Michigan’s CON Board Sidelines Promising Cancer Treatment

By AnneMarie Schieber

The Michigan Certificate of Need (CON) Commission has adopted rules restricting patient access to CAR-T cell therapy, a cutting-edge cancer treatment covered in part by Medicare and Medicaid.

The commission adopted the rule in September at the behest of several of Michigan’s established cancer treatment providers and on the advice of a panel of clinical experts it appointed to evaluate the need for the regulation.

The panel also recommended requiring providers to be accredited by the Foundation for the Accreditation of Cellular Therapy (FACT), a national nonprofit organization that inspects cellular therapy facilities.

MICHIGAN CON, p. 6

Costs of Employer Health Plans Are Rising Faster Than Wages, Inflation

By AnneMarie Schieber

Annual costs for employer-provided health plans are rising at a faster clip than wages and inflation, the 2019 Employer Health Benefits Survey by the nonprofit Kaiser Family Foundation shows.

Premium contributions, copays, and deductibles rose by 8 percent for a family plan in 2019 and by 4 percent for individual coverage. Workers’ wages increased by an average of 3.4 percent, and overall inflation was 2 percent. Employees contribute on average $6,015 for an employer family plan.

The average premium for family

EMPLOYER HEALTH PLANS, p. 8

VACCINE EXEMPTIONS UNDER FIRE

California will now review physicians’ writing of medical exemptions for vaccinations, raising concerns the state will “hold doctor’s integrity and clinical judgment hostage.” — P. 11
Your Promise:

Work for the good of your patients.
Treat your patients according to the best of your ability and judgment.
Do no harm.

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

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Michigan Grapples with Psychiatric Hospital Upgrade

By Madeline Peltzer

After months of delay, the Michigan Department of Health and Human Services has recommended the state downsize rather than expand the Caro Center, a 106-year-old regional psychiatric hospital in the state’s “thumb” area.

Gov. Gretchen Whitmer put the brakes on construction of a $115-million renovation and addition to the hospital in March, citing unforeseen costs. The new facility, which the legislature approved in 2017, was planned to hold 200 beds and span 225,000 square feet.

Hospitalization or Incarceration

The decision is the latest instance in a nationwide trend of eliminating large inpatient mental health treatment facilities, a movement that took off in the 1980s. Proponents of deinstitutionalization argue “insane asylums” dehumanize and stigmatize those with mental illness. They advocate for the exclusive use of family care and community-based health centers instead.

John Snook, executive director of the Treatment Advocacy Center, says in far too many cases the untreated mentally ill end up incarcerated.

“It’s cruel to these patients to not have a mental hospital for them,” Snook said. “If it were any other illness and we said we just can’t afford to open a hospital for them but hopefully they can get the treatment they need at a jail, people would be up in arms.”

Michigan state Rep. Mary Whitford (R-Casco Township), who chairs the House Health and Human Services budget committee, says she recognizes there is a real need for mental hospitals.

“I just had a tour of the Kalamazoo Psychiatric Hospital,” Whitford said. “There has been a patient who’s been living there for 50 years and can’t go back into the community. We still need the safety net that mental hospitals provide. We just need to be smart about it.”

Putting Public at Risk

The decline of mental hospitals has received new scrutiny with the increase in mass shootings and rising homelessness and drug abuse.

The Treatment Advocacy Center’s founder, psychiatrist E. Fuller Torrey, wrote about the connection between mental illness and mass murder in a Wall Street Journal op-ed on August 4, after back-to-back shootings in El Paso, Texas and Dayton, Ohio killed 31 people.

“With the best of intentions and the worst of planning, America has emptied its public psychiatric hospitals without ensuring that the released patients would receive the necessary treatment to control their symptoms. What did we think would happen?”

E. FULLER TORREY, FOUNDER, THE TREATMENT ADVOCACY CENTER
Poll: Voters Confused About Medicare for All

By Ashley Bateman

Democrat voters are confused about what a single-payer, Medicare for All plan actually means, a new poll shows.

The survey conducted by the Monmouth University Polling Institute and released on August 26 found voters who lean or identify as Democrat want to keep private health insurance, even though they express support for Medicare for All, a plan that would force everyone into a national, government-run system and ultimately end private health insurance.

The poll used phone interview responses from a sub-sample of 298 interviewees to collect views on current Democratic presidential candidates and Medicare for All. Although the majority support Medicare for All, nearly 80 percent of those polled prefer that private insurance remain available.

‘Positive View of Socialism’

Voters who support Medicare for All are generally in favor of socialism overall, says Merrill Matthews, a scholar for the Institute of Policy Innovation and policy advisor to The Heartland Institute, which publishes Health Care News. “The poll suggests that a majority of Democrats, 58 percent, support Medicare for All,” Matthews said. “This finding should not surprise anyone, since a Gallup poll suggests that 57 percent of Democrats have a positive view of socialism.”

The poll indicates confusion over what Medicare for All means, Matthews says. “Some think it is a generic term for wanting everyone to have access to health care. Even many seniors on Medicare seem to think that Medicare for All means that everyone would have what seniors have.”

