problem, if you’re a caretaker, if you’re a parent, if you’re pregnant, if you’re disabled, and several other things like that, it excuses you from the work requirement.”

Enrollees who are not exempt need only search for gainful employment, not actually be working, says Christensen. “The work requirement is not even a ‘work requirement,’” says Christensen. “It says you just have to look for a job, take job training to qualify for your job, and at least submit a certain number of applications each month.”

Double-Edged Sword

Although states are attracted to the additional federal funding for Medicaid expansion, it will lead to benefit cuts, in a position where Medicaid is crowding out funding that would normally go towards other equally important state projects.”

More Demand, Same Supply

Christensen says Medicaid expansion adds to the demand for health care without increasing the supply.

“The one thing no one wants to address is we’re putting 100,000 new people into care, and we didn’t get another doctor or nurse. We didn’t expand the service; we just expanded the welfare rolls.”

ALLEN CHRISTENSEN
UTAH STATE SENATOR

Poverty Trap Expansion?

Expanding Medicaid may trap people near the poverty level, says Czernecki.

“Medicaid should not become a weight that keeps people in the system,” said Czernecki. “The goal should be to lift people out of poverty and use those programs as a stepping stone on their path to prosperity.”

Entitlement programs shrink the economic pie instead of expanding prosperity, says Christensen.

“With Medicaid expansion, someone has to pay the bill sooner or later,” said Christensen. “Even in this whole country, we can’t keep giving things away to more and more people and still maintain a vibrant economy. You’re taking one person’s money and giving it to someone else. That’s not how the Constitution in this country was set up.”

Jesse Hathaway (think@heartland.org) is a policy advisor to The Heartland Institute.
surcharge of up to $35 million, create “a robust work referral program” by referring unemployed enrollees to a job training program, and require enrollees to pay a monthly premium of $25 a month.

No enrollees would be locked out of the program for failing to pay the premium. Instead, the unpaid premium would be referred to the state’s debt setoff program. There would also be a hardship provision, for enrollees unable to pay.

Checkered Past
Kansas has grappled with Medicaid expansion since the introduction of Obamacare. In 2017, lawmakers passed an expansion bill, but then-governor Sam Brownback vetoed it. In 2019, the Kansas House approved expansion, but it was defeated in the state Senate. That same year, while considering expansion, Kansas applied to the federal government to implement a work requirement and 36-month cap, but the Centers for Medicare and Medicaid Services rejected the cap and Kansas postponed the work requirement request.

If the current proposal is implemented, Kansas would become the 38th state (including the District of Columbia) to expand Medicaid. Obamacare allows states to expand their Medicaid programs to include able-bodied people up to 138 percent above the poverty level. The federal government covers 90 percent of the costs, more than for traditional Medicaid.

Kelly says expansion will keep the state financially stable.

“It’s long past time to expand Medicaid so that more Kansans have access to affordable health care, our rural hospitals can stay open, and the tax dollars we send to Washington can come back home to Kansas to help our families,” Kelly stated.

Not Convincen
Expanding Medicaid can be a fiscal trap, even with so-called free-market protections, says Matthew Glans, a senior policy advisor to The Heartland Institute, which publishes Health Care News.

“This proposal, like many of the faux ‘free-market’ plans passed in other states, allows for the expansion of a failed program and all the costs and waste it can create,” Glans said.

Glans said the reinsurance plan Kansas has proposed to control costs is not a fail-safe.

“While both popular and an effective tool for managing costs, reinsurance programs like those being considered in Kansas only serve to stabilize Medicaid and do little to address the real issues with the program,” Glans said. “Reinsurance creates a high-risk pool for insurers so they can cover claims from higher-cost individuals, reduce premiums, and attract healthier people. They do not address the unnecessary mandates, rules, and continually growing costs involved with Medicaid.”

The Kansas proposal doesn’t give recipients enough skin in the game, which will make it more costly than expected, Glans says.

“The lack of a work requirement, an essential reform, is concerning, as is the lack of any penalty for those failing to pay the premium, which makes any premium far less effective,” Glans said.

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

INTERNET INFO
Physicians Lose Jobs to Nurse Practitioners at Suburban Health Clinics

By AnneMarie Schieber

The Edwards-Elmhurst Hospital Health system announced it will replace 15 physicians at seven immediate care clinics in the Chicago suburbs with lower-cost nurse practitioners (NP s) on April 1.

Hospital administrators informed the physicians of their job terminations at a meeting in November, according to one physician who requested anonymity. The physician said administrators told the doctors the move would save the hospital $1 million over the next few years.

“We were offered no severance or other positions at the hospital,” the physician said.

The physician said it was not clear whether the hospital would enforce the noncompete clause physicians had to sign as part of their employment contracts. The clause prohibits physicians from working for a competing health care organization within a 30-mile radius for two years after employment, the physician said.

Unanswered Questions

A letter sent to physicians signed by CEO Mary Lou Mastro, a registered nurse, and Robert Payton, M.D., the hospital’s chief medical officer, stated “patient cost concerns” were the main driver behind the move, according to a November 26, 2019, article in Medpage Today.

“Patients have made it very clear that they want less costly care and convenient access for lower-acuity issues (sore throats, rashes, earaches) which are the vast majority of the cases we treat in our Immediate Cares,” the letter stated.

“We continue to assess our care delivery models in the interest of providing cost-effective care to our patients,” said hospital spokesperson Keith Hartenberger. “We shared with physicians that we have plans to change the model at some outpatient sites and are working with anyone affected to find alternative placement. Any advanced practice clinician working at Edwards-Elmhurst Health only does so under the supervision of a physician.”

Hartenberger did not answer whether the hospital offered the physicians jobs in other divisions, whether prices at the clinics will be lowered, what physicians will be overseeing the nurse practitioners, whether the hospital will enforce the noncompete clauses, how much of the decision was driven by under-reimbursement by third-party payers, and how patients have responded to the move.

Supplementing, or Replacing?

NPs and other nonphysician providers have an important role in health care, says Matt Glans, a senior policy analyst at The Heartland Institute, which publishes Health Care News.

“Allowing nurse practitioners to administer care under an expanded scope of practice would greatly reduce the growing health care and physician shortage,” says Glans. “Nurse practitioners are not the single answer to improving health care availability, but they can be an important part in solving the problem.”

In some states, NPs can write prescriptions and work independently after a certain number of clinical hours. Until that time, NPs must work under the supervision of a physician.

“The physician who spoke to Health Care News says health care organizations should not just assume nonphysician providers can replace physicians. NPs, advanced practice registered nurses (APRNs), and physician assistants (PAs) have traditionally served in a collaborative role, he says.

“You can become an NP with 500 hours of training and a PA with 3,000 hours,” the physician said. “Physicians, on the other hand, get 15,000 hours of clinical training over a minimum of seven years of clinical training, medical school, and residency.”

An area where the extra clinical training may make a big difference is in the detection of heart attacks, the physician says.

“Heart attacks can present very unusually,” the doctor said. “Sometimes it’s jaw pain, sometimes pain in the shoulder, or nausea. With extensive training, you learn to think out of the box and expand the differential diagnoses.”

Ongoing Trend?

Other health care organization are also replacing some physicians with nonphysicians. A Dallas television station reported 27 pediatricians were let go at a chain of clinics in 2018.

Charlotte-based Atrium Health in 2018 ended a 40-year contract with a 90-member physician group to work with an organization, Scope Anesthesia, that partners with certified registered nurse anesthetists.

Chad Beste, a partner with BDO Healthcare Advisory Practice, told Chicago Business News in a December 6, 2019, article, “a lot of these urgent care facilities, you have to see a high volume of patients to break even with an M.D.”

Deane Waldman, M.D., lobbied for expanding the market for mid-level providers in Texas after he reviewed 120 articles and published studies assessing the quality of their care.

“For the majority of minor illnesses and for triage, [a mid-level provider] is quite adequate,” said Waldman. “However, they should always have the ready ability to discuss with an experienced physician.”

APRNs can be particularly helpful in hospital and clinic settings, says Waldman.

“One MD can supervise or oversee a number of APRNs seeing and triaging patients while the doctor cares for the more complex patients. For rural communities without a physician, a [mid-level] provider may be the only primary care available, but again, there should be ready access to discuss with a physician by tele-technology.”

DEANE WALDMAN, M.D.

