VA Legislature Rejects Medicaid Oversight Bill

By Ashley Bateman

Virginia lawmakers failed to push through a bill to create a Medicaid oversight office after faulty forecasting resulted in a $462.5 million Medicaid shortfall over two years. Medicaid costs in Virginia have risen steadily in the past decade. Between fiscal years 2012 and 2016, state spending on the program rose by about 24 percent. In November 2018, the state Department of Medical Assistance Services (DMAS) announced the cost projections for the program were off by $462.5 million, a shortfall that would have to be covered over the next two years. The money will be pulled from the state government’s general fund. The announcement was made as...

MEDICAID OVERSIGHT, p. 4
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More Doctors Choosing Hospitals over Private Practices, Says New Report

By Ashley Herzog

Physicians are increasingly leaving private practices to join hospital networks, states a new report from the Physicians Advocacy Institute.

From July 2016 to January 2018, hospitals in the United States acquired approximately 8,000 private medical practices. Over the same period, 14,000 physicians left private practices to work for hospitals. In 2012, hospitals operated 35,700 private practices. By 2018, that number had increased to more than 80,000. Currently, 44 percent of physicians work for hospitals.

The trend affects consumers because outpatient hospital services are typically more expensive than services delivered by private medical practices, and it corresponds with the introduction of Obamacare, which began enrollment in 2014.

Multiple Advantages

Devon Herrick, a health care economist and policy advisor with The Heartland Institute, which publishes Health Care News, says there are several reasons for the trend.

“Solo or small practices have higher overhead, such that many doctors are tired of being self-employed,” said Herrick. “Enrollment in medical school is evenly split between the sexes now: 50 percent men and 50 percent women. Many women demand more work-life balance than is found in practices where physicians are self-employed.”

Doctors may also be attracted to the leveraging power hospitals have with third-party payers.

“Because hospitals get paid more for services performed in the hospital, the hospital can pay the doctors their previous salary while only requiring 40 hours of work a week rather than the 50 or 60 hours the doctors may have worked prior to being employed by the hospital,” Herrick said.

Hidden Fees

Hospitals are able to expand profits when they bring more physicians on staff.

“Hospitals tack on ‘facility fees’ for services performed in the hospital, including physician offices owned by the hospital,” Herrick said. “Hospital-employed physicians are also pressured to make all referrals to other hospital-employed physicians.”

Patients may be unaware of these facility fees, which hospitals can legally bill to Medicare, which increases the patient’s coinsurance.

“It could be the same physician they have seen numerous times in the past, not knowing the practice was sold to a hospital,” Herrick said. “It is often the very same office, so there is the appearance that nothing has changed, until a bill arrives.”

Costly ‘Provider Carousel’

Philip Eskew, founder of DPC Frontier, says hospital systems acquire private practices to offer all-encompassing care, which can result in higher costs to patients.

“Hospitals create incentives for patients to be referred around a provider carousel in their system so that the patients can be charged for three or four consults when one should have been enough,” said Eskew.

Like Herrick, Eskew says facility fees are a main driver for hospitals to acquire private practices.

“Why would Medicaid or Medicare pay a hospital more than a physician for delivering exactly the same service?” asks Eskew. “Realistically, there is no good answer. How did the hospital lobbyists make this argument with a straight face? Likely by arguing that their overhead was higher and thus justified higher reimbursement.”

Hidden Costs

Because the health care system is rife with third-party payments, consumers are not aware of the actual costs they incur. This lack of price transparency reduces incentives for health care providers, especially hospital systems, to keep costs down. Eskew says recent trends will only make matters worse.

“Independent practices are almost always a better value than going to a hospital-owned practice,” Eskew said. “Independent practices focused on price transparency, especially direct primary care practices, are the most important way out of our failing, insurance-driven health system.”

One way to decrease escalating costs is site-neutral payments, which would require third-party payers to remit the same amount for a service regardless of where it is performed, says Herrick.

“The easiest way to reduce the trend is for Medicare and governmental payers to stop paying hospitals more for services performed in hospitals than the same services performed outside the hospital,” Herrick said. “This makes sense because it creates competition to perform services in the most efficient manner.”

Calls for Consumer Power

Herrick says providers should give patients more decision-making power.

“A patient should have some discretion in referrals and should be told when a referral is in-house and be given the opportunity to seek care outside the closed referral process,” said Herrick.

“Patients need to always ask their physician, ‘How much does it cost?’” Eskew said. “If the physician cannot or will not answer this question, then start looking for a new physician.”

Ashley Herzog (aebristow85@gmail.com) writes from Avon Lake, Ohio.
Virginia Legislature Rejects Medicaid Oversight Bill

Continued from page 1

enrollment opened for Virginia’s expanded Medicaid program, but state Secretary of Finance Aubrey Lane said the unexpectedly high costs were not related to the shortfall.

To prevent inaccurate estimates in the future, Virginia state Sen. Ryan McDougle (R-Hanover) introduced Senate Bill 1352 to move responsibility and oversight of Medicaid from DMAS to a new state agency that would be called the Office of Medicaid Fiscal Oversight.

The bill made it through the state’s Senate on a 22–18 vote but stalled in a House subcommittee last March.

“I was very disappointed that the House took that direction,” McDougle said. “The arguments were that we already have this oversight. I don’t think that is a persuasive argument, because the things in place are to identify when a problem occurs, not to [predict and avoid] problems; $465.2 million is too high a number.”

Removing the Politics

The nearly $500 million shortfall accompanying the state’s Medicaid expansion should not have come as a surprise, McDougle says.

“Medicaid is the fastest-growing expense in our state budget,” McDougle said. “The only way I could see to … add some nonpolitical certainty that our numbers were accurate and plan so our numbers were better, was to create a system that was more transparent to the public, not just the executive and legislative branches, where we could see how the numbers were moving month to month, and not just at the end, when we see we have a problem.”

The proposed office McDougle helped design would do more than issue cost forecasts. It would also provide monthly oversight of Medicaid expenditures and review the potential impact of proposed policy changes. Employed actuaries would determine projections for growth in managed care rates, and the office would include an economist and data information analyst.

Changing the System

“These estimates were derived under the previous director of the previous governor, not the current director or current governor,” McDougle said. “But this shouldn’t be about individuals; this should be about a system. I wanted to put in a system that prevented it from happening again.”

“I was very disappointed that the House took that direction. The arguments were that we already have this oversight. I don’t think that is a persuasive argument, because the things in place are to identify when a problem occurs, not to [predict and avoid] problems; $465.2 million is too high a number.”

RYAN McDOUGLE
VIRGINIA STATE SENATOR

States Consider Options for Revamping Medicaid

By Nicole Staley

A number of states under pressure to expand their Medicaid programs are instead finding opportunities to customize their programs through federal waivers.

As of April 1, the Centers for Medicare and Medicaid Services (CMS) had approved 47 Section 1115 Medicaid Demonstration Waivers across 39 states, including 10 states that have not expanded their Medicaid programs, according to the Kaiser Family Foundation.

Legislative fights over Medicaid expansion have been taking place in several states. With Idaho voters having approved expansion in November 2018, the state is trying to limit eligibilidad for the expansion population to 100 percent of the poverty level.

In Kansas, lawmakers are dealing with a new governor who supports expansion. As of mid-April, the fate of expansion rests with the state Senate.

Georgia, which has not expanded its Medicaid program, enacted the Patients First Act in February, giving the governor authority to study the state’s program and apply for waivers.

Tennessee is considering a Medicaid work requirement, permission to block grant system that would give states more control over their programs. President Donald Trump’s budget proposal for the 2020 fiscal year would cut $1.5 trillion from Medicaid over the next 10 years. The budget also calls for strengthening work requirements for able-bodied people enrolled in Medicaid.

Open to Innovation

Giving states more authority to manage their programs would open the door for innovation, says Naomi Lopez Bauman, director of health care policy at the Goldwater Institute. Lopez coauthored the State Policy Network’s “Medicaid Waiver Toolkit,” which describes 20 reforms designed to improve delivery and control costs.

“Section 1115 waivers have been around for a long time, but it was not until recently that we have an administration more open to these innovative reforms,” Bauman said. “This is really the first time we’ve seen a willingness, an openness, and encouragement of states to innovate.”

Bauman says Medicaid funding is rapidly becoming unaffordable.

“We have a ballooning budget and a ballooning deficit and Medicaid spending that is on autopilot, which is not sustainable,” said Bauman.

Bauman says expansion is crowding out other spending in states.

“We have a Medicaid program that is on automatic spending, and it cannot be sustained,” said Bauman. Among the reforms Bauman advocates are closing programs when they reach certain enrollment levels, enrollment audits, implementing health savings accounts, setting time limits for enrollment, and measures that would require enrollees to have “skin in the game” by requiring them to pay a modest premium.

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

INTERNET INFO

Oklahoma Governor Calls for Medicaid Audit

By AnneMarie Schieber

Oklahoma Gov. Kevin Stitt requested an audit of the state’s Medicaid program to determine whether enrollees meet federal eligibility requirements.

The audit would be a first for Soonercare, Oklahoma’s Medicaid program, and the state’s Medicaid Children’s Health Insurance Program.