The accuracy of the survey is questionable, Matthews says, “because Monmouth polled a very small number of people and found a three-way tie among Joe Biden, Bernie Sanders, and Elizabeth Warren [for the Democrat presidential nomination], something no other polling company has discovered. The poll may be an outlier.”

Ending Insurance Choice

Matthew says true Medicare for All would eliminate private health insurance. “It would outlaw private insurance for anything covered by Medicare for All,” Matthews said. “By contrast, private insurance could continue to coexist under some limited Medicare for All plans, sometimes referred to as Medicare for More,” Matthews said. “But it would only be a question of time before the partial Medicare for All plans crowded out or shut down private insurance, including employer-based private coverage.”

That is the inevitable outcome of any plan that entails more government involvement in health care, says Meridian Baldacci, a research assistant at The Heritage Foundation.

“It’s the same lesson we keep seeing in poll after poll, that even when Americans say they want Medicare for All, they are reluctant to support a system that would abolish their private coverage,” Baldacci said. “The truth is, Medicare for All itself would do exactly that. Even so-called public options would move the market toward single-payer, albeit less abruptly.”

More Government, More Problems?

Baldacci says many policymakers and members of the public have a poor understanding of what has broken the nation’s health insurance market.

“Bad government policy contributed to the problems Americans face today, and Medicare for All would only double down by putting most Americans onto a single, government-run plan,” Baldacci said. “Medicare for All would eliminate choices and increase costs. That’s not patient-centered care.”

A “public option” which gives consumers the choice of a government plan is not a better alternative, Baldacci says. “[It] would move the market in this same direction, albeit more slowly,” Baldacci said. “Public options favor the government-offered plan so that it is hard for the private options to actually compete. These ‘options’ are simply a Trojan horse for Medicare for All.”

Surveys consistently show Medicare for All is not what the public really wants, Baldacci says. “What the polling points to more broadly is that Americans have genuine concerns,” Baldacci said. “They’ve seen their costs double in the individual market under Obamacare, and they often don’t have the coverage choices they want; but they also want a real solution. A real solution would increase choices, lower costs, and protect the vulnerable. In short, it would be a patient-centered policy.”

Ashley Bateman (bateman.ae@googlemail.com) writes from Alexandria, Virginia.
Trump Issues Executive Order to Protect, Improve Medicare

By AnneMarie Schieber

President Donald Trump signed an executive order aimed at shoring up Medicare’s financial health and delivering better care to the nation’s seniors.

In the October 3 order, Trump mentioned the proposed Medicare for All Act of 2019, which would significantly alter the program.

“America’s seniors are overwhelmingly satisfied with their Medicare coverage,” the order stated. “Medicare for All” would take away the choices currently available with Medicare and centralize even more power in Washington, harming seniors and other Medicare beneficiaries.”

Creating New Options

Trump’s order calls for expanding alternative payment methodologies, such as Medicare Advantage (MA), that “link payment to value, increase choice, and lower regulatory burdens imposed on providers.”

The Secretary of Health and Human Services (HHS) will have one year to propose a regulation and implement ways to expand plan choices. These could include a “Medicare Medical Savings Account” usable to pay for extra benefits and telehealth. Beneficiaries might even be eligible for rebates if they choose more cost-effective plans and services.

The current fee for service (FFS) model will remain, but the order gives HHS 180 days to issue a report on modifying FFS payments to more closely align with prices in MA or plans in the commercial insurance market. In addition, recognizing that “network adequacy,” or provider competition in individual markets, has a big effect on the success of MA plans, the order gives HHS one year to propose a regulation adjusting MA plan requirements to take into account anticompetitive government restrictions such as certificate-of-need laws, which impede service expansion in 35 states.

Putting Beneficiaries First

Beneficiaries should experience some improvements in the time they spend with providers as a result of the changes. The order calls for new regulations eliminating “burdensome billing requirements” and rewarding providers for time spent with patients.

This includes a review within one year by HHS of policies that “create disparities in reimbursement” for care and service from nonphysician care providers such as nurse practitioners.

The order also addresses a frustration for seniors who do not want to participate in Medicare but have pay for Part A through automatic deductions from their Social Security checks.

CMS Establishes Rating System for Obamacare Insurance Plans

By Ashley Bateman

The Centers for Medicare and Medicaid Services (CMS) are rolling out a star-based rating system to help people select health insurance plans on HealthCare.gov and to improve the overall quality of coverage.

Exchange health plans will be ranked on a five-star scale in three categories: member experience, medical care, and plan administration.

Ratings will be based on data issuers submit on past performance and are being provided for the 2020 Open Enrollment Period, which begins November 1, 2019.

Apples to Oranges

Physicians less tied to insurance providers are skeptical toward the ratings, saying they will deter patients from quality health care options not just within the exchanges but also outside them.

“In general, attempting to judge the quality of care using ICD-10 [International Classification of Diseases] codes are an exercise in futility,” said Philip Eskew, a physician, attorney, founder of DPC Frontier, and policy advisor to The Heartland Institute, which publishes Health Care News.

“The problem many doctors would have here is that the insurance company is telling them what to order,” Forrest said. “Many times, this has been done four times in that year, but since the insurance plan did not get charged, they think it was never done.”