“For the majority of minor illnesses and for triage, [a mid-level provider] is quite adequate. However, they should always have the ready ability to discuss with an experienced physician. One MD can supervise or oversee a number of APRNs seeing and triaging patients while the doctor cares for the more complex patients. For rural communities without a physician, a [mid-level] provider may be the only primary care available, but again, there should be ready access to discuss with a physician by tele-technology.”

DEANE WALDMAN, M.D.
Congress Considers Expanding Health Savings Accounts

Continued from Page 1

6.3 million in 2011 to more than 25 million in 2018, according to Devenir Research. Although the market share of HSAs has shown consistent growth, the bills’ sponsors argue further steps by Congress could unleash the power of the marketplace and expand HSAs further.

The Personalized Care Act would increase the maximum annual contribution limit for HSAs from $3,550 for individuals and $10,800 for families to $7,100 for individuals and $29,500 for families. The bill would also decouple HSAs from high-deductible health plans and extend HSAs as an option for those enrolled in Medicare, Medicaid, and the Children’s Health Insurance Program.

Addressing Tax Treatment Disparity

The PCA would expand people’s choice in selecting their health coverage by allowing them to use their tax-free HSA dollars to purchase health insurance plans. The proposed change would address the disparity in tax treatment between employer-provided health coverage and plans purchased on the individual market.

In further expanding the scope of HSAs, the PCA would allow the purchase of over-the-counter prescription drugs using HSA funds and allow users to purchase alternative coverage arrangements such as health sharing ministries, short-term-duration plans, medical indemnity plans, and direct primary care plans. The legislation would also allow individuals and families to use their HSAs to pay for health insurance premiums.

“In the post-Obama era, this number is expected to reach $3.8 trillion in 2019, and national health spending is expected to grow at an average rate of 5.5% per year to reach nearly $6.0 trillion by 2027,” Roy stated.

Upon introducing the legislation, Cruz stated now is the time for reform.

“The pressure to change the health care status quo is rightfully building, and the key question is whether Congress will use this pressure to finally create a true, free-market health care system or build on the failures of Obamacare,” Cruz said in a statement.

Neither the Senate nor House bill (they are identical) has any Democrat cosponsors. With Democrats controlling the House and Republicans far short of a filibuster-proof majority in the Senate, the bill stands little chance of enactment in this session of Congress, particularly in a highly charged election year.

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

West Virginia House Votes to Eliminate Certificate of Need Application Fee

The West Virginia House of Delegates passed a bill to eliminate a $1,000 fee charge that is usually refunded when seeking Certificate of Need (CON) approval.

House Bill 4108 (H.B. 4108) would stop the West Virginia Health Care Authority from charging the fee to health care services that are exempt from CON approval, such as alcohol and drug treatment centers, nonprofit birthing centers, and shared services between hospitals, including those that want to add or expand services or make capital expenditures under $5.3 million.

House Majority Leader Amy Summers (R-Taylor) told Health Care News she expects the bill to clear the state Senate and be signed by Gov. Jim Justice.

Delegate Pat McGeehan (R-Hancock) says he thought the House could have done more. “This is sort of a worthless bill,” Hancock told The Journal, as reported on January 22.

“Many people in this room [delegates] have gone out on the campaign trail and completely advocated for eliminating entirely the certificate of need in this state,” McGeehan said. “This to me is a joke. We are operating in the margins.”

Summers says the legislation is needed because the $1,000 on exempt providers is “ridiculous.” He says the state government should do more to reform its CON laws.

“We do have a repeal bill, but not enough votes to get that across the finish line, so each year we try to remove parts of the CON process,” Summers said.

“Repealing West Virginia’s CON laws would roll back an outdated rule that does real harm to health care in the state,” said Matt Glans, a senior policy analyst with The Heartland Institute, which publishes Health Care News. “In addition to lowering health care costs, eliminating West Virginia’s CON laws would improve the quality and access of health care.”

—Staff reports
Doctors’ Salaries Are Up, Specialists Outpace Primary Care Physicians

By Bonner Cohen

A merica’s doctors and advanced practitioners are taking home fatt er paychecks, but the earnings of primary-care physicians continue to lag well behind those of their specialist colleagues, the latest survey by clinician job board LocumTenens.com reports.

In 2018, the average salary for a physician rose to $363,924 and the average salary for physician assistants (PAs) and nurse practitioners (NPs) rose to $122,973. The average physician’s salary has increased 16.5 percent since 2015, according to the report, which was based on an August 2019 survey. Salaries for physician assistants and nurse practitioners have fluctuated over the past few years but have been on the rise since 2017, the report noted. Survey respondents were full-time, permanent practitioners, and the survey took into account annual salaries and bonuses.

Primary care physicians earned less than half of what orthopedic surgeons receive, and primary care nurse practitioners also earned less than other health care practitioners. In the survey, the average salary for a primary care physician was calculated based on those working in internal medicine, family practice, and pediatrics. There were stark differences within this category. Salaries for internal medicine doctors have risen by about 22 percent since 2016, while the average salary for family practitioners decreased by approximately 8 percent in 2018. Orthopedic surgeons, who are at the top of the salary list, saw an average salary increase of 10 percent since 2016. Of those surveyed, most physicians were employed by hospitals, and most PAs and NPs worked in clinics, community centers, hospitals, or group practices.

Government’s Market Distortions

The increasing difference in earnings between specialists such as orthopedic surgeons and cardiologists and primary care physicians may partly be a result of government distortion of the health care market. Set fees for Medicare and Medicaid patients, for example, distort the health care market, as do the intricacies of provider networks, says Beth Haynes, M.D., medical director at the Benjamin Rush Institute.

“The longstanding earnings discrepancy between primary care physicians—family medicine, internal medicine, and most pediatrics—when compared to specialists is well-known and undisputed,” said Haynes. “Some of the differences can be explained by the longer training and higher risk assumed by procedure-intensive doctors.”

Government health care coverage also plays an important part, says Haynes.

“A significant role goes to Medicare’s administrative price setting, heavily influenced by the American Medical Association’s (AMA) Relative Value Scale Update Committee (RUC),” said Haynes. “It would be fascinating to know what incomes would be if we had market prices in medicine. The gap could be larger or smaller; we just don’t know in today’s system.”

Specialist Domination?

Philip Eskew, D.O., J.D., founder of DPC Frontier and a policy advisor to The Heartland Institute, which publishes Health Care News, says the AMA’s RUC is indeed a cause of the increasing compensation disparities.

“Primary care physician salaries have remained flat while other physician salaries increased over time due to the biased distribution and outsized influence of the AMA’s RUC,” Eskew said. “There are 29 unelected physician members on the RUC, and only five of these represent primary care.”

Eskew says third-party fee-for-service reimbursement levels are tied to those RUC recommendations.

“Rather than increase primary care salaries to reflect the demand and shortage, large hospital systems that accept Medicare argue that they are boxed in and cannot offer a salary above certain MGMA [Medical Group Management Association] percentiles because it will adversely increase their audit risk,” Eskew said.

Tomorrow’s Doctors Notice

Young doctors typically leave medical school heavily in debt and gravitate to higher-paying specialties that enable them to pay off their student loans quicker. This can lead to a shortage of lower-earning primary care physicians, particularly in sparsely populated rural areas, says Chad Savage, M.D., founder of YourChoice Direct Care and a policy advisor to The Heartland Institute.

“Medical students will continue to forego these specialties for more lucrative specialties when this sort of disparity exists,” said Savage. “You get what you pay for. If you want more of them, you can achieve this by valuing them in the payment model. Currently, the value is determined by the centrally controlled Medicare system. In a free-market system, the health care consumer determines the value of these specialties and, thus, their relative prevalence.”

CHAD SAVAGE, M.D.
FOUNDER, YOURCHOICE DIRECT CARE

“There is a shortage of primary care physicians and psychiatrists. If you want more of them, you can achieve this by valuing them in the payment model. Currently, the value is determined by the centrally controlled Medicare system. In a free-market system, the health care consumer determines the value of these specialties and, thus, their relative prevalence.”

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.
Young Doctors Trend Toward Political Left, Study Finds

By Madeline Peltzer

Young physicians tend to align with left-of-center political viewpoints, a new study states.

The study by the international medical journal BMJ examined how political and current events have affected the moods and stress levels of young doctors. The survey considered nine political events and eight nonpolitical events occurring from 2016 to 2018 and questioned 2,345 participants on their mood from their time as medical interns to their time as residents.