The Oklahoma Healthcare Authority (OHCA) would fund the audit, which would be conducted by an independent, private firm. The audit would cover the years 2015 through 2018 and would focus on eligibility determination.

“States across the nation have already completed Medicaid audits and found significant savings because of it,” Stitt said in his announcement.

The audit request comes during a time of increasing interest in granting the governor more control over who runs OHCA, which manages the state’s Medicaid program.

Currently, a governing board appointed by the legislature and governor selects OHCA’s leader. One proposal would make the agency more accountable to elected leaders by requiring that the board’s leader be chosen by the governor and confirmed by the Oklahoma Senate.

“The governor [has] had no authority to hire or fire the head of that agency,” Oklahoma Insurance Commissioner Glen Mulready told Health Care News. “It has always been the frustration for many in the legislature because we have $1 billion out of $7 billion in appropriations going to an agency that the governor had no control over.”

Out-of-Control Cost Growth

Over the past 20 years, Oklahoma’s Medicaid rolls have more than doubled, from 450,000 to nearly 1.1 million recipients.

Mulready says plenty of bills have been filed to expand Medicaid, but none have made it out of committee and he doesn’t think that will change before the state’s legislative session ends in May.

Mulready says there has been pushback against the proposed audit.

“The nature of the beast in state government is a push for the status quo,” Mulready said. “Most agencies don’t like being put under a microscope. I don’t think anyone is saying that anyone is not doing a great job, but we need to make sure taxpayer dollars aren’t being wasted by covering people who don’t meet eligibility.”

Jonathan Small, president of the Oklahoma Council of Public Affairs, says the audit will be beneficial for the needy.

“Medicaid was designed for the aged, blind, disabled, and truly needy,” said Small. “When we expand Medicaid, either through Obamcare or allowing people to stay on the program who are ineligible, it endangers the program by making it too costly for those who rightly need it.”

Audits Save States Millions

Audits of Medicaid rolls have been successful in several states. Audits found eligibility lapses were costing taxpayers millions of dollars in Arkansas, Illinois, Minnesota, Nebraska, New York, and Ohio, according to a 2015 Foundation for Government Accountability Report titled Stop the Scam: How to Prevent Welfare Fraud in Your State.

Small says as health insurance becomes more expensive, Medicaid can attract people who don’t need it.

“People tend to abuse things that are free,” said Small. “What we don’t want is for people to drop their private coverage because copays are nearly nonexistent in Medicaid.”

Excessive Managed-Care Costs

It is important for states to remove from Medicaid rolls people who do not use the program, says Naomi Lopez Bauman, director of health care policy at the Goldwater Institute.

“We have a very fluid Medicaid population,” said Bauman. “People might move to another state or get a job where they get insurance. In this day, when so many states have moved their programs to managed care, states are paying by person, so audits can really make an impact in saving money.”

The U.S. Office of Inspector General examined a sample of people in California from October 2014 to March 2015 and found Medicaid paid $738.2 million on behalf of 366,078 ineligible beneficiaries.

The FGA report states the U.S. Department of Health and Human Services determined 10 percent of all Medicaid payments are improper.

In 2016, total Medicaid spending was $576 billion, according to the Centers for Medicare and Medicaid Services, up from $456 billion in 2013.

AnneMarie Schieber (amsieber@heartland.org) is managing editor of Health Care News.
Generic Drug Price Gouging Decision Survives Appeal

Continued from Page 1

general could then petition a court to
demand documentation from a generic
drugmaker of the price increase and
then restrain the maker from selling
the drug for a particular price, using
the state’s definition of “price-gouging.”
The court could then impose a civil pen-
alty of up to $10,000 for each violation.

Violated ‘Dormant Commerce Clause’
The Association for Accessible Medi-
cines (AAM), a trade group for the
generic and biosimilar drug industries,
challenged the law, which it says vio-
lates the U.S. Constitution’s Dormant
Commerce Clause. The Dormant Com-
merce Clause essentially restricts
states from interfering with interstate
commerce. In 2018, the U.S. Court of
Appeals for the Fourth Circuit sided
with AAM, stating the law does regu-
lates prices outside the state.

Maryland petitioned the U.S.
Supreme Court to hear the case in
October 2018. In a news release, Mary-
land Attorney General Brian Frosh said
that will set payment levels for drugs,”
states the advocacy group Patients for
Affordable Drugs.

Targeting Cases, or Industry
Chip Davis, president and CEO of
AAM, says he understands the public’s
frustration regarding high drug prices
but he says sweeping laws are not the
answer.

“We have to craft solutions that deal with those
cases individually, because they are, relatively
speaking, isolated incidents, and I don’t say that
to minimize the impact on people affected, but
you need targeted solutions as opposed to what
Maryland tried to do, which was to say, ‘We’re
going to go after the entire generic drug industry.’”

CHIP DAVIS
PRESIDENT AND CEO, ASSOCIATION FOR ACCESSIBLE MEDICINES

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“We have to craft solutions that deal with those
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generic drug industry.’”

CHIP DAVIS
PRESIDENT AND CEO, ASSOCIATION FOR ACCESSIBLE MEDICINES

twist their proposals in the hope that
they can squeak past another court’s
scrutiny.”

“It is difficult to think of a work-
around that will satisfy the Dormant
Commerce Clause as the framers
intended it to apply,” Sepp said. “Unfor-
fortunately, the Supreme Court’s narrow
and, in our opinion, wrongly decided
Wayfair ruling has provided very limit-
ed barriers against the states’ continu-
ing to try.”

Sepp sent an open letter to Minne-
sota lawmakers in response to House File No. 4, which targets prescription
drug prices.

In 2018, the U.S. Supreme Court
upheld a South Dakota law challenged
by online retailer Wayfair. The law
compelled out-of-state sellers to collect
and remit sales taxes for customers in
the state. The high court decided the
law did not interfere with interstate
commerce as Wayfair had argued. Davis
says states’ attempts to control
generic drug prices using legal argu-
ments are misguided.

“Only in the political environment
would you go after the ecosystem deliv-
ering 90 percent of the market for 25
percent of the cost and think we are the
problem,” said Davis.

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

INTERNET INFO
Peter Sepp, Letter to the Commerce
Committee of the Minnesota House
of Representative on HF 4, February
20, 2019: https://www.heartland.org/
publications-resources/publications/
open-letter-to-fiscal-conservatives-
on-house-commerce-committee-
concerning-hf4-minnesota
Arkansas, Kentucky, New Hampshire Fight to Protect Medicaid Work Rule

By Nicole Staley

It took two attempts, but the Arkansas House of Representatives passed a Medicaid funding bill after rejecting it just days after U.S. District Court Judge James Boasberg blocked the state, along with Kentucky, from implementing a work requirement for able-bodied Medicaid beneficiaries.

The funding rejection came despite an appeal by Arkansas Gov. Asa Hutchinson and leaders of the state Senate and House expressing confidence the Trump administration would defend the work requirement in litigation. The Senate voted on and passed the $8 billion Medicaid budget bill before Boasberg’s decision. Budget bills require a supermajority in both chambers in the state.

Initially, the Medicaid budget bill in the House fell short by 10 votes. On April 9, it passed by three votes, with seven members not voting.

Kentucky had planned to launch its work requirement on April 1. Boasberg ruled against the Kentucky waiver in 2018, and after minor changes to the Kentucky HEALTH initiative, the U.S. Department of Health and Human Services approved the waiver a second time in March. Boasberg once again ruled against it, along with Arkansas’s rule, in a March 27 decision.

Meanwhile, New Hampshire’s Medicaid work requirement is under attack. In March, several Medicaid advocacy groups announced they are suing the federal government for approving the state’s work requirement request under a Section 1115 waiver. The National Center for Law and Economic Justice, one of the plaintiffs, said in a press release the waivers violate Medicaid’s stated purpose. The National Center for Law and Economic Justice also cited the decline in participation in Arkansas when its work requirements went into effect June 2018 as a reason for why the waivers should be struck down.

Bridge to the Workplace

Opponents of Medicaid work requirements fail to recognize the importance of work, says Grace-Marie Turner, president of the Galen Institute and a policy advisor to The Heartland Institute, which publishes Health Care News. “According to advisors to former President Obama, 40 percent of the people initially eligible for coverage under Medicaid expansion had an offer of private coverage, primarily through the workplace,” said Turner. “What a tragedy it would be if states were to lure them with free coverage through Medicaid but discourage them from working and having an incentive to find their right place in the workforce.”

In the current system, fear of losing government benefits discourages low-income individuals from increasing their income, says Rea Hederman, executive director and vice president at The Buckeye Institute.

“By keeping enrollees connected to the workforce, Medicaid work requirements will help people gain experience and learn new skills,” said Hederman.

Helping Hand, Not Handout

“Work requirements actually are a helping hand,” said Turner. “People can continue on Medicaid while they are getting their feet on the ladder of economic independence by getting a job, searching for work, and volunteering. States implementing work requirements are actually using the program to make it a helping hand rather than a handout.

“Giving people incentives to search for work is the right thing to do,” Turner said. “Courts that are striking down work requirements are actually harming people by taking away their incentive to work and succeed.”

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

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MI Governor Questions Upcoming Medicaid Work Requirements

By Andrew Whitney

Recently elected Michigan Gov. Gretchen Whitmer wrote a letter to the Centers for Medicare and Medicaid Services (CMS) Administrator Seema Verma claiming reporting requirements under the state’s Medicaid work rule could “take away health insurance from people struggling to make ends meet” and would do little to improve employment.