Insurance Bias

In judging plans on member experience, ratings will be based on member satisfaction surveys and reported ease of access to appointments and services. That will place some providers at a disadvantage over which they have no control, Forrest says.

“In rural or underserved communities, it may be more difficult to get in for appointments simply due to less providers or facilities,” Forrest said.

The second category, “medical care,” involves care management such as regular screenings, vaccines, and the monitoring of certain health conditions. Forrest says this measure is likewise problematic, because it is based on claims data, not patient histories.

“For example, I provide free flu shots to all of my patients without a copay or filing any insurance,” Forrest said. “According to those patients’ health plans, they did not get a flu shot since it was never billed to insurance. The plan or the provider might get a lower rating due to misleading or false data.

“I get letters from insurance companies sometimes telling me they recommend I check a lab test on a patient because it looks like it has not been done in a year,” Forrest said. “Many times, it has been done four times in that year, but since the insurance plan did not get charged, they think it was never done.”

Insurers’ Cost Focus

The third category is plan administration, based on information access and appropriate treatment and testing. Forrest says this too could be shortsighted.

“The problem many doctors would have here is that the insurance company is telling them what to order,” Forrest said. “Many times, this is based on keeping the insurance companies’ costs down, rather than what the patient actually needs.”

AnneMarie Schieber (amsieber@heartland.org) is managing editor of Health Care News.
MI’s CON Board Sidelines Promising Cancer Treatment

Continued from Page 1

Limiting Competition
CON laws are designed to keep health care providers from engaging in unnecessary capital outlays that would ultimately be passed on to patients in the form of higher costs. In practice, this means hospitals and other health care providers must get the approval of a state agency before offering new services, expanding their operations, or implementing new medical technologies. Dominant providers frequently use CON laws to limit competition from smaller hospitals.

CAR-T therapy is different from most health care services, says Anna Parsons, a policy coordinator with the American Legislative Exchange Council, because it does not require a capital investment (see article on page 22).

“An FDA-certified hospital should be capable of offering these treatments, since all the high-tech bioengineering is done at other locations,” Parsons told Reason.com.

Michigan As Outlier
Michigan state Sen. Curt VanderWall (R-Ludington), who chairs the Senate Health Policy and Human Services Committee, says he opposes CON regulation of CAR-T.

“It is concerning to me that the CON commission expanded a requirement into a new clinical service area that goes well beyond the federal requirement,” VanderWall told Health Care News.

The Centers for Medicare and Medicaid Services do not require FACT accreditation, according to an August statement. The ban on FACT accreditation, according to them, has no medical rationale for the ban.

“Patient choice and access are priorities for me,” VanderWall said. “Patients will be able to work with their doctors to find the best treatment site based on safety and access. Michigan should not be an outlier.”

CURT VANDERWALL
MICHIGAN STATE SENATOR
(R-LUDINGTON)

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

Tennessee Certificate of Need Phaseout Faces Resistance

By AnneMarie Schieber

Forces are lining up against a proposed legislative phaseout of Tennessee’s certificate of need (CON) laws as a key lawmaker appears to be siding with a hospital system that claims repeal will put community hospitals in financial jeopardy.

Two bills to reform the state’s CON laws are under consideration in the state Senate. H.B. 1085 would eliminate the state’s CON laws over a five-year period, except for those regarding nursing homes. H.B. 0075 would address CON in distressed, rural areas by allowing providers to bypass CON approval if an area lacks an emergency room, surgical center, or a particular outpatient diagnostic service.

The chairman of the Tennessee Senate Health and Welfare Committee, state Sen. Rusty Crowe, told WJHL-TV he does not support full repeal, saying, “Our process is pretty darn good. I think it needs to be modified, and we’re going to modify it.”

Crowe does contract work for the state’s only hospital system, Ballad Health, which issued an even stronger criticism of proposed reforms.

In a written statement, Ballad Health said “certificate of need laws have long protected the public from for-profit and other organizations cherry picking profitable services while leaving community hospitals to care for those with Medicaid or without the means to pay. Unnecessary duplication of services leads to financial jeopardy for community hospitals.”

Clean Bill of Ethical Health
Crowe told Health Care News he has taken steps to eliminate any conflict of interest.

“I did ask for an advisory opinion relative to votes that might in any way affect Ballad,” Crowe said. “The Ethics Committee response was that all my actions were proper, following all ethics disclosure and rules. I would always cast my vote based on what is right and maintain neutrality.”

Crowe says Ballad is prohibited from opposing a certificate of need award to competitors under terms it accepted this summer when Wellmont Health System and Mountain States Health Alliance merged to become Ballad Health. The prohibition applies only to competitors who accept Medicaid and uninsured patients.

“Our state’s CON rules will most probably change in the near future, as we are currently studying and looking at what other states are doing,” Crowe said. “We want to make it as fair as possible for all who apply.”

The Tennessee General Assembly reconvenes on January 14 to finish its biennial session.

Limits to Growth
CON laws require health care providers to get government permission to build or expand facilities or offer new services. CON laws emerged four decades ago when the federal government, in an attempt to improve quality and access, compelled states to restrict competition in health care markets. The laws failed to achieve those goals, and Congress repealed the federal statute in 1987.