The survey found statistically significant mood declines of at least 25 percent after the 2016 presidential election and subsequent inauguration, with women experiencing more than twice as much mood decline as men after those events.

Other developments of a conservative political nature, such as the Muslim travel ban and the confirmation of Justice Brett Kavanaugh to the Supreme Court, also correlated with mood declines. Events of a more liberal political nature prompted positive mood shifts.

"The directionality of these findings is consistent with evidence that young voters and voters with postgraduate education tend to identify as liberal leaning, and supports previous work showing a strong left shift in political affiliation among physicians over the past 25 years," the report states.

The margin of error for the poll was reported as 5 percent.

Medical School Politics

The findings raise the question of whether more left-leaning individuals are pursuing the medical profession or medical schools are making students identify more as progressive. Both are true, says Jane Orient, M.D., executive director of the Association for American Physicians and Surgeons and a policy advisor to The Heartland Institute, which publishes Health Care News.

"I think young doctors are getting a heavy dose of indoctrination in medical schools, partly from the student section of the American Medical Association," Orient said. "In my opinion, this is due to four years of college education with predominantly liberal professors," Fappiano said. "Additionally, the MCAT [medical school entrance exam] is putting more emphasis on traditionally liberal-dominated topics—especially sociology—rather than pure science."

The spike in liberal-leaning students and faculty suggests science and medicine are no longer immune to politics, and this should alarm patients, Orient says.

"The system comes first, and somebody else's idea of 'justice,' instead of the patient," Orient said. "It also means less time is available for learning medicine."

Changing Viewpoints

These attitudes may change over time, says Chad Savage, M.D., founder of YourChoice Direct Care and a policy advisor to The Heartland Institute.

"While the study shows that young physicians tend to be liberal, the findings could simply reflect the students' age and the fact that progressive politics tend to be more popular with young people," Savage said.

Fappiano says he agrees.

"I have found that the working doctors I do my rotations with are more level-headed and, at most, will gripe about their political ideology but never act on it," Fappiano said. "The students are much more active in pushing political goals, whether it's through clubs, bringing in speakers, or changing course teaching."

Large practitioner organizations have a big influence on the political stance of medical school curricula, Fappiano says.

"The entire health care industry is controlled by the two licensing agencies: the National Board of Medical Examiners and the National Board of Osteopathic Medical Examiners, as well as the AMA," Fappiano said. "If schools were able to create their own curriculum and prerequisites, it would allow the emphasis to be put back on medicine rather than political goals. This would require large institutional changes and deregulation of the field of medicine."

Physician Group Endorses Single Payer, Public Option

The American College of Physicians (ACP), which claims to be the largest medical-specialty society in the world, has endorsed single-payer and public-option health care proposals “to achieve a better U.S. health care system.”

In its position paper on Envisioning a Better U.S. Health Care System for All: Coverage and Cost of Care, released on January 21, 2020, ACP provides a list of reasons why the organization believes the nation must make a radical change in the health care system. These include the costs of hospital care, prescription drugs, and administration and health care outcomes compared to those in other countries.

Universal health care coverage is essential, the paper states. Although this in and of itself does not ensure better quality and lower costs, a “lack of health insurance coverage is associated with higher preventable mortality,” the paper states.

‘One Plan for All’

The Association of American Physicians and Surgeons (AAPS) states the ACP plan ultimately would drive out all private-sector health care.

Jane Orient, M.D., executive director of AAPS and a policy advisor to The Heartland Institute, which publishes Health Care News, says the ACP plan states universal coverage must be compulsory and mandatory and restrict “duplicative coverage.”

“Never mind ‘Medicare for all who want it,’” Orient said. “This is one plan for all, and nothing else.”

Orient says the ACP plan acknowledges demand for health care will exceed the resources available to respond to it.

“Rationing is given a positive spin,” Orient stated.

An example of the acceptance of rationing is that the paper mentions palliative care, which refers to relieving suffering instead of trying to cure illnesses, when noting one-quarter of Medicare dollars are spent in the last year of life, Orient says.

“ACP writes, ‘Palliative care has been shown to reduce costs, particularly in the hospital setting, and increase patient and physician satisfaction,’” Orient said.

“‘That assures prompter, cost-efficient death,’” Orient said.

—Staff report
New Medicare Payment Model to Incentivize At-Home Kidney Dialysis

By Kelsey Hackem

The Centers for Medicare and Medicaid Services (CMS) are finalizing rules for a mandatory payment model intended to improve kidney care and reduce costs.

The End-Stage Renal Disease (ESRD) Treatment Choices (ETC) Model was proposed to begin on January 1, 2020. The comment period for the rule ended on September 16, 2019, but as of January 23, CMS had not issued its final rule, which involves payment adjustments.

“If finalized, we would provide information on the effective date of payment adjustments under the ETC Model in the final rule,” the CMS states on its website.

The ETC rule and four voluntary payment models were proposed in a July 2019 executive order by President Donald Trump and were expected to help reduce Medicare spending. The CMS spends $114 billion per year on dialysis patients in 2016 used in-center dialysis, and they spent an average of 12 hours per week receiving this treatment.

Devon Herrick, a health care economist and policy adviser to The Heartland Institute, which publishes Health Care News, says ESRD disproportionately affects the poor and minorities. It is the only disease in the United States that is automatically covered by Medicare, Herrick says.

“As a result, [the system] is cumbersome, prone to fraud, and very inconvenient,” Herrick said. “People literally spend hours a day, often two or more days per week, at a dialysis center. There they recline in threadbare recliners for hours on end while a dialysis machine spins, cleansing their blood of toxins. The current system does them a disservice.”

Encouraging Alternatives

The advantages of undergoing dialysis at home include convenience for patients and lower costs, Herrick says.

“The idea of treating ESRD patients in their own homes is far better,” Herrick said. “Machines that cost something like $25,000 could be used eight hours a day every night, while patients sleep. This would be far more convenient and better for their health than eight hours a week at a dialysis center.”

The fee-for-service structure of the Medicare ESRD system pays providers more when they provide more services, encouraging them to prescribe dialysis instead of kidney transplants, which could extend a patient’s lifespan and save money but mean less revenue for the provider.

According to the U.S. Renal Data System’s 2018 Annual Report, a year of hemodialysis treatment costs $90,971, whereas a kidney transplant costs $34,780. A 1999 study in the New England Journal of Medicine found the long-term mortality rate for transplant patients is 48 to 82 percent lower than for those on dialysis.

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

Investors Are Clamoring to Advance Kidney Care, HHS Deputy Secretary Says

President Donald Trump’s kidney care initiative has energized investors and innovators, Health and Human Services (HHS) Deputy Secretary Eric Hargan told The Heartland Daily Podcast, a project of The Heartland Institute, which publishes Health Care News.

Hargan says there could soon be significant advances in treatment for end-stage kidney disease.

“We [have been] stuck in this past technological mode with regard to dialysis and have been for decades, with very little innovation,” Hargan said.

Last summer, Trump issued an executive order on kidney care to encourage transplants and at-home dialysis. End-stage kidney disease, the ninth-leading cause of death in the United States, consumes one of every five dollars the federal government spends on health care, says Hargan. For four decades, Medicare has covered dialysis costs regardless of the age of the recipient.

“That was a great system in the ’70s, and government has done a great job in bringing down the margins, which is a good thing because the taxpayer isn’t paying more for the dialysis services,” Hargan said. “But at the same time, and I’ll let you fill in the blanks, innovation has completely stalled on a low-margin item being delivered and paid for by the government.”

Hargan said there has been a tremendous response from investors and innovators to the kidney initiative and many have told him they are excited to have “a strategic vision” for the first time.

It is instructive to compare kidney disease to cancer over the past 40 years, says Hargan.

“Many types of cancer have been cured or turned into chronic disease or substantially alleviated,” Hargan said. If such innovation were applied to dialysis, “they’d be watching a flat screen TV, reading an iPhone instead of magazines, and maybe have a motorized easy chair instead of one with levers.”

HHS has launched the “Kidney X” project, which offers a prize for innovations in kidney care. Hargan says the program has attracted people who aren’t traditionally involved in medical innovation, such as engineers and college students.

—Staff reports
HHS Explores Reforms to Increase Providers’ Coordination of Patient Care

By AnneMarie Schieber

U.S. Health and Human Services (HHS) Deputy Director Eric Hargan says his agency is trying to eliminate regulatory barriers to health care in order to improve delivery and maintain patient safeguards.