In December 2018, CMS approved Michigan’s Medicaid work requirement waiver requiring able-bodied people with up to 133 percent of the federal poverty level in annual income to work to receive their benefits. In 2018, Michigan legislators approved a bill directing the waiver application, and shortly after, then-Gov. Rick Snyder signed Public Act 208. The work requirement is scheduled to go into effect on January 1, 2020.

In her letter dated February 8, Whitmer claims P.A. 208 is more stringent than the waiver granted in Arkansas, where 18,000 individuals were removed from the Medicaid rolls in the first year. Whitmer called Michigan’s pending work reporting requirements “onerous” and said the law provides no resources for “job training, job search, or job supports.”

Whitmer concluded her letter by stating she will be working with state legislators to make changes to the Healthy Michigan Plan and while “new policies could change our requests from CMS,” Michigan accepts the terms of the waiver. Whitmer also wrote “technical corrections” may be forthcoming.

Work Requirements Under Fire

Medicaid work requirements are under attack in other states, too. Arkansas was the first state to require recipients to work to receive Medicaid benefits. Media coverage has focused on anecdotal reports of individuals not understanding reporting requirements or of having difficulty reporting their employment.

In June 2018, U.S. District Judge James Boasberg halted Kentucky’s Medicaid work requirement. Boasberg stated although Health and Human Services Secretary Alex Azar “is afford-ed significant deference in his approval of pilot projects like Kentucky’s, his discretion does not insulate him entirely from judicial review.” Boasberg ruled Azar failed to consider the adverse effects of the waiver on Kentucky’s low-income population.

Path to Prosperity

Doug Badger, a senior policy advisor at the Galen Institute, says Medicaid work requirements guide people toward self-sufficiency.

“A study by The Buckeye Institute found that men who comply with Medicaid work requirements can expect to earn $300,000 more over a lifetime than those who don’t,” Badger said. “Those whose earnings trajectories follow established patterns will see lifetime earnings rise by more than $1 million, compared with those who spend their productive years on Medicaid and don’t work.”

Badger says work requirements provide an equally important benefit to taxpayers.

“This could lessen the costs paid by Michigan taxpayers, as many jobs offer health care benefits,” Badger said.

“The Michigan waiver holds the potential for lifting residents out of poverty,” Badger said. “The governor and legislature should give the waiver a chance to work, rather than assume the worst about the program and Medicaid recipients.”

Andrew Whitney (agwhitney97@gmail.com) writes from Lansing, Michigan.

CMS Approves Ohio Medicaid Work Requirement

By Cory Compton

Ohio has become the eighth state to receive federal approval to implement a work requirement for its expanded Medicaid program.

Ohio requested permission to alter federal eligibility rules under a Section 1115 waiver and received approval from the Centers for Medicare and Medicaid Services (CMS) on March 15.

The work rules will apply to any able-bodied adult covered under the state’s expanded Medicaid program and would not apply to caregivers, individuals aged 50 or older, those with a chronic medical condition, or those who qualify for the Supplemental Nutrition Assistance Program or the Able-Bodied Adults Without Dependents Program.

To remain eligible for the program, Medicaid recipients must show they are working at least 20 hours a week, looking for work, receiving education or training, or participating in community service.

It is unclear when Ohio will begin enforcing the new rule. Litigation has delayed Medicaid work requirements in Arkansas and Kentucky. A similar suit is pending in New Hampshire.

Indiana has a fully implemented work rule. Alabama, Mississippi, Oklahoma, South Dakota, Tennessee, Utah, and Virginia are waiting approval for their work rule waiver requests.

‘One Stop Shop’

“If you are struggling to get ahead, we want to make sure that you have access to health care coverage, but we do expect you to work in return for that coverage,” said Ohio Lt. Gov. Jon Husted in an interview with WSYY-TV.

“This was a controversial part of the Obamacare plan, and the legislature has resisted Medicaid expansion for a number of years,” Husted said. “[Former Gov.] John Kasich implemented it. What we sought was a waiver to that policy, so that we could add a work requirement.

“And also, upon signing up for this, we are going to give them the ability to sign up for job training or apply for a job. It will all be a one-stop shop,” Husted said.

Work Requirement Bonus

Ohio’s decision to request a work requirement is smart for the taxpayers and good for Medicaid enrollees, says Rea Hederman, vice president and executive director of The Buckeye Institute.

“Research has shown that Medicaid expansion can lead to enrollees working less, leaving the labor market entirely [in order] to maintain Medicaid benefits,” said Hederman. “Welfare reform has shown us that work requirements encourage people to find jobs. Ohio policymakers are aware of this research and want to ensure that Ohio’s system helps keep people connected to the workforce, which our research shows will help recipients gain valuable work experience and generate higher earnings and incomes.”

According to the 2018 report Healthy and Working: Benefits of Work Requirements for Medicaid Recipients, a work requirement could increase lifetime earnings by close to $1 million for individuals who transition off of Medicaid and improve lifetime earnings by more than $300,000 for those who remain on Medicaid for their entire working life.

“By keeping enrollees connected to the workforce, Medicaid work requirements will help people gain experience and learn new skills,” Hederman said.

Cory Compton (thecomptonjr@gmail.com) writes from Cheboygan, Michigan.
Utah Rolls Out Partial Medicaid Expansion

By Ashley Bateman

Lawmakers in Utah rolled out a “partial” Medicaid expansion program on April 1, after the Centers for Medicare and Medicaid Services (CMS) granted approval of a request to allow the state to only enroll people making under $12,500 per year, well below the $17,200 limit voters approved in 2018. CMS also approved the state’s request to cap enrollment. Utah lawmakers are trying to get enhanced funding for Medicaid expansion while working to limit income levels that would qualify. Additionally, the state is seeking a waiver for a work requirement for Medicaid recipients.

Utah state Sen. Allen Christensen (R-Ogden) says he is optimistic CMS will approve the requests. The income limit would be the first of its kind in the nation.

“I’m just really optimistic on this whole thing, and maybe it’s misplaced and more wishing and hoping than optimism, but I think it’s going to happen,” said Christensen.

Expensive Expansion

Christensen proposed S.B. 96 after voters in November approved expanding Medicaid to adults with incomes up to 138 percent of the federal poverty level. Under the Affordable Care Act (ACA), the federal government will fund 90 percent of the costs of the expanded coverage in 2020 and beyond, instead of the traditional 70 percent match. Christensen says full expansion would have been too costly for Utah, which is constitutionally required to maintain a balanced budget.

His bill for “partial expansion” calls for requesting a 90 percent match on coverage to adults with incomes at or below the 100 percent poverty level. Adults with incomes between 100 percent and 138 percent of the poverty level could buy subsidized coverage through the federal exchange.

“I’ve opposed full expansion for years, but the people asked for it, so this is our solution,” said Christensen. “We have offered per capita caps, which the federal government has liked, and we feel we’re the first ones to make that bargain, so hopefully that will come through.

The Utah Governor’s Office of Management and Budget and the state’s Legislative Fiscal Analyst found voter-approved expansion under Proposition 3 would create a $47 million deficit in fiscal year 2023 and a shortfall of $83 million in FY 2025. Utah’s Medicaid expansion was scheduled to begin April 1, regardless of waiver approval. Christensen said lawmakers appropriated funds to cover the initial cost.

Does Not Guarantee Access

“The partial expansion is anticipated to cover about 90,000 people, which is about an estimated 60,000 fewer than full expansion,” said Naomi Lopez Bauman, director of health care policy at the Goldwater Institute. “If the federal government does not provide an enhanced match, it will actually be a bigger budget hit than full expansion, which would be triggered in order to obtain the enhanced match.”

Bauman says in either case, expansion does not mean improved health care access.

“There have been access issues under the Medicaid program for years, with few doctors accepting new Medicaid patients,” Bauman said. “Expansion does not address these access issues, which are driven in large part by low reimbursements. Lawmakers across the country have handed out millions of Medicaid cards but have left the access issue unaddressed.”

Matthew Glans, a senior policy analyst with the Heartland Institute, which publishes Health Care News, says partial expansion will create high costs and unsustainable enrollment growth.

“Contrary to expansion supporters’ claims that the new federal funding is ‘free money,’ Medicaid expansion, even a partial expansion, is expensive,” Glans said. “It creates new costs for states the federal government doesn’t cover or will not cover forever, leaving state taxpayers on the hook for new liabilities.

“It is important to remember federal matching funds are unlikely to remain permanent,” Glans said. “No long-term funding source for Medicaid currently exists, and the national government is already drowning in more than $22 trillion in debt.”

A Hot Mess

Glans says Utah should take a lesson from the experience of other states that have expanded their Medicaid programs.

“According to a study by the Goldwater Institute, three years into Arizona’s expansion, the costs paid by private payers increased to around 27 percent above hospital costs, or approximately $2.1 billion,” Glans said. “Goldwater also found that hospital costs for health care services increased more for insured patients than for the uninsured and that total charges increased across the board.”