Tennessee is one of 35 states that have kept CON laws on the books. Its laws restrict and regulate 26 health care services, more than most states, according to the Mercatus Center at George Mason University, which monitors these laws.

CON laws are bad for the health care system, says Matthew Glans, a senior policy analyst at The Heartland Institute, which publishes Health Care News.

“Certificate of need laws are obtrusive barriers to the natural development of the health care market,” Glans said. “The United States leads the world in health care quality and innovation because we embrace the power of the market and health care competition. States with CON laws, like Tennessee, unnecessarily limit the expansion of health care providers and services and hinder competition.”

MATTHEW GLANS, SENIOR POLICY ANALYST, THE HEARTLAND INSTITUTE

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“You can put the brakes on innovation and keep the cost of care high,” Glans said. “In the United States, states that have eliminated CON are doing much better than states that have kept CON.”

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AnneMarie Schieber (amschieber@heartland.org) is managing editor of Health Care News.
Medicare Coverage of CAR-T Cell Therapy Raises New Questions

By Bonner Cohen

The Trump administration’s green-lighting of CAR-T cell cancer therapy for Medicare patients nationwide put an end to the patchwork of local determinations on the use of the innovative and expensive treatment.

Still to be determined is how hospitals and other health care facilities will be reimbursed for the therapy and whether patients will have access to the therapy under health care proposals such as Medicare for All or a so-called public option.

One of the most promising cancer treatments to come along in years, CAR-T cell therapy uses the body’s own immune system to attack and kill cancer cells. The treatment involves bioengineering T cells, a white blood cell that fights foreign substances in the body, and equipping them with new Chimeric Antigen Receptors that target cancer cells.

CAR-T cell therapy has been approved by the U.S. Food and Drug Administration (FDA) for children with leukemia and adults with advanced lymphoma. The therapy is typically used alongside other, more traditional treatments such as surgery, chemotherapy, and radiation. Its use in combattting other forms of cancer is pending with the FDA, an agency known for its slow approval process.

Hefty Price Tag

There are currently two approved CAR-T treatments: Novartis’ Kymriah (tisagenlecleucel) and Gilead’s Yescarta (axicabtagene). Like most newly introduced cutting-edge treatments, the two products come with a hefty price tag. A course of treatment of Kymriah costs $475,000 for pediatric and young adult patients with leukemia, and both are priced at $373,000 to treat lymphoma in adults, according to biopharma.com. Under Centers for Medicare & Medicaid Services (CMS) regulations published in August, Medicare will reimburse hospitals for 65 percent of the treatment’s cost, or about $242,000, through Part B.

Although hospitals will likely welcome Medicare’s financial commitment, there still remains a sizable gap. Further complicating reimbursement is the lack of a separate Medicare billing code for CAR-T treatment, which will be handled via codes for bone marrow and stem cell transplants until a CAR-T billing code is developed, which could take up to three years.

CMS worked closely with the FDA and the National Cancer Institute in developing the new regulations, a time-consuming process rooted in the complexities of developing a reimbursement scheme and overseeing an innovative and evolving therapy.

At a July 31 Heritage Foundation panel discussion on Medicare for All, CMS Administrator Seema Verma discussed the challenges government programs face in approving innovative treatments. “Much of the problem is when Congress says you can cover durable medical treatment, supplies, and drugs,” Verma said. “Sounded great when they wrote that law 30 to 40 years ago but doesn’t make sense in today’s environment. All of these new treatments are coming out, and they don’t fit nicely into the way the law has been constructed, and it creates problems for the agency.”

Seema Verma
Administrator
Centers for Medicare & Medicaid Services

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By Kenneth Artz

Louisiana Medicaid Expansion Claims Questioned

By Kenneth Artz

Louisiana’s latest report on the economic impact of its three-year-old Medicaid expansion program is under fire for claiming it is “supporting more than 14,000 jobs across the state and supporting $889 million in personal earnings.”

Medicaid Expansion and the Louisiana Economy, from the Louisiana Department of Health (LDH), says expansion brought in $1.7 billion in new federal funding for fiscal years 2018 and 2019 and “supports approximately 14,000 jobs.” The report was released on the Friday before Labor Day. An April 2018 LDH forecast stated “a federal injection of just $1.85 billion created and supported almost 19,200 jobs.”

Pelican Institute Senior Fellow Chris Jacobs questions the methodology behind the 2018 report (see commentary on page 20) and says although the 2019 report has more realistic numbers, it is still problematic.

“The researchers have yet to offer an explanation or a retraction of their inflated claims [or] answer the many questions about the circumstances surrounding these flawed studies,” Jacobs wrote on the institute’s website.

High and Rising

Louisiana state Sen. Conrad Appel (R-Metairie) says the natural growth of the Medicaid expansion program is very troubling and potentially devastating for Louisiana.

“The state’s cost for expansion is on autopilot, growing at nearly $100 million a year compounded,” Appel said. “It’s $100 million, the next year it’s $200 million, and the year after it’s $300 million and continues at this pace into the future.”

Appel says he worries what those figures would be like during an economic downturn, when enrollment will rise because of job losses and state revenues will decline because of unemployment. “There’s no bailing out, and there will be no federal government to rescue us,” Appel said.

Calls It a Bad Deal

Appel says Gov. John Bel Edwards is to blame for not getting a better deal from the federal government.