Speaking on The Heartland Daily Podcast, Hargan discussed his signature project, Regulatory Sprint to Coordinated Care, and how it can open the door for more effective arrangements between health care providers and between providers and patients.

The initiative is looking closely at four areas: the Health Insurance Portability and Accounting Act; the physician self-referral law known as the Stark Law; the anti-kickback statute; and privacy protections on substance abuse disorder, known as 42CFR Part 2.

“We have a decentralized health care system in the U.S. which allows for a lot of achievement, creativity, and innovation, but it prohibits the coordination of care,” said Hargan.

Stark Interpretation

Hargan gave several examples of how well-meaning regulations intended to protect patients have instead interfered with care.

The Stark Law is one example, says Hargan. Passed in 1989 and named after its sponsor, then-Congressman Pete Stark, the law was intended to eliminate financial self-interest in health care referrals.

The pendulum has swung too far the other way, Hargan says.

“We have supported value-based care but prohibit it,” Hargan said. “It isolates physicians from every other provider, and so they’re isolated from one another.”

The law has created a bonanza for lawyers, says Hargan.

“It’s not really the law; it is just how people have interpreted the law,” Hargan said.

Hargan says HHS wants to address the Stark Law at the regulatory and educational levels. One way is through promoting value-based health care delivery models, which reimburse outcomes, instead of fee-for-service systems, says Hargan.

Opioid Privacy Crisis

Another area where HHS is looking to improve coordination of care is substance abuse disorders, says Hargan. In 1975, Congress enacted the federal confidentiality law known as “42 CFR Part 2” to encourage patients to seek treatment without fear of discrimination or self-incrimination.

“The law was a standalone law and interpreted over the course of decades to the point where it now has created significant clinical and safety challenges for providers because they cannot share information with other providers,” Hargan said.

Hargan cited the case of Huntington, West Virginia, where the state is trying to address the opioid crisis by taking a more holistic approach to care. In addition to substance abuse treatment, patients are offered help in dealing with social and legal problems. One provider told Hargan she had to fill out 11 release forms before helping a patient.

“It slows down care,” Hargan said. “In modern times, information is a critical, critical part of how care is delivered in the health space.”

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

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Feds Crack Down on Health Care Providers to Release Patients’ Records

By Kelsey Hackem

The Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services has begun enforcing a provision of the Health Insurance Portability and Accountability Act (HIPAA) that has been in effect since 1996.

OCR launched the Right of Access Initiative in 2019, promising vigorous enforcement of the provision which gives patients the right to prompt access to their medical records without being overcharged and in the readily producible format of their choice. HIPAA rules generally require covered health care providers to provide medical records within 30 days of the request and charge a reasonable, cost-based fee.

There have been two enforcement actions and settlements by OCR under HIPAA since the initiative was launched. The first case involved Bayfront Health St. Petersburg (Bayfront), which paid $85,000 to OCR and adopted a corrective action plan to settle a potential violation of the right to access provision of HIPAA in which Bayfront failed to provide a mother with timely access to records about her unborn child.

The second case, involving Korunda Medical, LLC (Korunda), resulted in the same fine and corrective action as the case against Bayfront. Korunda was found to have failed to provide timely records in electronic format to a third party and charged more than the reasonable cost-based fees permitted under HIPAA.

Calls for ‘Total Access’

Phillip Eskew, D.O., J.D., a physician, founder of DPC Frontier, and policy advisor to The Heartland Institute, which publishes Health Care News, says the right of access to medical records is good for patients. Patients with ready access can promptly notify physicians about any missing or inaccurate areas, Eskew says.

“Even if HIPAA were not in place, many states have similar laws regarding the timely release of medical records to patients upon their request,” Eskew said.

Private-Sector Initiative

The private sector is also working on solutions, Eskew says.

“I wish all practices took the ‘open notes’ approach,” Eskew said. “Open notes is a national movement in the United States that encourages clinicians to offer patients ready access to their encounter notes.”

A patient’s right to access his or her medical records should be treated like other goods or services, says Kimberly Legg Corba, D.O., a direct primary care physician who is certified in HIPAA compliance.

“Good or bad, one could argue that HIPAA’s ‘right to access’ should not be something the government should mandate,” Corba said. “Patients should not have to be granted a ‘right to access’ their protected health information (PHI). It should just be theirs to begin with.”

KIMBERLY LEGG CORBA, D.O.
DIRECT PRIMARY CARE PHYSICIAN

“Good or bad, one could argue that HIPAA’s ‘right to access’ should not be something the government should mandate. Patients should not have to be granted a ‘right to access’ their protected health information (PHI). It should just be theirs to begin with.”

“Prior to HIPAA and HITECH (Health Information Technology for Economic and Clinical Health), no one was trying to ‘steal’ PHI, no one was gathering data for the purposes of quality analyses for payment purposes or cost-containment, and entities were not hesitating in the sharing of a patient’s own, personal health records, particularly at the patient’s request,” Corba said.

Electronic Record Change Landscape

Most physicians are employed by large health systems, and patients’ medical records are increasingly embedded in elaborate electronic health records (EHR) systems, says Corba.

“Large entities like these have entire departments staffed by individuals who are trained to handle transfer of medical records,” Corba said.

Big organizations can also hire outside vendors to handle records, and these trends have led to some controversies, Corba says.

“Now EHR vendors are claiming concerns with patients being able to screen-shot and share their own PHI due to potential damage to the company’s ‘trade secrets,’” Corba said.

That helps explain why some EHR companies are hesitant to share information with patients, Corba says. “Perhaps moving the storage and ‘ownership’ of patient PHI away from the medical-industrial complex and to the patients themselves is a solution,” Corba said.

“I think if patients could choose to have instant access to all of their medical records and PHI at all times, and choose themselves when and with whom they want to share, it would make the flow of information and resulting continuity of care much more efficient and improve the quality of care,” Corba said.

Kelsey E. Hackem (khackem@gmail.com) writes from Washington.
HHS Urged to Update HIPAA to Protect Patient Medical Records

By Ashley Bateman

A prominent health care policy organization is calling for the federal government to update the Health Insurance Portability and Accountability Act (HIPAA) to allow patients to opt in, instead of having to opt out of, such arrangements and to outlaw coercive consent forms.

The Citizens’ Council for Health Freedom (CCHF) President and cofounder Twila Brase sent a letter on December 6 to Roger Severino, director of the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS) detailing why the law should be revised. The letter states that HIPAA is too permissive and “establishes unconsented access” to private medical records and electronic health records.

Data-Mining ‘Gold’

CCHF sent the letter days after a November 2019 Wall Street Journal report about a data-sharing agreement between Google and Ascension Health, a large private health care organization. Ascension Health will transfer the data in question, including patient names and private medical records of approximately 50 million people from 21 states, to Google through March of this year.

In a blog post, Google stated 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.”

The WSJ article says Google is not charging for the service, which Brase says is telling.

“Patient data is the twenty-first century version of gold, so they don’t need to charge for it,” said Brase on The Heartland Daily Podcast.

“They can rummage through our records to do data mining, to figure out algorithms through artificial intelligence, to essentially create a brand-new business for themselves on the use of patient data,” Brase said. “[They can] do predictive analytics to see how expensive patients are going to be in the future.”

‘Coercive Consent Forms’

HIPAA does not protect patient privacy, as many people assume, but is instead “a notice of disclosure practices over which [patients] have no consent,” Brase says.

Brase refers to the documents patients are required to sign at health care provider visits as “single-signature coercive consent forms.” The HIPAA privacy rule, which became law in 1996, requires patients to opt out of information-sharing.

In its letter, CCHF acknowledges the Ascension-Google arrangement “is legal, as much as we wish it were not so,” as “both companies point to the ‘health care operations’ (HCO) data-sharing provision of HIPAA” authorizing “at least 65 non-clinical business activities.” A health care operation is a “covered entity” authorized to disclose or receive health information without individual consent. “In short, the HCO provision is an open door to data-sharing,” the letter states.

“The shocking disclosure that the Ascension health care system is sharing the medical records of 50 million people in 21 states with Google shows clearly that HIPAA does not protect patient privacy, was never written to protect patient privacy, and has been used to deceive Americans into believing they have privacy rights when they have none,” the letter states.