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

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“Contrary to expansion supporters’ claims that the new federal funding is ‘free money,’ Medicaid expansion, even a partial expansion, is expensive. It creates new costs for states the federal government doesn’t cover or will not cover forever, leaving state taxpayers on the hook for new liabilities.”

MATTHEW GLANS
SENIOR POLICY ANALYST
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Florida Considers Allowing More Competition in Health Care

By Ashley Herzog

Florida lawmakers are addressing what the state’s House speaker has called the “hospital-industrial complex” with several bills aimed at increasing competition and reducing government’s role in health care.

Florida’s legislative session began March 4 and lasts 60 days. As of April 10, lawmakers were considering bills dealing with a number of consumer reforms in areas such as telemedicine, certificate of need, licensing of practitioners, direct primary care, and ambulatory care centers. One bill would address Medicaid costs by eliminating retroactive eligibility periods for non-pregnant adults.

Michael Ciampi, a physician and policy advisor to The Heartland Institute, which publishes Health Care News, says the proposals would introduce much-needed competition in several areas of health care.

“In most states where certificate of need laws are in place, the large hospital groups are able to lobby the government heavily in order to protect the status quo and keep new players, who would be more open to offering discounts and cash pricing, out of the market,” said Ciampi.

Expanded access to telemedicine would also bring a vast improvement in the provision of expert care to patients in rural and remote areas, Ciampi says.

“It works well when a patient’s primary care provider coordinates with the remote specialist to optimize the care,” said Ciampi.

Less Government, Better Outcomes

Florida House Speaker Jose Oliva (R-Miami) is leading the reform charge while avoiding proposals that would expand the role of government health care programs such as Medicaid.

“Oliva is smart to avoid expansion of these government programs,” said Ciampi. “While the intentions may be good, in other states it has been found that simply giving people this type of health care coverage has not translated to them getting better access to care or being healthier.”

Ciampi says government programs, such as Medicaid, do not guarantee access to quality care.

“The Medicaid reimbursement rates being so low and the red tape involved in getting paid make it a losing proposition for most health care providers to take on more Medicaid patients,” said Ciampi.

“It is a common misconception to think that health care coverage is the same thing as health care,” said Ciampi. “Having an insurance card in your wallet that no one accepts really doesn’t do much good.”

Rejecting the Status Quo

Patients in Florida, which has one of the highest rates of uninsured people in the nation, would benefit from free-market reforms, Ciampi says.

“The argument that health care is too complicated to react to free-market forces is an argument made by the very people who benefit from keeping it complicated,” said Ciampi.

Third-party payers benefit from the Byzantine billing system that they have created, because they intimidate consumers. They convince them that because the system is so complicated, the consumer needs the third-party payer to help them navigate it.”

Ciampi says all Floridians would benefit from more freedom in the health care marketplace.

“If consumers were shown fair market prices that were transparent, not dependent on provider networks that inflate charges just to tout anemic discounts of said prices, they would clearly see that the free market can work very well,” Ciampi said.

Ashley Herzog (aebristow85@gmail.com) writes from Avon Lake, Ohio.

Nurse Practitioners Offer to Meet Growing Primary Care Demand

By Ashley Bateman

Nurse practitioners (NPs) in states across the country are asking lawmakers to relax onerous licensing regulations so they can help fill an anticipated shortage of primary care doctors.

The Association of American Medical Colleges projects a primary care physician shortage of 14,800 to 49,300 by 2030. Currently, 84 million Americans live in Primary Care Health Professional Shortage Areas, according to the federal government.

Tay Kopanos, vice president of state government affairs for the American Association of Nurse Practitioners (AANP), says NPs can fill the gap.

“Nurse practitioners are licensed to provide a higher level of care than what half of the states are willing to allow,” said Kopanos.

States license nurse practitioners but can restrict what can do.

“What they can provide and what they are able to do legally is what’s driving disparity and inefficiencies in the health care system and putting states in a poor position to address the rising elderly population, the rise in chronic disease, and growing health care costs,” said Kopanos.

Although all states and the District of Columbia recognize NPs as health care providers and their training is standardized, a patchwork licensing system exists.

“There have been studies done on outcomes of care for those in a full practice authority state; Outcome of care does not go down,” said Kopanos.

AANP defines full practice authority as evaluating patients; diagnosing, ordering and interpreting diagnostic tests; and initiating and managing treatments, including prescribing medication and controlled substances, under the exclusive licensure authority of the state board of nursing.

A License Needing Permission

Kopanos says the current NP licensing situation is “like having a driver’s license but needing to get a permission slip from someone with authority to use it.”

Primary care access improves when states remove licensing barriers on NPs, Kopanos says.

“Five years after removing the ‘physician permission slip’ in Arizona, there was a more than 50 percent increase in NP’s working in the state, and more than 70 percent in rural or underserved counties,” said Kopanos.

The National Council of State Boards of Nursing has written model legislation for states looking to expand nurse practitioner care.

“That is the gold standard,” Kopanos said. “The biggest takeaway for states is how we are going to reduce health care costs and get timely care to people.”

Ashley Bateman (bateman.ae@googglemail.com) writes from Alexandria, Virginia.
Florida and Washington Consider Expanding Non-Physician Health Care

By Ashley Bateman

To meet the growing demand for health care in Florida and Washington State, lawmakers have proposed bills that would expand the scope of services the government allows advanced registered nurse practitioners (ARNP) and physician assistants (PA) to perform.

In Florida, House Bill 821 would authorize PAs and ARNPs to practice without the direct supervision of a physician if they meet certain criteria. As of mid-April, the bill was gaining traction in the House but the Senate had not taken it up. The legislative session is scheduled to end May 3.

In Washington, H.B. 1432 would provide a technical fix to grant to ARNPs and PAs hospital privileges. It passed unanimously in both chambers of the legislature and was awaiting the governor’s signature at press time. The bill would become effective 90 days after signing. The website for ARNP United in Washington State says its next focus will be on getting a hearing and vote on payment parity in the 2020 legislative session.

Response to Provider Shortages

Brandon Miller, a legislative aide for Florida state Rep. Cary Pigman (R-Glades County), who introduced H.B. 821, says the bill is necessary because Florida is experiencing a shortage of primary care providers.

“Our goal is to simply allow ARNPs and PAs the ability to practice to the full extent of their training while providing the same level of quality care as our physician friends carry out,” said Miller. “As Rep. Pigman says, far too often, go in to any emergency department and you’ll see more people waiting to be seen than what the hospital can provide in a timely manner.”

Arlene Wright, an NP in Fort Myers, says it is encouraging that Pigman, an emergency room physician with first-hand experience, is championing the bill.

“Things have moved quickly in the past, so I wouldn’t completely count it out yet,” Miller said.

Changing Mindsets

Some opponents of allowing NPs and PAs more freedom to practice claim non-physicians provide less-effective care than doctors. Miller says this is not true and patients will benefit if restrictions on NPs and PAs are loosened.

“We believe that is due to two factors: one being the increased advocacy by NPs over the years, and two, when opponents have asked for data that shows decreased outcomes when care is provided outside of physician supervision, none can be brought forth,” Miller said. “We believe this is because none exists.”

Twenty-three states have expanded NPs’ practicing authority.

“I think you have legislators who have listened, and they’ve put aside maybe some of the more emotional rhetoric and scare tactics from lobbyists and really focused on what’s best for the population of Florida,” said Susan Perry, vice dean at the University of South Florida College of Nursing.

Who’s in Charge?

Unlike Florida, Washington State has permitted NPs and PAs to practice autonomously for years. Bob Smithing, an ARNP in Kent, Washington, says PAs can effectively deliver some services outside of the direct supervision of a physician.

“No one is really autonomous in health care anymore, but full-authority practice enables us to provide high-quality care to our patients while continuing to work with physicians for specialized care,” Smithing said.

“At the beginning, we had to do a little convincing, because we had no track record, but over time we had a solid referral network,” Smithing said. “There still is a culture that believes a health care team needs to be run by physicians. We believe a health care team needs to be run by the patient. We are advisors that give recommendations, but ultimately, it is the patient’s life. We have to listen to them and listen carefully. You have to be able to listen both verbally and nonverbally, and that is a nursing skill set.”

Community Perspective

Smithing says H.B. 1432, clearing the way for NPs to practice in hospitals, is a step in the right direction.

“We need legislation that will help us to be able to practice to the maximum scope of our licensure,” Smithing said. “If we don’t, then no matter what goes on in the community we won’t be able to provide the care the way we need to.”

Smithing says communities will benefit if NPs and PAs have more freedom to manage patients’ care.

“I have never heard of a physician being driven out of practice because a nurse practitioner opened their doors. I have seen communities that have not had their health care needs met now being met because a nurse practitioner opened their doors. If an NP has to work with a physician, they have to work with their model, vision, and oversight, which may not fit the needs of the community. Diversity is good, and that’s what we need in health care. We need to bring in different areas of expertise from different licensures and work together and use them.”

BOB SMITHING
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Ashley Bateman (bateaman.ae@googlemail.com) writes from Alexandria, Virginia.
Telemedicine Offers Remedy for Rising Travel and Wait Times

By Leo Pusateri

Travel and wait times for health care cost patients $89 billion annually, according to an analysis by Altarum, bolstering arguments for the removal of regulatory and legal barriers to the growth of telemedicine.