“One of the terms any businessperson would have negotiated with the Obama administration is protection for the state in the event of a recession, but our governor didn’t do that,” Appel said. “So, we have a contract with the federal government to insure as many people that want to get onto Medicaid and are eligible forever and we’ve got to pay 10 percent forever.”

Louisiana’s Medicaid program has also been marred by fraud and abuse, Appel says.

“In the initial setup for expanding Medicaid, a number of people didn’t qualify because they didn’t meet the financial guidelines,” Appel said. “I think it was about 1,600 of them who actually made more than $100,000 per year, and they were put on the expansion rolls. Then they set up a new set of rules for eligibility and another group of people, I think it was 65,000, fell off for failure to report their income properly.”

Kenneth Artz (kennethcharlesartz@gmx.com) writes from Dallas, Texas.
Costs of Employer Health Plans Are Rising Faster Than Wages, Inflation

Continued from page 1

plans increased by 22 percent over the last five years and 54 percent since 2009, the report states. In 2009, individual and family plans cost an employer an average of $3,515 and $9,860, respectively. Worker contributions jumped by 25 percent in the last five years and are 62 percent above what they were ten years ago.

The results are based on 2,012 interviews with large and small public and private employers. The annual premium for an employer-based family plan ranges from $18,433 to $21,002, up 5 percent over last year, and $6,211 to $7,103, up 4 percent, for individual coverage. On average, employees contributed between 18 and 24 percent towards their premiums. Helping to offset some of this expense is employer contributions to a Health Savings Account. Those contributions ranged from $572 to $3,255.

Health Care Gold Rush
There is no such thing as a free employee benefit, says Devon Herrick, a health care economist and advisor to The Heartland Institute, which publishes Health Care News. “Economists agree health benefits are just a noncash form of compensation,” Herrick said. “As such, the cost of coverage is ultimately borne by workers in lieu of greater cash wages. If the average employee realized how much health benefits were costing them, they’d demand control of the funds.”

Health insurance is one of the most attractive benefits for employees, according to Glassdoor Economic Research, especially after Obamacare upended the individual market where consumers buy plans outside of the workplace. The plans became prohibitively expensive, and between 2016 and 2018, 2.5 million unsubsidized people dropped out of the exchanges (see related article, page 9). Of the firms in the Kaiser survey, 54 percent of small employers (less than 199 workers) don’t offer health insurance. The Trump administration is attempting to change that by opening the door for tax-advantaged Health Reimbursement Accounts which allow employees to shop for their own coverage while receiving the tax benefits of employer-provided health insurance.

Herrick says such reforms are sorely needed. “Health care has turned into a gold rush where ‘stakeholders’ grab as much as they can from employers and employees,” Herrick said. “This cannot go on much longer before workers rebel.”

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

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DEVON HERRICK
HEALTH CARE ECONOMIST

Illinois Mandates Insurance Coverage of EpiPens for Children, Teens

By Ashley Herzog

Illinois is the first state to mandate insurance coverage of epinephrine injectors, more commonly known as EpiPens, for children. House Bill 3435, which Gov. J.B. Pritzker signed into law in August, goes into effect on January 1, 2020. All health insurance companies doing business in Illinois will have to cover “medically necessary epinephrine injectors for persons 18 years of age or under.”

Rising Popularity
The Michigan legislature is considering a similar bill, and the measures have been popular with the public, says Roger Klein, a physician, attorney, and policy advisor on drug pricing and precision medicine at The Heartland Institute, which publishes Health Care News. The Eppen mandate is “a political gesture with uncertain substantive benefits,” Klein says.

The real problem is the price of EpiPens, not insurance coverage, a problem H.B. 3425 does not address, Klein says. “Injectable epinephrine, a potentially lifesaving medication for people experiencing severe allergic reactions, has been in the news for several years because of concerns about rising prices,” Klein said. “In addition, there have been shortages of some brands of this medicine. However, this law does not deal with cost issues, many of which have been addressed by increased competition. It mandates insurance coverage for epinephrine although it is not clear that coverage is a problem and most insurers appear to pay for it.”

Even the reported cost problems may be exaggerated, Klein says. “In fact, through prescription services like GoodRx the price is about what it cost in 2009 when manufacturer Mylan bought the rights to the EpiPen and began raising the price,” Klein said. “It is possible shortages of some brands could result in insurance denials if insurers do not cover alternative brands and that this could be dealt with through regulations issued under the law. However, I have not seen reports of this problem, and it is even possible that it is less expensive for some people to pay out-of-pocket than to use their insurance to pay for epinephrine injections.”

Unintended Consequences
The new mandate might cause further problems, Klein says. “It is possible premiums will go up if the law ends up increasing the insurance companies’ costs, perhaps through the imposition of regulations that at a minimum create an administrative burden,” Klein said. “However, because it is unclear what, if any, effect the law actually has, it is difficult to estimate potential excess costs. It could end up doing and costing little.”

There is much more to the issue of EpiPen availability and affordability than the Illinois governor’s office has disclosed, Klein said. “The governor mentioned the new law in a 140-character tweet, and the media jumped on it, providing headlines and positive publicity for Illinois politicians, but very little analysis or explanation of what the impact of the law is likely to be,” Klein said.