‘These Intrusive Enterprises’

The OCR is investigating “to learn more information about this mass collection of individuals’ medical records,” The Wall Street Journal reported in November 2019.

Brase says now is a perfect time to review HIPAA.

“Privacy rights are less about privacy than they are about control,” Brase said. “We say ‘he who holds the data, holds the rules.’ It’s about the reach into the exam room.”

The CCHF letter states Google and Ascension Health are not alone in sharing patient medical records, as other technology companies are making similar deals with other health care organizations.

“What emerges from these intrusive enterprises may or may not be in the patient’s best interest—but patients aren’t being given a choice,” the letter stated. “They have been stripped of their rights. Their data is not theirs. They have no control—because of HIPAA.”

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

Physician Group Sues Rep. Schiff for Trying to Censor Vaccine Debate

The Association of American Physicians and Surgeons (AAPS) and a New York State resident are suing U.S. Rep. Adam Schiff (D-CA) for trying to suppress what he deems inaccurate vaccine information on the internet.

The suit, filed January 15, 2020, in the U.S. District Court for the District of Columbia, claims Schiff contacted Amazon, Facebook, and Google in February and March of 2019 to advocate the Internet giants discourage parents from not getting their children vaccinated. Social media companies responded by diminishing access to anti-vaccine information on their platforms.

In a letter posted on Schiff’s congressional website, Schiff wrote such information “is a direct threat to public health” and asked for additional information “on the steps that you currently take to provide medically accurate information on vaccinations to your users.”

Links Changed

AAPS and Katarina Verrelli of New York, on behalf of others seeking information about vaccines, say Schiff’s actions are an abuse of power and an infringement of the right to free speech.

“What appointed Congressman Adam Schiff as Censor-in-Chief?” asked AAPS General Counsel Andrew Schlaffly in a press release. “No one did, and he should not be misusing his position to censor speech on the internet.”

AAPS said a search for any of its articles on vaccines now leads to links to webpages for the World Health Organization, the Centers for Disease Control and Prevention, and the National Institutes of Health.

“AAPS is not ‘anti-vaccine,’ but rather supports informed consent based on an understanding of the full range of medical, legal, and economic considerations relevant to vaccination and any other medical intervention,” said AAPS Executive Director, Jane Orient, M.D, a policy advisor to The Heartland Institute, which publishes Health Care News.

The suit asks for a declaratory judgement that Schiff violated the plaintiffs’ First Amendment rights, an order for Schiff to cease action against publishers of vaccine-related information, and publication of a link to such an announcement.

—Staff reports
Feds Nix Wyoming’s Plan to Regulate Air Ambulances Through Medicaid

By AnneMarie Schieber

The Centers for Medicare and Medicaid Services (CMS) denied Wyoming’s request to expand Medicaid so it can control the price and distribution of its air ambulance services.

In a January 3, 2020, letter, CMS stated the plan “does not align with the core objectives of Medicaid” under section 1115a and cannot be used to “circumvent other federal statutes.”

Air ambulance service is regulated, in part, by the Airline Deregulation Act of 1978, which prohibits states from interfering with air carrier rates, routes, and service.

Big Bills for Consumers

Wyoming was attempting to regulate air ambulance service like a public utility. Air ambulance service is run primarily by private providers who are grappling with under-reimbursement by government-run health care programs and private insurance companies reluctant to make up the difference, says Carter Johnson, a spokesperson for Save Our Air Medical Resources (SOAR). As a result, air ambulance providers are shuttered out of insurance networks, leaving consumers stuck with a “surprise medical bill.”

Wyoming has a particular challenge with its sparse population and expansive geography. Wyoming’s plan was for air ambulance contracts to be offered through a bidding process, which it could only do if all such service was covered under Medicaid and operated by the state.

Lives at Risk

SOAR, an air medical service advocacy group, agrees with the CMS decision to deny the waiver.

“The waiver would have posed a direct risk to all Wyoming patients, including current Medicaid beneficiaries, because of the diminished access to emergency critical health care services,” said Johnson.

“Air medical service is both critical and complex, and we want policymakers to have the information, understanding, and data needed to address the root causes of balance billing, which include the chronic under-reimbursement by Medicare and other government programs,” Johnson said.

Reimbursement Problems

SOAR’s next challenge is getting lawmakers to get to the reason for “balance billing”: bills for out-of-network costs sent to consumers. The U.S. Department of Transportation’s Air Ambulance and Patient Billing Advisory Committee is working on this, Johnson says.

“Air medical service is both critical and complex, and we want policymakers to have the information, understanding, and data needed to address the root causes of balance billing, which include the chronic under-reimbursement by Medicare and other government programs,” Johnson said.

Virginia Likely to Change Directions on Health Care Policy

By Ashley Bateman

A change in power in the Virginia legislature will put reforms of the state’s fiscally challenged Medicaid program on the back burner, say minority party members.

Democrats won control of both the Virginia State Senate and House of Delegates in the November 5 election last year, with several candidates running on a platform of “more affordable health care” and protection for people with preexisting conditions.

Weeks after the election, Gov. Ralph Northam, a Democrat, told his cabinet to suspend negotiations with the Trump administration on phasing in a work requirement for able-bodied Medicaid recipients and to have them pay premiums.

Reversing Direction

“The Democrats campaigned on radical policies, and they won,” said Paul Milde (R-District 28), who ran on a Medicaid expansion reform platform and lost in the election.

“Their leadership is heavily represented by their more liberal wing,” Milde told Health Care News. “The only impediment is their party’s own decision to go slow. Therefore, I expect them to move on a broad array of issues.”

In the previous legislative session, Republicans held a razor-thin majority in both chambers. In a special session in 2018, the GOP agreed to Medicaid expansion only with a work requirement, and Northam accepted the compromise. Weeks after his party’s victory in the 2019 election, the governor told his Medicaid director to hold off on the federal Medicaid waiver request for a work requirement.

“Virginians made it clear they want more access to health care, not less,” Northam said in a statement at the time.

Expanding Rapidly

Coverage under the expansion went into effect in January 2019. By October, enrollment in the program had increase by 325,000.

“Numerous Republican-led efforts to reform the health care system by providing more options and lower costs have been vetoed by Democrat governors in the last six years, which hindered us from making progress,” Del. David A. LaRock (R-District 33) told Health Care News.

“At the same time, any Democrat effort to go beyond Medicaid expansion to ‘universal health care’ is going to be very difficult to accomplish due to provider shortages and other factors. [Democrats] don’t seem to understand the gap between ‘coverage’ and ‘care,’” said LaRock.

Milde says he agrees it will be hard for Democrats to push through radical health insurance changes such as a single-payer system.

“Fortunately, I expect health care not to be their focus,” said Milde. “They have Medicaid expansion. [In other states,] the courts have overturned work requirements. So they will turn to abortion.”

The Virginia General Assembly convened on January 8 and runs for 60 calendar days, with a 30-day extension option.

“Ensuring every community has access to air medical, and that no patient receives a balance bill because insurance fails to cover emergency care, should be the goal,” Johnson said.

“This will require looking at different aspects, including patient mix, chronic under-reimbursement by government programs, increasing denials by private insurers, narrow networks, and air base closures.”

AnneMarie Schieber (amschieber@heartland.org) is managing editor of Health Care News.
Demand for Psychiatric Urgent Care Exceeds Expectations, New Provider Reports

By Ashley Bateman

One of the nation’s first psychiatric urgent care centers has attracted nearly 3,000 patients since it opened six months ago, according to its operator, Pine Rest Christian Mental Health Services, in Grand Rapids, Michigan.

Rising numbers of walk-in facilities have opened around the country to treat low-acuity mental health problems such as stress and grief. The Pine Rest center is one of the first to deal with acute psychiatric symptoms. There is a growing need for such care, Pine Rest’s website states. In 2016, in western Michigan where Pine Rest operates, there were 14,623 visits to hospital emergency rooms for behavioral problems.

The clinic serves adults only and is open from 10 a.m. to 8 p.m., Monday through Friday, and from 10 a.m. to 2 p.m. on weekends. The average cost for an uninsured patient is $286. The center has attracted patients from 52 of the state’s 82 counties and from Canada.

The number of visits to the center has exceeded expectations, says Bob Nykamp, chief operating officer at Pine Rest.

“It has improved access to psychiatric care and fills a gap in the local behavioral health care system,” Nykamp said.