Patients travel an average of 34 minutes for health care and wait 11 minutes once they arrive at the facility, the analysis found. Health care travel and wait times exceed those for most other professional services, including the time to obtain a driver’s license or have a car repaired. Time spent traveling and waiting for health care was more than half the time spent getting care.

“Time spent on travel and waiting for care is an underappreciated burden of the U.S. health care system,” writes Corwin Rhyan, a senior analyst for Altarum, in the report. “It results in a significant cost on patients, as individuals must forgo either leisure, work, or home activities.”

The analysis comes as lawmakers debate ways to improve health care access. Telemedicine allows providers to offer clinical care from a distance, but there are licensing hurdles when care crosses state lines.

‘Big Fan of Telemedicine’

Sally Pipes, president and CEO of the Pacific Research Institute, says the emerging field of telemedicine could help alleviate the long travel and wait times for health care.

“I’m a big fan of telemedicine,” said Pipes. “I think it is a way to reduce costs and get better care, particularly for seniors who don’t have ready access to transportation, and also for people who live in rural areas where they also might have a hard time getting to a doctor. This way, through telemedicine, they can contact their doctor wherever their town is, but, just as importantly, also have access to a wider variety of specialists.”

Pipes says telemedicine gives patients access to doctors who are otherwise unlikely to be available to them.

“For instance, today if you live in a small town and are diagnosed with cancer, through telemedicine you have the potential to get in touch with the very best cancer doctors, whether it be at the Sloan Kettering Cancer Center, the City of Hope, or the M.D. Anderson Cancer Center, and really get the very best without having to fly to New York, Houston, or Pasadena,” said Pipes.

‘More Competition and More Options’

With advancing technology and decreasing costs of accurate, home-based medical apps, the telemedicine industry is on the cusp of major innovations that will bring better outcomes for patients, Pipes says.

“As modern technology continues to improve, the apps will get even better,” said Pipes. “Doctors may be remote, but they can provide advice through their apps and through telemedicine to patients.

“This is only going to get better,” said Pipes. “It also means more competition and more options to getting better health care, particularly for people who are older or for people in rural areas,” said Pipes.

Calling on Congress

Pipes says lawmakers should remove regulatory and legal barriers to the expansion of telemedicine.

“Congress needs to step up to the plate,” said Pipes. “I think it’s a bipartisan issue, really. I think there are also a lot of members on the Democratic side who would see telemedicine as a way to get their constituents better health care. So Congress should introduce legislation to enable telemedicine to thrive.

“I understand sometimes doctors are nervous about telemedicine or communicating by email to patients because of the threat of medical malpractice suits, but I think that Congress should step up to the plate and introduce and pass legislation allowing telemedicine to be an option to patients,” said Pipes.

Leo Pusateri (psycheist@fastmail.fm) writes from St. Cloud, Minnesota.

Analyst Explores Neglected Health Care Cost: Time

Corwin Rhyan, a senior analyst at Altarum’s Center for Value in Health Care, told Health Care News what prompted the creation of his study titled “Travel and Wait Times Are Longest for Health Care Services” and what policymakers and the public can learn from it.

“While we often measure the cost of health care in how much we spend on products and services, such as hospital care and prescription drugs, in this work I wanted to explore some of the ‘hidden’ costs of health care that result from the burden of time required to treat and maintain health,” Rhyan said. “The American Time Use Survey is an excellent source for this information, and in our analyses I found that travel and wait times are a significant component of total time spent on health. When compared to travel and wait times for other professional services, we found the notable result that health care services were the most difficult to access.”

Rhyan says governments should implement regulatory and licensing reforms to allow new technology to improve the situation.

“One of the more surprising findings of this work was that, unfortunately, there is no evidence travel and wait times have improved to date,” Rhyan said. “There is excellent potential that through technological innovations and changes in health care delivery we can decrease the burden of time spent receiving health care. Some of those improvements can be made by providers, such as improving appointment systems and office efficiency, but other systematic changes—such as expanded telehealth and home-based care—are also very important in reducing travel burdens and increasing access to care.

“Legislators and regulators should move to responsibly increase access to telehealth and home-based care, while ensuring that the care provided in these ways maintains the same level of quality,” Rhyan said.

—Staff reports

INTERNET INFO

More States Consider Regulation to Curb Surprise Medical Bills

By AnneMarie Schieber

Following Arizona’s lead, Georgia, Texas, and Washington State are considering bans or mandated arbitration and price transparency in response to consumer complaints about surprise medical bills from out-of-network providers.

Texas Senate Bill 1264, introduced by state Sen. Kelly Hancock (R-North Richland Hills), and a companion bill, which will be introduced by state Rep. Trey Martinez Fischer (D-San Antonio), build upon an arbitration program enacted in 2009 and bolstered in 2015. The legislation would trigger mediation between the health insurance company and provider for disputed charges and prohibit bills to consumers until the pay dispute is resolved.

The proposed law allows for a “baseball-style arbitration” where an arbitrator chooses either the provider’s charge or the initial payment from the health plan. The idea is get each side to bring the most reasonable price to the table.

“Mediation works,” said Hancock during a press conference. “When it is available and used, we can confidently say that surprise bill mediation has saved Texas patients well over $30 million.”

Arizona, Washington Attempt Fix

The State of Washington is considering more sweeping regulation. The state’s House of Representatives overwhelmingly passed House Bill 1065, the “balance billing protection act,” which would ban balance billing outright for insurance plans offered to public employees and self-funded groups. Health plans electing to be subjected to the act. Balance billing is the difference between the provider’s charge and the allowed amount by an insurer.

For cases not involving public employees or self-funded group health plans, the bill requires settlement action to be made in good faith.

Arizona’s new law on surprise medical bills went into effect on January 1. It sets up a procedure where patients can request dispute resolution through the state’s Department of Insurance. Unresolved disputes will enter arbitration. If an enrollee participates in an informal settlement conference (IST) beforehand, the law spells out an enrollee’s liability: “By virtue of having participated in the IST, the enrollee can only be held responsible for paying the amount of the enrollee’s cost-sharing requirements (copay, coinsurance and deductible) plus any amount the health insurer paid the enrollee for the services provided by the out-of-network health care provider.”

Steven Briggs, spokesperson for the Arizona Department of Insurance, says it is too early to measure the public response.

“We had received several inquiries up through February, but no one has submitted a request for arbitration,” said Briggs. “We believe that is still too soon to expect a surprise bill to work its way through the billing process since the law requires the service to be received after January 1 of this year. I’m sure we will start to get some.”

Wants More Changes

Surprise medical bills and the related practice of balance billing typically occur after surgical or emergency procedures, when patients have no control over all the providers in the process. Providers who are out of a patient’s network can charge beyond what is usual and customary, and patients are financially responsible for the costs, which can reach thousands of dollars.

Devon Herrick, a health economist and advisor to The Heartland Institute, which publishes Health Care News, says informing patients of billing practices is paramount.

“Mediation is a good start, but Texas and other states need to find solutions that avoid or discourage billing disputes in the first place,” said Herrick. “One way to do that is to require greater transparency in fees and network status in order for out-of-network medical bills to be collectible.”

Kicking It Down the Road?

Georgia is also trying to address surprise medical bills. House Bill 84 failed by one vote, but the more sweeping Senate Bill 56 did pass. S.B. 56 would set up a database of prices that insurance companies would have to pay. The bill would have to be approved in the House, where passage is unlikely. Rep. Richard Smith (R-Columbus) told the Atlanta Journal Constitution, “we will have a hearing, but a hearing only.”

David Hyman, author of Overcharged: Why Americans Pay Too Much for Health Care, says these statutory attempts to address the problem by setting up an arbitration process do not answer consumers’ biggest concern, which is the high prices they are paying for care.

“What you’re doing is throwing the problem to someone else to try to figure out what the price should be, where there is no market in which you can measure the market price,” Hyman said. “It’s too hard to do price-setting. We have a long history with price-setting, and it usually doesn’t work. Often, you’re too high. Sometimes you’re too low. Bad things happen when you’re not right on the money.”

Hyman says mandated price transparency is not the answer, either.

“There is lots of health care consumption where people are not in a strong position to price-shop or price-negotiate, and being brought in on a stretcher is not a time you want to be negotiating prices. So price transparency is important, but it’s not going to solve every problem, and there are some areas where it won’t do very much.”

Addressing Billing Practices Directly

Hyman says a better approach is to hold providers responsible for their charging practices, similar to getting a car fixed when you are given a price estimate and that is what you can expect to pay.

“We should force hospitals to solve this problem by prohibiting their providers from sending out more than one bill,” Herrick said. “And the hospital has to negotiate a market price for the emergency department, for example, for the services they’re providing.”

AnneMarie Schieber (amschieber@heartland.org) is the managing editor of Health Care News.
Trump Administration Holds Comment Period on Two CMS Rule Changes

By AnneMarie Schieber

The Trump administration will wrap up comment periods in May for two consumer-oriented initiatives reforming the way health insurance providers use patient data and allow them to operate across state lines.

On March 11, CMS posted notification for comment on a proposed rule that would allow health insurance companies to sell policies across state lines.

On March 4, the Centers for Medicare and Medicaid Services (CMS) posted notification of a patient data access rule that includes a measure preventing health care providers “from inappropriately restricting the flow of information to other health care providers and payers.” Contracts between providers and payers are closely held agreements that traditionally have been confidential.