“During the 30 years EpiPen has been on the market, why haven’t other states passed similar laws?” Klein said. “The lesson is to be skeptical and not to uncritically accept everything one reads, even from established media sources. Today’s news cycles appear to allow limited time for analysis and even essential factchecking.”

The Illinois Governor’s Office did not respond to a request for comment on this article.

Ashley Herzog (aebristow85@gmail.com) writes from Avon Lake, Ohio.
Report: Unsubsidized Individuals Are Fleeing the Obamacare Exchanges

By Bonner Cohen

The Obamacare exchanges are having an increasingly difficult time keeping people who must pay the full premiums out of their own pockets, the Centers for Medicare and Medicaid Services reports.

Although overall enrollment in Obamacare exchanges remained steady in 2018-19, the story was quite different for those not qualifying for the Affordable Care Act’s federal subsidies, known as advanced payment of premiums tax credits, or APTCs. Between 2016 and 2018, 2.5 million unsubsidized people dropped out of the exchanges, a 40 percent decline, CMS reports.

“As President Trump predicted, people are fleeing the individual market,” said CMS Administrator Seema Verma in a press release. “Obamacare is failing the American people, and the ongoing exodus of the unsubsidized population from the market proves that Obamacare’s sky-high premiums are unaffordable.”

Unaffordable, Sky-High Premiums

The latest figures on Obamacare enrollment are in two CMA reports: “Early 2019 Effectuated Enrollment Report” and “Trends in Subsidized and Unsubsidized Enrollments Report.” These documents provide information on the stability of the individual health insurance market during the 2018 plan year and offer preliminary insights into the 2019 market.

In 2018, the average monthly enrollment in the exchanges increased by 1 percent over 2017, and the early 2019 data show that by February, 10.6 million consumers had continued to pay their premiums, about 1 percent less than at the same time last year, CMS found.

The 2019 decrease occurred even though the Trump administration took steps to reduce the average monthly premium by 1 percent from the previous year, according to CMS.

“In part, actions taken by the Trump Administration to promote more stability, including the finalization of the Market Stabilization Rule in 2017 and rulemaking to give states new tools and flexibility in regulating their insurance markets have helped to lower premiums and increase choice,” CMS stated in its press release. “As a result of increased efficiency, the administration also reduced the user fee charged to insurers on the Federally Facilitated Exchanges beginning with the 2020 plan year, a reduction that will be passed on to consumers in the form of lower premiums next year.”

Priced Out of the Market

CMS found people who do not qualify for the APTC are increasingly being priced out of the market. Following a decline of 1.3 million people in 2017, another 1.2 million unsubsidized people left the market in 2018.

“These enrollment declines among unsubsidized enrollees coincided with increases in average monthly premiums of 21% in 2017 and 26% in 2018,” CMS stated.

People receiving subsidies through the APTC are largely shielded from these premium increases, a major reason why their enrollment numbers have remained steady. Those not eligible for subsidies have been bearing the brunt of the ACA’s rise in premiums.

The rising cost of Obamacare plans over the years is driving consumers to new alternatives, says Philip Eskew, physician, attorney, founder of DPC Frontier, and policy advisor to The Heartland Institute, which publishes Health Care News.

“As patients learn about other options outside of traditional insurance, such as health sharing ministries combined with direct primary care practices, they pursue them in increasing numbers,” Eskew said.

“My hope is that one day patients will realize three truths,” Eskew said. “One, most of health care can be delivered in the primary care setting; second, most of this care is affordable; and third, it should never be their goal to meet their health insurance deductible but rather to never use their insurance at all.”

Uninsured Rates Climb

In a related development, the Census Bureau on September 10 reported the number of Americans without health insurance climbed by 1.9 million in 2018, the first year-to-year increase since the ACA was passed in 2010. The Census Bureau said 27.5 million people did not have health insurance in 2018. The increase in uninsured coincided with the drop in unsubsidized enrollees at the Obamacare exchanges.

“ACA plans don’t offer good value to most consumers as an insurance product, but as an entitlement for individuals with preexisting conditions and those who are eligible for subsidies, it seems to have established a stable pool of enrollees,” said Chris Pope, a senior fellow at the Manhattan Institute. “The increase in the number of Americans uninsured is very slight and largely reflects the growth in incomes pushing households above the eligibility cutoff for Medicaid. Next year’s data, which will reflect the repeal of the individual mandate, may show a more significant shift.”

Who’s Dropping Insurance

To get a better picture of why people are dropping insurance, it is helpful to look at the demographic groups where it is occurring, says Brian Blase, president of Blase Policy Strategies and a senior fellow at the Galen Institute (see commentary, page 21).

Not only did the numbers rise among people with incomes above 400 percent of the poverty line, but also among people below the poverty level in states that expanded Medicaid. That tells us two things, Blase says.

“One, [the uninsured] placed little value on the coverage over time, as more of them are not signing up, but the other important point is these people are not insured,” Blase said. “You can sign up for Medicaid retroactively. If you go to the hospital and you’re poor and you don’t have coverage, they’ll sign you up for Medicaid once you are at discharge.”