Providing Prompt Care
Like emergency-room treatment, Pine Rest’s Psychiatric Urgent Care Center is not designed for long-term care. Patients receive a series of assessments to determine the level of care needed, with social work, psychiatric, illness education, and follow-up care professionals. Patients are then referred to their primary care doctors, therapists, and other treating physicians.

Treatment is meant to be same-day, says Kris Brown, marketing manager at Pine Rest.

“Patients can receive assessment and treatment sooner than if they had to wait for an outpatient appointment, and it is more cost-effective than receiving behavioral health treatment in an emergency department,” Brown said.

Nearly half of the patients who have sought care at the center are in the 18-29 age group. Pine Rest says it hopes to expand services to children and adolescents. The center can treat a range of symptoms and illnesses, including depression, anxiety, panic attacks, disturbing thoughts, thoughts of suicide, grief, and substance use disorders, its website states.

“We have found that 80 percent of the people we assess have avoided higher, more expensive levels of care,” stated Center Director Megan Auffrey-Zambiasi.

Expanding Choices
Demand for psychiatric care across the country has grown in recent years, and programs like Pine Rest can help address that growing need, says Robert Emmons, M.D., a psychiatrist and clinical ethics advocate in Burlington, Vermont and policy advisor to The Heartland Institute, which publishes Health Care News.

“In general, access to urgent psychiatric care is so limited around the country that we can welcome any independent clinicians or agencies. Not every patient will want services offered by clinicians with religious affiliations, but not every patient wants the services offered in mental health agencies funded primarily by Medicaid, for that matter.”

ROBERT EMMONS, M.D. PSYCHIATRIST AND CLINICAL ETHICS ADVOCATE

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“In general, access to urgent psychiatric care is so limited around the country that we can welcome any independent clinicians or agencies,” Emmons said. “Not every patient will want services offered by clinicians with religious affiliations, but not every patient wants the services offered in mental health agencies funded primarily by Medicaid, for that matter.”

“Each funding source has its own limitations and ideologies about treatment, and it is generally better for patients to have more choices,” Emmons said.

Psychiatrist Shortage Discussed
A challenge for any new model in mental health care is a shortage of psychiatrists. The shortage became an issue at a December 5 legislative hearing in Michigan over a proposal to remove psychiatric beds from certificate of need approval.

“The issue isn’t the beds,” stated James “Chip” Falahee, chairman of Michigan’s CON Commission. “It’s the people that staff the beds.”

Al Jansen, Pine Rest’s corporate director for community and residential services, told the lawmakers there are plenty of available psychiatric beds at his organization’s in-patient facility but the lack of outpatient facilities is “almost an epidemic.”

Instead of blaming the physician shortage, Jansen said the problem is reimbursement rates from third-party payers, which he characterized as “very low.”

“We think that would be a place to invest,” Jansen told the panel.

Ashley Bateman (bateman.ae@googlemail.com) writes from Alexandria, Virginia.
Hospital Mergers Worsen Patient Outcomes, Study Finds

By Bonner R. Cohen

A new study states the growing trend of hospital consolidation has led to “moderately worse patient experiences and no significant change in readmission or mortality rates.”

The study, “Changes in Quality of Care after Hospital Mergers and Acquisitions,” published on January 2 in the New England Journal of Medicine, triggered a new round of finger-pointing between the payer and provider sectors of the industry.

“Despite industry claims to the contrary, evidence indicates large hospital mergers not only drive up costs but also do not improve quality of care,” America’s Health Insurance Plans (AHIP), an insurance industry group, said in a statement.

The study examined 246 hospitals that were acquired between 2007 and 2016 and a control group of 1986 hospitals that were not acquired. Researchers measured the hospitals’ performance in four areas: mortality, readmission, patient experience, and clinical process. Patient experience refers to interactions patients have with a health care system, such as timely access to information and good communication. Clinical process measures health care outcomes.

Growing Trend
Mergers and acquisitions among hospitals and health care systems have been on the rise in recent years. Citing a 2018 report by the management consulting firm Kaufman Hall, fiercehealthcare.com reports there were 90 such deals in that year, including several “megamergers” among large regional health care systems. AHIP says mergers play a key role in driving up costs.

“By no surprise, research has found that when health systems in a region get bigger and squeeze out competition, prices go up for consumers,” AHIP said in a statement last June before a U.S. Senate hearing on hospital consolidation. “That’s just the economic reality.”

The hospital industry disagrees. The American Hospital Association (AHA) released a statement saying the study is flawed because it relies on responses from patients to a Centers for Medicare & Medicaid Services “Hospital Consumer Assessment of Health Care Providers and Systems,” which the group says is not a valid measure.

Melinda Hatton, AHA’s general counsel, said although the survey could be useful in measuring patient experience, “using data collected from patients making claims about quality fails to recognize that it is often incomplete, as patients are not required to and do not always respond comprehensively.” Hatton stated the survey “does not capture information on the quality of care as it is delivered today.”

Hospital mergers are a symptom of a health care system coping with government meddling, says Devon Herrick, a health care economist and policy advisor to The Heartland Institute, which publishes Health Care News.

“Hospitals merge into hospital systems to raise market share and boost negotiating power in order to increase profits,” Herrick said.

Bonner R. Cohen, Ph.D. (bcohen@nationalcenter.org) is a senior fellow at the National Center for Public Policy Research and a senior policy analyst with the Committee for a Constructive Tomorrow.
Rural Hospital Consolidation May Undermine Care, Access, New Study Finds

By Bonner Cohen

Hospital consolidation, often seen as a financial lifeline for rural hospitals and encouraged by the Affordable Care Act, may result in cutbacks in services and reduced patient access, a new study concludes.

More than 100 rural hospitals in the United States have closed since 2010, and another 430 are at risk of closing, according to data compiled by the University of North Carolina and released in September of 2019. Hospital managers attempting to avoid that fate have increasingly affiliated with larger health care systems to improve their financial performance. The rise of consolidations has created larger regional and national hospital systems while reducing competition among providers.

In a study supported by the RAND Center on Excellence on Health System Performance and published in *Health Affairs* in December 2019, researchers Claire O’Hanlon, Ashley Kranz, and Maria DeYoreo examined the effects of affiliation on rural hospitals and their patients.

The study, “Access, Quality, and Financial Performance of Rural Hospitals Following Health System Affiliation,” compared rural hospitals that affiliated with a health system in the period 2008-17 with those that did not affiliate. The study analyzed structure, utilization, quality, and financial performance.

**Service Reductions**

Researchers found rural hospitals that affiliated with larger hospital systems underwent a significant reduction in services such as diagnostic imaging, obstetric and primary care, and outpatient non-emergency visits. Analyzing how the changes affect patient access is “an important next step,” O’Hanlon told Reuters Health in a December 5, 2019 article.

Meanwhile, operating margins increased by 1.6 to 3.6 percentage points, the researchers found, raising the question of whether the financial performance is related to decreased operating costs. O’Hanlon discussed the study during a webcast on rural health delivery conducted by researchers at the University of Washington and published in August 2019 by the National Bureau of Economic Research (NBER).

“Rural closings increase travel times for patients, and lead to outmigration of health care professionals post-closure, severely dismembering patient access to care and exacerbating social disparities in health outcomes,” the NBER study reported.

**Rising Criticism**

The decline in the number of rural hospitals coincides with the growing concentration of hospitals in metropolitan areas.

A recent report by the Health Care Cost Institute (HCCI) found places where hospital markets have become more concentrated also had larger increases in inpatient prices, and vice versa. The correlation held up only in areas with hospital merger and acquisition activity.

Not unlike the RAND findings, the HCCI study found consolidation leads to less competition, higher prices, and fewer choices for care. The American Hospital Association disputes the HCCI’s findings, saying the group failed to consider consolidation among insurance companies.

**Boosting Market Power**

The findings in the Rand study come as no surprise to Devon Herrick, a health economist and policy advisor to The Heartland Institute, which publishes *Health Care News*.

“Hospitals seeking to merge with competitors claim their goal is cost savings from economies of scale,” Herrick said. "However, it is more likely the primary goal is boosting market power in order to extract higher prices from patients, employers, and insurers.”

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.

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“Obamacare encouraged consolidation by incentivizing providers to coordinate care and adjust Medicare services to make mergers a smarter financial option. Consolidation, by design, reduces competition. So, it should be no surprise that the new corporate behemoths have raised prices.”