The two rules are outcomes of President Donald Trump’s Executive Order 13813, issued October 2017, titled “Promoting Healthcare Choice and Competition Across the United States.”

The order calls for the Trump administration to use its regulatory powers to lower prices and improve access by increasing competition and giving consumers more choices in ways consistent with federal law.

**Obamacare Impediments**

The rule changes have some hurdles to cross before they can have the desired impact on health care costs and access, says Lindsey Killeen, vice president for strategic outreach and communications at The Mackinac Center for Public Policy. For cross-state insurance sales to make a big impact, Congress must allow more freedom to buy policies that do not offer all of the “essential health benefits” (EHBs) required by the Affordable Care Act, says Killeen.

“The current EHB requirements have driven up costs and limit the choices that consumers have between prices and benefit packages when shopping between insurance carriers,” said Killeen. “Until insurers can begin offering greater variation in their plans—meaning, until EHB requirements are reformed—there is little incentive to the insurer or to the consumer to invest in cross-state insurance sales.”

**Need for Interstate Agreements**

In addition to Congress easing Obamacare restrictions—which is not likely in the foreseeable future with a divided Congress—states have been slow about fostering interstate health insurance sales, says Killeen.

“Several states have had laws in place allowing them to form compacts with other states for the sale of health insurance across state lines,” Killeen said. “Despite these laws, there has been no meaningful activity between states and insurers to make use of this option. This is largely because the cost of compliance with state regulations varies and requires additional financial investments from insurance carriers to establish business in multiple states.”

Killeen says the comment period is important.

“States need to let CMS know their interest in broadening health insurance sales and to align more closely to the administration’s other initiatives, such as broadening access to short-term and association-based health plans,” said Killeen.

**Transparency Snags**

In a similar effort to improve access and help Americans “make better informed choices,” as Executive Order 13813 states, the administration is proposing to require greater transparency in the price deals between providers and third-party payers.

Describing the plan in one sentence under the subtitle “clinicians and hospitals,” the administration stated, “We are also proposing policies to prevent health care providers from inappropriately restricting the flow of information to other health care providers and payers.”

Dr. Don Rucker, national coordinator for health information technology at the Department of Health and Human Services told *The Wall Street Journal* on March 7, “It’s an effort by the president to help put Americans back in control of price data.”

Michael Cannon, director of health policy studies at the Cato Institute, says he’s not sure it will work as desired.

“Insurance companies will have a hard time excluding providers if they all of a sudden learn the provider cut a better deal with another insurer,” said Cannon. “If a provider is cut, the consumer won’t view it in sympathetic terms; they’ll just see it as restricted access. They’ll rebel, and that constrains the insurer’s ability to say no. In a third-party payer system, if consumers don’t care about costs, transparency means nothing.”

The 28-day comment period for the price transparency rule ends May 3, and the comment deadline for the rule on cross-state border health insurance sales is May 6.
Michigan Considers Protecting Local Libraries in Opioid Crisis

By AnneMarie Schieber

The Michigan House of Representatives passed legislation that would allow public libraries to stock and administer opioid overdose drugs.

House Bills 4366 and 4367 are designed to protect libraries from civil liability if an opioid-induced injury occurs and the library staff acts in good faith to provide emergency treatment.

Opioid-induced injuries are a rising threat, with the number of opioid overdose deaths in Michigan having tripled from 681 in 2012 to 2,729 in 2017, according to a House Fiscal Agency analysis.

Hotspots for Abuse

According to the analysis, libraries have become a frequent site of drug abuse.

“The fact that libraries are open to all, offer relative anonymity, and generally allow patrons to stay as long as they like make them uniquely vulnerable to those seeking a place to do drugs,” the trade publication American Libraries reports.

Naloxone hydrochloride, a nasal spray also known as Narcan, is commonly used to treat opioid overdoses. Although Michigan has passed “Good Samaritan” laws for individuals administering overdose drugs, there are limits. Librarians asked for specific liability protection because public library workers do not have the government immunity afforded to police and other emergency workers and they believe that the current laws do not fully protect them.

Because the legislation is not a mandate, local communities would be responsible for funding the overdose drug purchases and training library staff, if they choose to participate in the program.

Tackling a Growing Problem

Representatives from the Michigan Library Association and the East Lansing Public Library testified in favor of the legislation.

“At first, we were hesitant of the need for librarians to stock the overdose drug at all, but the overdose numbers continue to rise,” said Teri Ambs Langley, a legislative aide for Rep. Jason Sheppard (R-Monroe County), who sponsored the legislation. “We heard moving testimony, including one case where a librarian found a woman, a friend, who overdosed in the library bathroom. She tried to save her with CPR but couldn’t. Had she had the overdose drug, the outcome may have been different.”

Sign of Failure

As in many communities, Traverse City, Michigan’s homeless population commonly uses public libraries for shelter. Jason Gillman, former president of the Traverse Area District Library Board, says he is neutral on the legislation but believes there is a larger issue at stake.

“This is a sign of our failed mental health system,” said Gillman. “We abandoned our state institutions where the severely mentally ill could get proper treatment. Because we ignored this population, we now have a homeless problem which is costing us far more in money and grief, compounded by the opioid addiction epidemic, and we are turning to legislation such as this, where libraries become clinics.

“I also have concern what this will mean for libraries if they choose not to have these drugs on hand, and their potential for liability,” Gillman said.

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California lawmakers missed the deadline to implement a universal, government-run health insurance program in the Golden State this year.

During his 2018 gubernatorial campaign, Gov. Gavin Newsom endorsed Senate Bill 562, also known as the Healthy California Act. The bill, introduced in 2017, would have created a government-run health care system in California to replace private insurance. The bill stalled in the General Assembly.

“There’s no reason to wait around on universal health care and single-payer in California,” Newsom told a gathering of nurses at a campaign rally in February 2018. “It’s time to move [S.B.] 562 along. It’s time to get it out of committee. It’s time to move it along the legislative track. It’s time to do that now. We don’t need to wait for the governor’s race. We don’t need even to wait another year.”

Daunting Cost Estimates

A University of Massachusetts at Amherst analysis found the plan would cost $330 billion per year initially, and the California Legislative Analyst’s office estimated it would cost $400 billion annually, twice the overall state budget. These price tags would have necessitated a huge tax increase to cover the basic costs.

Despite his campaign promises, Newsom hasn’t pushed for a new version of S.B. 562 since taking office.

Instead, Newsom has proposed a state-level “individual mandate” requiring Californians to have health insurance. He has also pitched state-funded health insurance for illegal aliens, and he says he wants to explore ways to lower prescription drug spending by having all state agencies purchase drugs together in bulk. Activists are urging him to support 20 bills that would bring California closer to universal government health care.

Supporters Unwilling to Pay

Universal government health insurance programs face a key obstacle, says John C. Goodman, president of the Goodman Institute for Public Policy Research and a senior fellow at the Independent Institute.

“If you ask people if everyone should have health insurance, they answer yes, but then if you ask them how much they would pay of their own money to achieve this goal, it’s about $100. People think the goal is admirable, but they don’t want to commit any of their own money to it.”

That’s the problem universal health care coverage has had, regardless of people’s expressed sentiments, says Goodman.

“It got defeated in Colorado, it was defeated in Vermont, and everywhere this has come up, they get huge voter resistance,” Goodman said.

Kenneth Artz (kennethcharlesartz@gmx.com) writes from Dallas, Texas.
Washington State Lawmakers Propose ‘Pathway’ to Single-Payer

By Kenneth Artz

During the 2019 session, the Washington State Legislature again declined to pass a bill imposing single-payer health insurance on the state. Instead, legislators chose to move the bar incrementally by introducing two bills to create a working group to determine a “pathway” to a single-payer health care system.

House Bill 1877 and Senate Bill 5822, which passed the Senate on March 13, would initiate a study to draft recommendations on implementing a “universal,” “publicly funded,” and “privately delivered” health care system in Washington State. The working group would be tasked with creating a “pathway” for universal health care and would include representatives of consumers, businesses, health care providers, health insurers, and legislators.

Governor on Board

The bills coincide with Gov. Jay Inslee’s announcement of his support for a “public option” plan. Unlike a single-payer plan, which is a completely government-run health insurance system covering everyone—like Canada’s health care system—the “public option” is a government-run health insurance plan that would compete with private insurance companies.

“This public option will ensure consumers in every part of the state will have an option for high-quality, affordable coverage,” Inslee said at the King County Public Health Center in Seattle.

Inslee’s plan would direct the state’s Health Care Authority to contract with health insurers throughout the state, guaranteeing coverage to anyone in the state’s individual insurance market. His plan, which does not include a price tag, would subsidize premiums for people with incomes up to 500 percent of the federal poverty level, which is about $128,000 for a family of four, and make reimbursement rates to providers consistent with those of Medicare.

Unaffordable ‘Free’ Health Care

Single-payer health care bills have come up many times in the Washington legislature but always failed to make it to the floor for a vote because there’s no way to pay for such a plan, says Dr. Roger Stark, a health care policy analyst at the Washington Policy Center and a retired physician.