Blase says uninsured rates are not going up in states that didn’t expand their Medicaid programs.

“What is going on there is the economy grew,” Blase said. “Employers compete for workers by offering wages and benefits, and some of these poor individuals are working, and they enrolled in private coverage. Unlike in expansion states, the government program did not crowd out private coverage.”

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The very fabric of America is under attack—our freedoms, our republic, and our constitutional rights have become contested terrain. The Epoch Times, a media committed to truthful and responsible journalism, is a rare bastion of hope and stability in these testing times.
Despite Protests, States Limit Exemptions from Mandatory Vaccines

By Ashley Bateman

D
epite loud protests from the public, more states are limiting individual exemptions to mandatory child vaccination laws.

Lawmakers were galvanized by a recent outbreak of measles which peaked in April with 341 new cases that month. Since then, the number of new cases has decreased radically, to 24 in August, according to the Centers for Disease Control and Prevention. As of September, the total number of cases for 2019 was 1,241, with more than 75 percent linked to outbreaks in New York State.

Five states—California, Maine, Mississippi, New York, and West Virginia—do not allow exemptions from mandatory childhood vaccinations for personal, philosophical, or religious reasons. On September 9, California Gov. Gavin Newsom signed legislation clamping down on medical exemptions as well. S.B. 276 allows the government to investigate physicians who write more than five medical exemptions for vaccines within one year for children who attend schools with immunization rates under 95 percent.

Opponents of these policies are not going away quietly. In Maine, they are seeking to overturn the law by putting the issue on the March 2020 ballot.

Interfering with Doctors’ Orders
The medical exemption restriction in California applies to all physicians, including those who treat immune disorders.

“There is no exception,” said Marilyn Singleton, an anesthesiologist and attorney in California and president of the Association of American Physicians and Surgeons (AAPS).

“If the state determines a physician is ‘contributing to a public health risk,’ it will report the physician to California’s Medical Board,” Singleton said. “This process takes the final judgment out of the hands of the patient’s physician.”

The law could have a chilling effect on doctors’ decision-making, says Jane Orient, a physician, executive director of AAPS, and policy advisor to The Heartland Institute, which publishes Health Care News.

“Not only does [S.B. 276] severely restrict acceptable contraindications, it is so onerous that most doctors will decline to write any at all, out of fear of harassment or even loss of licensure,” Orient said.

Tweaking an Unpopular Bill
S.B. 276 gained a large amount of attention. During the legislative debate, thousands of protesters descended on the state capitol. Several were arrested. Hours before a scheduled vote, Newsom pushed for amendments to the bill. What emerged was a companion bill, S.B. 714, which would invalidate any medical exemption written by a physician who has faced disciplinary action and grandfather in exemptions written before January 1, 2020. To prevent a mad rush to a doctor’s office before that date, the law requires students to get a new exemption at kindergarten, 7th grade, and any time the child moves to a new school. It also removes a provision requiring doctors to certify under penalty of perjury that an exemption is accurate.

The provisions are improvements but do not eliminate the law’s overreach, Singleton says.

“The law holds a doctor’s integrity and clinical judgement hostage to the state by intimidation and fear of losing one’s license and livelihood,” Singleton said.

“The law strips individuals of their right to choose their medical treatment and benefit from their physician’s judgment based on the patient-physician relationship,” Singleton said. “The law interferes with the physician’s right to practice medicine according to the ethics embodied in the Oath of Hippocrates.”

‘More State Control’
Limiting exemptions, not measles, is the reason behind the new laws, Singleton says.

“The powers that be saw that medical exemptions were on the rise since the elimination of the personal-belief exemption,” Singleton said. “The increase in measles cases helped spur the new legislation. This is an opportunity, not for a measured evaluation of public health concerns, but for more state control.”

“There is a push in many states to either remove exemptions or make it very difficult to get them, like onerous ‘education’ burdens on parents,” Orient said.

Orient says parents have a right to be concerned about side effects of vaccines, and lawmakers should respect the Nuremberg Code, which sets ethical guidelines for medical research and influenced the process for informed consent.

“Nuremberg was supposed to establish the right to informed consent,” Orient said. “It is considered unethical and illegal to violate this basic human right. The vaccine exemption is a dangerous precedent.”

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

“…individuals of their right to choose their medical treatment and benefit from their physician’s judgment based on the patient-physician relationship. The law interferes with the physician’s right to practice medicine according to the ethics embodied in the Oath of Hippocrates.”

Marilyn Singleton
President, Association of American Physicians and Surgeons

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Company Helps Physicians Leave Third-Party Payment System

By AnneMarie Schieber & Leo Pusateri

A new company is helping free physicians from the “hamster wheel” of the third-party health insurance payment system.

Freedom Healthworks opened its doors in 2016 as a professional organization to help physicians open direct care practices, such as direct primary care (DPC). Since then, the company has expanded into a full-grown operation with a medical director, communications team, and vision to expand well beyond its Indianapolis, Indiana home base.

“We recognized there was a hunger among physicians, so we built a platform that would help physicians transition to the DPC model,” said Adam Habig, cofounder and president of Freedom Healthworks and a policy advisor to The Heartland Institute, which publishes Health Care News.