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Available online at store.heartland.org.
Supreme Court Declines Review of ACA Constitutionality

By AnneMarie Schieber

THE U.S. SUPREME COURT SAID IT will not fast-track a request by 19 states to take on a decision by a federal appeals court that ruled the Obamacare individual mandate is unconstitutional.

The Court sent the case back to a U.S. district court to decide whether the entire law, known as the Affordable Care Act (ACA), should be thrown out.

In a radio interview, U.S. Health and Human Services Secretary Alex Azar said there is no need to expedite any action on Obamacare “unless and until there’s a final Supreme Court decision,” which Azar said would be “some time away.”

No Competitive Market

On December 19, 2020, the Fifth Circuit Court of Appeals upheld a decision by U.S. District Judge Reed O’Conner, stating the “individual mandate is unconstitutional because it can no longer be read as a tax, and there is no other constitutional provision that justifies this exercise of congressional power.”

In its opening summary, the Appeals Court quoted an amicus brief filed by the Association of American Physicians and Surgeons (AAPS) which stated the ACA “has deprived patients nationwide of a competitive market for affordable high-deductible health insurance” and patients have no alternatives to “skyrocketing premiums.”

AAPS states the ACA has been unconstitutional from the beginning because the federal government has no power to provide medical care or health insurance and the ACA interferes with states’ rights to regulate their insurance markets.

Moved to Medicaid

Although the law may have increased insurance coverage in the 10 years since it was enacted, it did so by putting people on Medicaid, not on desirable insurance plans, says Grace-Marie Turner of the Galen Institute, who cowrote Why Obamacare is Wrong for America shortly after the ACA became law.

“The net reduction in the uninsured is almost entirely attributable to making non-disabled adults eligible for Medicaid—a program designed as a safety net for the poor and vulnerable,” Turner stated on the American HealthCare Choices website. “Virtually all of the newly insured are getting huge government subsidies to underwrite their increasingly expensive coverage.”

The Supreme Court’s decision puts a politically heated issue on the back burner as the nation approaches the November general election. The Court begins a new term on October 1.

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

Supreme Court to Decide Abortion Safety Requirements

By Bonner Cohen

IN WHAT PROMISES TO BE A LANDMARK ruling on a highly charged issue, the U.S. Supreme Court will soon hear June Medical Services v. Gee, which challenges a 2014 Louisiana law requiring abortion providers to have admitting privileges at a nearby hospital.

The Louisiana law has never gone into effect, because lawsuits have kept it tied up in litigation since it was enacted. Since the Supreme Court legalized abortion in 1973 in the landmark Roe v. Wade case, state laws restricting abortion have faced the certainty of legal challenges, even if those laws are intended to protect the safety of the patient.

Ambulatory surgical centers (ASCs) in Louisiana must meet the admitting-privilege requirement. Many abortion providers, however, do not apply for or are denied hospital privileges. If complications arise requiring a patient to be transferred to a hospital, these providers, lacking hospital privileges, cannot participate in the treatment. The patient will then be treated by a hospital physician who may not know what caused the problem and may not even be able to communicate with the physician who performed the abortion.

The Court will hear oral arguments in the case on March 4.

High Complication Rate

In an amicus brief filed in support of the Louisiana statute, the Arizona-based Association of American Physicians and Surgeons (AAPS) noted the requirement is identical to the rule governing physicians who perform other outpatient procedures in an ambulatory surgical setting.

“The complication rate for procedures done at ASCs is 0.1%, which is lower than the (likely understated) complication rate of up to 0.5% for abortions,” AAPS stated. “Hundreds if not thousands of women are hospitalized each year for abortion complications, and few states mandate reporting them.”

AAPS noted abortion clinics do not qualify for admitting-privilege exemptions granted to certain office-based procedures, because abortion providers may use sedation or anesthesia.

Different Standards in Place

Physicians have an ethical duty to their patients to ensure continuity of care in case of a hospital transfer, AAPS states. Patients have the right to “expect their physician will cooperate in coor-

dinating medically indicated care with other professionals, and that the physician will not discontinue treating them when further treatment is medically indicated without giving them sufficient notice and reasonable assistance in making alternative arrangements for care,” the AAPS brief states. “By failing to hold abortion providers to the same standards as doctors, a state would deny women who undergo abortion the same right to high-quality care provided to women undergoing other surgical procedures.”

More than two-dozen amicus briefs from researchers, health care professionals, and lawmakers have been filed with the court. The Trump administration also expressed its support of the Louisiana law in a friend-of-the-court brief.

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New FDA Commissioner Should Remove Agency Bloat, Put Patients First

By Henry Miller, M.D., Jeff Stier

ow that the Trump Administration’s new U.S. Food and Drug Administration (FDA) commissioner, Dr. Stephen Hahn, has been confirmed, he’ll find he has one of the most difficult and important jobs in government. The FDA’s purview is wide, regulating pharmaceutical and other medical, food, and vaping products that account for more than 25 cents of every consumer dollar spent in the United States—more than a trillion dollars per year.

Government regulation offers some reassurance to the public, to be sure, but when it is wrongheaded or not cost-effective, it actually costs lives: directly, by withholding lifesaving and life-enhancing products, and also indirectly, by diverting resources to gratuitous regulatory compliance.

Dr. Hahn is inheriting an organization that is huge, critical, and dysfunctional. The stakes are high. For example, the FDA has pushed the average cost (including out-of-pocket expenses and opportunity costs) of bringing a new drug to market above $2.5 billion. That ensures many new drugs will have a hefty price tag, and it means others will never be developed at all.

Putting the FDA on the right track will require toughness and discipline at an agency where more than 99.9 percent of the employees are civil servants who cannot be fired even for incompetence or insubordination. (Did we hear someone mutter, “deep state?”)

Expanding Bureaucratic Power

Government regulators have vast power and wide discretion. Unfortunately, the incentives that guide them are perverse.

The late, great economist Milton Friedman said you should look to self-interest to understand the motivations of an individual or organization. The self-interest of regulators lies not necessarily in serving the public interest, but in expanded responsibilities, bigger budgets, and grander bureaucratic empires for themselves.

Former FDA Commissioner Frank E. Young once quipped that “dogs bark, cows moo, and regulators regulate.” Consistent with that tendency, the FDA has sometimes exceeded its congressional mandate. Regulators have concocted additional criteria for approval of a new drug, above and beyond the statutory requirements for demonstrating safety and efficacy, that could inflict significant damage on patients and pharmaceutical companies.

For example, the regulators have arbitrarily demanded a new drug be superior to existing therapies, although the Food, Drug, and Cosmetic Act requires only a demonstration of safety and efficacy. Additionally, Phase 4 (post-marketing) studies are now routine, whereas the FDA used to reserve them for rare situations, such as when there were subpopulations of patients for whom data were insufficient at the time of approval.

Deadly Delays

The damage done by FDA regulators’ self-serving actions ranges from the creation of disincentives to research and development (which inflates costs) to significant threats to public health, such as the years-long delay in approval of a much-needed meningitis B vaccine.

Another egregious example of the effect of excessive risk-aversion is the sorry saga of a drug called pirfenidone, used to treat a pulmonary disorder called idiopathic pulmonary fibrosis (IPF), which used to kill tens of thousands of Americans every year. The FDA unnecessarily delayed approval of the drug for years, although it had already been marketed in Europe, Japan, Canada, and China. During the delay, more than 150,000 patients died of IPF in the United States, many of whom could have benefited from the drug.

Mission Creep

Many years of fat budgets have enabled the FDA to waste resources. In 2017, for example, the agency sought public comments about its use of focus groups, claiming they “provide an important role in gathering information because they allow for a more in-depth understanding of patients’ and consumers’ attitudes, beliefs, motivations, and feelings.” FDA officials seem to have forgotten that their mission is to make science-based decisions—primarily about product safety, efficacy, and quality—as expeditiously as possible, regardless of the public’s beliefs, motivations, and feelings.

A particularly dubious policy is the FDA’s self-declared jurisdiction over all “genetically engineered” animals. The agency then took more than 20 years to approve the first one—an obviously benign, fast-growing salmon—and then made a colossal mess of the five-year review of a single field trial of a mosquito to control the mosquitoes that transmit the Zika, yellow fever, dengue fever, and chikungunya viruses.

The FDA eventually relinquished jurisdiction over that mosquito and other animals with pesticidal properties to the U.S. Environmental Protection Agency, where they belong.