“The adults in Olympia realize the state can’t afford a single-payer system—see Vermont, Colorado, and California,” Stark said. “So, what do politicians do? They form a ‘working committee’ to hold meetings and hearings to waste taxpayer money. This is what is happening with the single-payer issue in Washington State.”

Both chambers passed a “public option” plan separately in March that would be available on the state’s Affordable Care Act exchange. Lawmakers are currently working out differences between the bills.

“Inslee is ready to sign the final bill into law,” Stark said. “Subsidies will be available to anyone earning up to 500 percent of the federal poverty level. Oh, and no meaningful funding mechanism is, at the present time, included in the legislation.”

Unions in Opposition

One of the Democrats’ natural allies, labor unions, may be playing a role in Washington State’s decision to proceed slowly on single-payer.

“The unions are not the place where socialized medicine plays well,” said John Dale Dunn, a physician and attorney in Brownwood, Texas. “Unions already have their health care benefits set up and will be unwilling to give up their health benefits packages and go to some kind of government-run program that leads to inferior care than what they’re already receiving. They’re not the people who are going to support single-payer.”

Another factor, of course, is the cost of single-payer, says Dunn.

“As they found out in Vermont—where Democrats were all hot to have single-payer—they couldn’t afford it. In Oregon, they had a weird, hybrid system consisting of a gigantic Medicaid system that rated medical problems and had all kinds of medical arrangements to emphasize provided services in this or that area. But once Oregon got their single-payer plan, it ended up being too expensive and irritating to a lot of people because they ranked procedures by priority,” said Dunn.

“What it amounted to was a disguised form of rationing,” said Dunn.

“There were certain things they thought were important and were paid for, and there were other things that were not paid for—but that’s what you get when you have government-controlled health care.”

Kenneth Artz (kennethcharlesartz@gmx.com) writes from Dallas, Texas.
States Seek to Strike Obamacare Rule from Federal Regulations Code

By Kenneth Artz

Eight states are requesting a court to strike an Obamacare rule they say violates their authority to protect the judgment and conscience rights of medical professionals.

At issue is a U.S. Department of Health and Human Service (DHHS) rule that interprets sex or gender as a “state of mind, not a biological fact” and applies that definition to Obamacare anti-discrimination provisions, according to a statement released by Texas Attorney General Ken Paxton, who is leading the legal fight.

The rule could force doctors, health care workers, and state employers providing health insurance to perform or pay for sex change surgeries and abortions with taxpayer funds, even if they object because of their religious beliefs or best medical judgment.

In August 2016, the states asked a U.S. District Court to strike down the requirement. The following year, the court issued a nationwide preliminary injunction against enforcement of the rule.

The states pointed out failure to comply could cost them billions of dollars in federal health care funding. Arizona, Kansas, Kentucky, Louisiana, Nebraska, Mississippi, Texas, and Wisconsin are requesting a summary judgement to strike the rule from the federal code.

Separation of Powers Argument
The case hinges on an Obama administration interpretation of the provision of the 1964 Civil Rights Act that prohibits discrimination based on sex. The administration tried to broaden the definition of sex or gender to include an individual’s state of mind, not simply their biology, says Dr. Merrill Matthews, a resident scholar with the Institute for Policy Innovation.

“Obama officials knew full-well this was never the intent of the civil rights law, and they also knew Congress was unlikely to make the change,” Matthews said. “So they decided to make law.”

The Obama administration tried to impose the new definition on schools, employers, and health care officials. President Donald Trump has moved to reverse those policies.

“The Trump administration has appropriately pushed back on their effort, as have the states,” said Matthews. “These states have taken a very important step in rolling back the Obama administration’s effort to create law rather than apply and enforce it.

“It’s up to Congress, not bureaucrats, to make laws,” Matthews said. “Paxton and the states are trying to reaffirm this constitutional principle.”

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

INTERNET INFO


Texas AG Files New Brief in Planned Parenthood Lawsuit

By Kenneth Artz

Texas Attorney General Ken Paxton (R) filed a brief in a lawsuit brought by Planned Parenthood, asking the U.S. Fifth Circuit Court of Appeals to deny lawsuits by individual Medicaid recipients intended to force taxpayer funding for abortions.

This follows Planned Parenthood’s removal from the state’s Medicaid program by the inspector general of the Texas Health and Human Services in 2016 for failing to meet the definition of a “qualified” provider under the state’s Medicaid Act.

The inspector general said he based his decision on a determination Planned Parenthood acted unethically and violated state and federal laws when an undercover video showed agents of the organization discussing modifying abortion procedures to preserve body parts of aborted fetuses to provide researchers with a larger number of intact fetal cadavers.

Planned Parenthood sued the state in federal court to restore funding, and in 2017, a U.S. District judge blocked Texas from terminating the abortion provider’s Medicaid funding, calling the action “arbitrary and capricious.” In January 2019, the Fifth Circuit rejected the injunction and sent the case back to the lower court.

Venue Question
In his brief for the Fifth Circuit Court in March, Paxton said Planned Parenthood had a right to challenge the termination through administrative proceedings but had chosen not to do so and instead enlisted a handful of patients as plaintiffs to file a federal lawsuit. The Medicaid Act does not permit individuals to challenge a state agency’s determination that a service provider is not qualified under the Act, the brief argues.

“We’re confident that our reading of the law is correct and that the full 5th Circuit will rule that individual plaintiffs should be dismissed from this lawsuit,” Paxton stated in a news release. “Taxpayer resources should be used to provide health care to the most vulnerable among us, not to defend the government against lawsuits from Medicaid recipients who would prefer to do business with Planned Parenthood.”

“Planned Parenthood reportedly received about $1.5 billion in taxpayer dollars between 2013 and 2015, most of it from the Medicaid program. While federal law prohibits that money from being used to provide abortion services, money is fungible.”

DR. MERRILL MATTHEWS
RESIDENT SCHOLAR
INSTITUTE FOR POLICY INNOVATION

Stopping the Money-Go-Round
Dr. Merrill Matthews, a resident scholar with the Institute for Policy Innovation, says Planned Parenthood deserves the scrutiny it is receiving in Texas.

“Planned Parenthood reportedly received about $1.5 billion in taxpayer money between 2013 and 2015, most of it from the Medicaid program,” said Matthews. “While federal law prohibits that money from being used to provide abortion services, money is fungible. It can be used to pay many of the fixed expenses, freeing up other monies to provide abortion services. Attorney General Paxton’s effort to defund Planned Parenthood simply recognizes that financial relationship.

“And while Planned Parenthood used to play down its role in providing abortions, that era has ended under the new head, Dr. Leana Wen, who has been very assertive about its abortion-providing role,” Matthews said.

Kenneth Artz (kennethcharlesartz@gmx.com) writes from Dallas, Texas.
Medicare for All Would Cost $60 Trillion Over First Decade, Report Says

By Chris Talgo

A new report estimates a single-payer health care system in the United States would cost between $54.6 trillion and $60.7 trillion over the first 10 years.

Implementation of Medicare for All (M4A) would require enormous tax increases, report author Charles E. Blahous of the Mercatus Center concludes.

Blahous states “the initial federal obligations would be in the ballpark of $10,000 annually per person. Even if M4A fully liberated Americans from all their current health care expenses, ... a family of four might still strongly object to having to send an additional $40,000 to Washington each year on top of their current tax burdens.”

Could Be Worse ...

“The Unanswered Questions of Medicare for All” expands on the author’s previous cost analysis of M4A and shows the assumptions behind the program could send costs much higher.

In his earlier report, Blahous calculated a cost of $32.6 trillion over the first 10 years and possibly $38.8 trillion based on provider rate and drug price assumptions.

Blahous’ earlier estimate was based on an incremental addition to current spending on federal programs, such as Medicare, Medicaid, the Affordable Care Act, and employer-provided health insurance.

“The aim of my research was purposely narrow, not to opine on the merits or demerits of single-payer health care itself, but to estimate its effect on the federal budget,” wrote Blahous.

M4A, however, involves a number of unanswered questions impacting price, such as how much consumers are willing to trade off in an all-encompassing program.

“Without intending it, [my original] study ended up revealing much more,” Blahous wrote. “Policy advocates’ diverse reactions to the cost analysis illuminated a striking lack of national consensus on fundamental value judgements that must be made in the course of crafting future health care policy.”

Those judgements involve whether the country is ready to eliminate private insurance completely, how it will tax individuals to pay for the program, how it will manage the spike in demand, and what impact provider payment cuts would have on supply.

‘Unprecedented Expansion’

Charles Silver, a professor at the University of Texas School of Law, says M4A would cause a cascade of adverse economic outcomes.

“M4A would require an unprecedented expansion of the size of the federal government, with all that entails: vastly greater taxes, deadweight losses that exceed any savings reasonably to be expected, massively increased corporate lobbying, and bureaucratic decisions regarding who gets paid how much for what,” Silver said.

Silver says a federal government takeover of the U.S. health care system, which represents about 18 percent of GDP, would drive health care costs much higher.

“The point that the federal government has no track record of controlling health care spending is also well-taken,” Silver said. “The best predictor of the future is the past, and the past is replete with spending hikes and giveaways to health care interests.”

With those cost increases, M4A will hike federal spending overall, Silver says.

“National spending under M4A is more likely to rise than to fall, ... leaving Americans poorer on average,” Silver said.