“Significant legislative changes, or even meaningful congressional oversight, would go a long way toward reining in an agency deeply and culturally invested in more regulation. Unfortunately, political realities make this unlikely to happen anytime soon. If we are to realize the kind of aggressive, innovation-promoting deregulation President Donald Trump has rightly called for, Hahn will have to disrupt the agency’s built-in bias toward overregulation.”

Ideas Available

The public interest calls for structural, policy, management, and cultural changes that would create incentives for the FDA to regulate in a way that is evidence-based and imposes the minimum burden possible. Policymakers and others have offered several possible approaches and remedies to accomplish that, ranging from radical to conservative. None has been undertaken.

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Generic Drugs Approved but Slow to Reach the Public

By Jesse Hathaway

The U.S. Food and Drug Administration has approved generic versions of pharmaceutical products at a record-setting pace since 2016, but few of the newly certified products are available to patients, according to an analysis by IQVIA.

IQVIA is a multinational company that uses data analytics to study health care and recommend new avenues of research. According to its study, cited in a November 19 Wall Street Journal article, fewer than two-thirds of newly approved generic drugs are actually available for use by patients.

In addition to logistical and financial challenges producers face, the report identified another potential cause of the delay between market approval and market availability: evergreening.

“Evergreening” is a practice among pharmaceutical companies “to obtain a second patent before the first one expires,” according to the book Overcharged, Why Americans Pay Too Much for Health Care, co-authored by Charles Silver and David Hyman. “Drug companies can obtain these secondary patents by tweaking their drugs in various ways,” the book states.

Keeping Competitors Out

Evergreening is a problem for the industry, says Karin Hessler, assistant general counsel with the Association for Accessible Medicines, an organization representing the interests of generic drug manufacturers and distributors.

“Competition is ultimately good and results in lower drug prices,” Hessler said. “Obviously, if there is no generic competition and it’s just the brand product at the brand price point, patients will pay higher prices for a longer period of time.”

Hessler says one thing that can help free the market is for government not to interfere in legal settlements in patient cases. To settle claims against their patents (as in the case of evergreening), brand-name drug companies sometimes offer generic drug manufacturers money not to produce the drug over an agreed-upon period of time.

“If settling became difficult, it would be left to generic and biosimilar companies to try to defeat every brand patent there is, and that would be a high burden to us,” Hessler said. “Settlements are frequently necessary because companies can’t spend all of their time and money in court fighting patent disputes. Settlements have a beneficial impact.”

Third-Party Payment System

Evergreening is a symptom of a larger problem: a health care system that is expensive and ineffective, says Silver, who is also a law professor at the University of Texas at Austin School of Law and an adjunct scholar with the Cato Institute.

“Health care costs too much because we pay for it the wrong way,” Silver said. “We rely on third-party payers—Medicare, Medicaid, and private insurers—to cover the cost of goods and services that we should purchase directly. Third-party payers don’t care about costs nearly as much as consumers do.

“People should use insurance to cover catastrophes, not to pay for things like routine visits to doctors, blood tests, imaging studies, and so forth,” Silver said.

Special-Interest Influence

Another factor inflating prices is government’s vulnerability to influences by those with the most money and loudest voices.

“Pharmaceutical companies, hospitals, insurance companies and medical device manufacturers practically ran the table in Congress, winning hundreds of billions of dollars in tax breaks and other gifts through old fashioned lobbying, re-exerting their political prowess,” a December 20, 2019 Washington Post article on the omnibus spending bill stated.

“It is simply impossible for Congress to resist pressure from special interests to spend more,” Silver said. “That’s why Senators Bernie Sanders and Elizabeth Warren, who think Medicare for All will save money, are crazy. If Medicare for All is enacted, spending will go through the roof.”

Fixing the Larger Problem

To increase competition in the prescription drug market, it’s important to attack the larger problem, which is created by government policies, Silver says.

“Lawmakers should eliminate or reduce tax incentives to purchase insurance, including the exclusion for insurance purchased through employers,” Silver said.

The government should return the power to consumers to make more individual health care decisions, Silver says.

“They should eliminate the Veterans Administration medical system and let veterans buy treatments from ordinary providers,” Silver said. “They should replace Medicare and Medicaid with cash transfer programs that enable people to shop for what they want and to buy catastrophic coverage. The faster the system shifts from third-party payment to first-party payment, the sooner prices and spending will fall.”

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Why Americans Pay Too Much for Health Care

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Organization Warns of the Dangers of Socialized Medicine

By Tim Anaya

If there is a robust discussion on the dangers of socialized medicine in the United States, chances are the Pacific Research Institute (PRI) is front and center.

Under the leadership of Sally Pipes, the organization’s president, CEO, and Thomas W. Smith Fellow in Health Care, PRI has become a leading voice on the perils of Obamacare and the folly of doubling down on its worst excesses in the form of a single-payer system. Pipes speaks from experience, as a naturalized U.S. citizen from Canada.

PRI’s Center for Health Care has been shaping the legislative process for many years by brainstorming with policymakers, meeting with legislators, and providing testimony before Congress and state legislatures. Pipes’ research on single-payer health care was cited in testimony presented at a hearing in April 2019. PRI’s Center for Health Care has also been an effective tool for PRI. In September 2019, Pipes participated in a high-profile, New York City debate titled “Replace Private Insurance with Medicare for All.” The audience selected Pipes and her debate partner, Nick Gillespie of Reason, as the winners for their argument that Medicare for All will leave everyone worse off.

In January, Pipes released her latest book, False Premise, False Promise: The Disastrous Reality of Medicare for All. The book exposes the many problems with the Medicare for All plans under consideration in Congress, details the horrors of a single-payer system with heart-wrenching stories of patients suffering, and offers a workable vision for delivering the affordable, accessible, quality care Americans are looking for.

The book makes a timely debut in this election year, when voters will be choosing the next U.S. president and deciding who will lead Congress, and health care policy is dominating candidate debates with promises of lofty solutions such as “free health care.”

PRI plans to stay focused on its core mission in health care: educating the public on the best way to improve quality and access and decrease costs: the free market.

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Canadian Organization Tells the Real Story of Socialized Medicine

By AnneMarie Schieber

When senior citizen Jenny Mackenzie of Vancouver, Canada learned it would take two years for her to receive hip surgery, SecondStreet.org brought her tale of woe to the public’s attention.

SecondStreet.org is a Canada-based think tank named after the most common street name in Canada, and for good reason. The organization devotes its energies to documenting the stories of Canadians from coast to coast and how government policies, such as the country’s single-payer health care system, affect people.

Mackenzie’s story is one example. Although the Canadian government health care system foots the entire bill for hip surgery, it can take months or years to make it through the queue. Mackenzie went from being an active senior citizen to spending nearly every day in an apartment managing her pain.

No Free Lunch

SecondStreet.org reminds Canadians there is nothing free about the country’s health care. Canadians pay for the program through higher taxes and in time waiting and looking for care. Canada bans private health care options, so Canadians often leave the country for medical treatment. SecondStreet.org has been documenting this “medical tourism” on its website.

Using government data, SecondStreet.org determined Canadian citizens took 217,500 trips outside the country for health care in 2017 alone.

The organization’s president, Colin Craig, says his group’s website and Facebook page, featuring articles and videos, could be useful to Americans who think socialized medicine is the answer to the nation’s health care problems.

“Politicians like Bernie Sanders never seem to discuss Canada’s long waiting lists when advocating for the U.S. to copy our health care system, so our material can be a real eye-opener for some,” said Craig.

Stats vs. Stories

True stories can help people understand health care, says Craig.

“Health care discourse in Canada often features lots of large statistics,” Craig said. “We’re trying to tell the stories behind the numbers, like what it’s like to wait a year for hip surgery or travel abroad to get surgery on your back.”

SecondStreet.org also devotes time to researching and educating the Canadian public about potential alternatives to the nation’s single-payer health care system, Craig says.

“Ultimately, we hope Canadians understand that there are much better health care models,” Craig said. “[And perhaps] American visitors to our sites will see our system is not worth copying.”

AnneMarie Schieber (amschieber@heartland.org) is managing editor of Health Care News.
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For more information on Free to Choose Medicine, go to freetochoosemedicine.com, where you can also order a copy of the third edition of Bartley Madden’s book, Free to Choose Medicine.

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