Expect Access to Decrease

Justin Haskins, a research fellow at The Heartland Institute, says low reimbursement rates to providers, a staple of big government health care programs, are likely to increase provider shortages and decrease access to care.

“Medicare reimbursement rates are much lower than the rates provided in the private market,” Haskins said. “If lawmakers force doctors to take big pay cuts, thousands of doctors might choose to retire, potentially creating a nationwide doctor shortage.”

Haskins says it is likely M4A will cost far more than its proponents say.

“If lawmakers increase reimbursement rates, then Medicare for All would end up costing significantly more money,” said Haskins. “There’s simply no way Medicare for All would end well for patients, doctors, and taxpayers.”

No Free Lunch

Sally Pipes, president and CEO of the Pacific Research Institute, says M4A would cause health care demand to increase, which would trigger higher costs over the long term.

“No government program ever costs what it is estimated to cost,” Pipes said.

“When people think something is free, they demand a lot more of it and supply cannot meet demand and the price goes up,” Pipes said. “And that is when wait times and rationing kick in because government cannot afford the cost.”

Massive Tax Increase

Tim Benson, a policy analyst for The Heartland Institute, which publishes Health Care News, says Medicare for All is unaffordable.

“The cost of the program is simply too much without dramatic tax increases across the board, which nobody in Washington has any appetite for,” Benson said.

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

INTERNET INFO

The Centers for Medicare and Medicaid Services (CMS) initiated a public comment period on possible federal reform that would allow health insurance companies to sell plans across state lines. Although Republicans have pushed this reform as a way to reduce costs for coverage prior to the passage of the Affordable Care Act (ACA), an effort now is unlikely to have meaningful impact without reform to the ACA’s insurance regulations, which remain intact. Nevertheless, this move by CMS continues the Trump administration’s march toward increased federalism in health care through its regulatory powers.

Within CMS’s request for information are nearly two dozen questions for state governments, policymakers, and other stakeholders on cross-state sales of health insurance. The questions include how regulatory changes could affect health coverage and costs for states and insurers, and how the federal government could make it easier for states to form compacts that respect each other’s regulatory decisions. Republicans have called for regulatory changes that would allow cross-state sales for decades.

In October 2017, President Trump signed an executive order promoting choice and competition in health care. In early 2018, the Departments of Health and Human Services, Labor, and Treasury responded with proposed regulatory changes. Their recommendations included easing federal restrictions on association health plans, making it easier for associations to band together to provide quality, lower-cost insurance to employees. More recently, several federal agencies collaborated on a report, “Reforming America’s Health Care System Through Choice and Competition,” which outlines options for market-based reforms at state and federal levels. Even within the constraints of the ACA, these options could reduce costs and increase access to quality health care.

CMS’s request reveals that its efforts to reform the ACA will be limited. Because of the ACA’s mandates on required benefits, it is unlikely to be meaningful without reform to the ACA’s insurance regulations, which remain intact.

How States Can Work Together

As of 2018, at least six states had passed a law to allow insurers to sell health plans across state lines: Georgia, Kentucky, Maine, Rhode Island, Washington, and Wyoming. No states have established or entered into interstate compacts necessary to move forward, and no insurers have taken advantage of the new laws. The current call by CMS won’t do much good absent congressional action to reform the ACA as a whole, or at least its rules on essential benefits. This shouldn’t discourage states from embracing the proposed changes and the posture set forth by the Trump administration.

How should states respond to the latest call from CMS for information? First, they should indicate a desire to work with the administration on this effort and other consumer-driven reforms. Second, legislators should align their laws with recent changes in federal rules, which give consumers, businesses, and governments more flexibility to use short-term health plans, association-based health plans, and interstate health compacts. Third, they should apply for state innovation waivers, known more formally as Section 1332 waivers, to seek federal permission for additional means of reducing costs and improving access to coverage.

The good news about CMS’s latest action isn’t that it will, by itself, significantly reduce the high costs of health insurance. Rather, the decision by CMS reinforces that the Trump administration, unlike its predecessor, is willing to negotiate and collaborate with states to find ways to reduce health care costs.

Lindsey Killen is vice president for strategic outreach and communications at the Mackinac Center for Public Policy. An earlier version of this article was published by the Hill on March 15, 2019. Reprinted with permission.

A project of the Galen Institute, ObamaCareWatch is your go-to online destination for credible, substantive news about the health overhaul law plus the most cogent commentary and analysis from free-market health policy experts.
**Unlocking the Medicare/Medicaid Trap**

**By Jane Orient, M.D.**

Politicians are proposing the idea that Americans over age 50 should be permitted to buy into Medicare, thus expanding government influence in medicine and further crowding out the private sector.

Americans should keep in mind that Ponzi schemes are kept afloat only by constantly attracting new “investors.” It is becoming increasingly difficult to deny the insolventy of Medicare as the program passes age 50 and Baby Boomers retire.

Instead, Congress should be letting people, both patients and physicians, opt out of the system. Since all workers have had to pay in, the government should instead be offering to buy them out. Or perhaps someday the equivalent of a bankruptcy court will need to settle with them.

If Americans received a monthly deposit into a medical savings account, perhaps a fraction of the actuarial value of Medicare Part A, this could help fund a post-payment plan for medical expenses or a means to pay premiums on catastrophic insurance if it became available. Another incentive might be exemption from the capital gains tax if people had to sell assets to pay medical bills, and exemption from payroll taxes if they continued to work.

Why Escape Something ‘Free’?

Why should Americans want to escape from a “free” entitlement? Plaintiffs in Hall v. Sebelius wanted better insurance, from their employers. Under the Social Security Act (SSA), “It is unlawful for a person to sell or issue to an individual entitled to benefits under part A or enrolled under part B of this title … a health insurance policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under this title or title XIX.” While Medigap is regulated by the states, SSA requires that policies meet or exceed National Association of Insurance Commissioners Model Standards. These stipulate, “No Medicare supplement policy or certificate in force in the state shall contain benefits that duplicate benefits provided by Medicare.”

Most retired Americans do not have the option of employer-provided insurance if they become ineligible for Medicare. Why would they choose to be uninsured or self-insured?

Medicare beneficiaries lose their choice of physician. Unless their physician is completely opted out, private treatment, at least for covered services, is not explicitly allowed, and the physician is generally not willing to risk becoming a test case. If the physician accepts government money, he is effectively agreeing to government rules and cannot offer services for which he can’t recover the cost. The most important loss to the patient is access to the physician’s time and best judgment. The physician and staff are laboring under a costly and onerous compliance and reporting burden, with draconian penalties for deviations such as providing “unnecessary” service.

In Hall v. Sebelius, the U.S. District Court for the District of Columbia opined patients are not required to “use” their Part A entitlement, but can or will hospitals bill Medicare Part A-enrolled patients outside the prospective payment system or circumvent the Medicare regulatory regime?

**Health Care’s Iron Curtain**

When proponents of socialized medicine deplore a two-tiered system, there does not seem to be any doubt about which tier delivers better care. Thus, like President Lyndon Johnson, they want a universal “everybody-in-nobody-out” system to prevent leakage into the private sector, something like an Iron Curtain for health care.

Medicare and Medicaid are increasingly dominated by managed-care gatekeepers, tighter restrictions, and “full first” policies. Early hospice admission and refusal of treatment, including feeding and hydration, are encouraged. “Burned-out” physicians are being replaced with minimally trained surrogates or robots. If private medicine is permitted to survive, patients may increasingly seek out independent physicians.

**Central Control Is Central Premise**

Physicians must recognize that price controls, massive data collection, and tightened constraints are not an optional component that can be fixed by more enlightened legislation or regulation. They are inevitable in the structure of the program.

Hiring more compliance staff will not reliably protect a practice from penalties. The only relative safety is in not being under the jurisdiction of government or insurance bureaucrats at all, by refusing their money. Real, total nonparticipation (not as in Medicare “nonpar” status) might be the only way to assert constitutional protection, under the 10th Amendment, which reserves powers to the states and to the people; the Fifth Amendment’s Takings Clause, which bars taking private property for public use without just compensation; and the Thirteenth Amendment, which bars involuntary servitude. Courts have upheld what once seemed unacceptable by claiming that participation is voluntary. Physicians have unwittingly surrendered their rights, for “consideration” (tax-funded payment).

Why should patients and physicians not be allowed to move back and forth between the two sectors? Restoring the ability of Medicare “nonparticipating” (nonpar) physicians and their patients to opt out of filing claims on a case-by-case basis would enable patients to retain some of their Medicare benefits. Medicaid enrollees should be allowed to seek private care on a self-pay or charitable basis without reporting or triggering penalties for doctors or patients.

Managed-care plans should not be allowed to impose their constraints on physicians who do not sign contracts with them (i.e. physicians who are “out of network”).

“Medicaid enrollees should be allowed to seek private care on a self-pay or charitable basis without reporting or triggering penalties for doctors or patients. Managed-care plans should not be allowed to impose their constraints on physicians who do not sign contracts with them (i.e. physicians who are ‘out of network’).”

Jane Orient, M.D. (jane@aapsonline.org) is an internist and executive director of the Association of American Physicians and Surgeons. This article is excerpted from a white paper published in The Journal of American Physicians and Surgeons in Spring 2019.
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