‘Only Appealed to Mavericks’

Habig and his brother, Christopher, who cofounded the firm, bring a personal perspective to their line of work. Their parents, both of whom were physicians, retired early because of burnout caused in large part by the struggle to comply with government regulations and with rules for third-party reimbursements. The increasing bureaucracy was taking time from patients.

Instead of following in their parents’ footsteps to become doctors, the Habigs thought they could better serve the profession by becoming entrepreneurs focused on independent practice. The first thing they did was tour the country to talk with physicians.

“We found if there were 100 physicians who made the leap, so to speak, there were 100 different paths through the metaphorical weeds,” Habig said. “There was no systematic approach to finding best practices or even following them. And because that was the case, it really limited the appeal of the direct model. It only appealed to mavericks who were comfortable with a little risk, and that did not appeal to a majority of physicians.”

One-Stop Shop

With the help of Risheet Patel, M.D., the company’s medical director, the Habigs developed a system that can help physicians open up a direct care practice more quickly and cheaply. On their listening tour, the Habigs learned starting a DPC practice could cost $300,000 and take three years. Freedom Healthworks offers a program that can reduce the costs to about one tenth of that, Habig says.

“It’s equivalent to [the difference between] building your own house or hiring someone who knows how to do it,” Habig said.

The company also helps physicians build a patient base and market their practices. Ultimately, Freedom Healthworks hopes to create a network of independent physicians so independent practices can become even stronger.

“Doctors don’t want to feel like they’re operating on an island,” Habig said. “By linking them together under the Freedom Healthworks umbrella, we can create a community which can provide mutual support structures.”

Improving Regulatory Climate

One development that has helped increase direct care is the growing number of states with laws declaring direct primary care is not insurance. Laws exempting independent practices from insurance regulation are critical for growth, says Phil Eskew, a physician, attorney, and founder of DPC Frontier.

“When states define DPC as outside of insurance, they send a signal to risk-averse physicians that this model is accepted,” Eskew said. “These same physicians benefit from lower legal start-up costs as well, since they feel less pressure to pay an attorney to read through the insurance code.”

DPC Frontier monitors the enactment of such laws and posts on its website a map showing 27 states as having favorable laws. The organization also keeps an eye on other laws that can affect direct care growth, such as allowing physicians to “opt out” of Medicare and Medicaid, to dispense pharmaceuticals, and to get more competitive prices for laboratory services, where wholesale prices can be obscured by cost-shifting.

There have been welcome reforms at the federal level too. This summer, the Trump administration approved a new rule that opens the door for more employer health insurance options through health reimbursement arrangements. Additionally, President Donald Trump issued an executive order to start the process that will allow tax-advantaged health savings accounts to pay for DPC services.

Reaching Out to Employers

Habig says he hopes as more and more direct care practices open, an increasing number of employers will offer independent care to employees.

“If you have 100 employees with dependents, you’re going to have a hard time finding a big enough practice to accommodate an entire business. To offer DPC with their health benefits, employers need a network, and that doesn’t exist today,” Habig said.

Habig says DPC will save employers money because it enables doctors to spend more time with patients.

“Research shows that by actually increasing the frequency of contact at the primary level with a single doctor, not with a rotating battery of staff physicians, it will drive down the incidence of specialty visits and hospitalizations down the line,” Habig said.

Breaking Barriers

A shift to more consumer-driven health care will not happen overnight, says Habig.

“There is a lot of vested interest in the current $3.5 trillion-a-year system,” Habig said. “There are so many today who are functionally uninsured who won’t get the care they need, no matter what their health insurance ‘covers.’

“A hefty deductible will compel consumers to shop smarter, but at the same time, it’s also a barrier to care,” Habig said. “We want to make sure the high deductibles are not a barrier to seeking out the ‘front-line’ care that can make a huge impact on costs down the road.”

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Costs of Employer Health Plans Expected to Rise Further in 2020

By Leo Pusateri

LARGE employers expect health care costs to rise by 6 percent in 2020, to $15,375 per employee, according to a survey by the National Business Group on Health.

The report released in late August is based on responses from 147 large employers covering 15.6 million workers and their families. Employers indicated they expect no change in the percentage of costs they will cover, which is currently 70 percent, meaning workers can expect out-of-pocket costs of nearly $4,500. The open enrollment period for employer health care plans typically takes place in November.

An analysis in May by the Commonwealth Fund found 23.6 million Americans with employer plans were paying 10 percent or more out of their household paychecks for health care costs. The annual costs can range between $300 and $12,080, the report states.

Benefit or Burden?

The current predicament of rising cost-sharing and premiums has been a decade and a half in the making and can be traced back to policies enacted in the 1950s, says Devon Herrick, a health care economist and policy advisor to The Heartland Institute, which publishes Health Care News.

“In the early 1950s, Congress placed their imprimatur on the Internal Revenue Service’s earlier declaration for health insurance to be a fringe [non-taxable] benefit for employees,” Herrick said. “Really, that was a huge mistake.”

The ruling and subsequent statute have allowed employers to get a discount on what would otherwise be taxable wages, Herrick says.

“Over time, workers began getting more and more of their medical care tax-free,” Herrick said.

As a result, employers and employees have less incentive to shop for the best price when getting care, Herrick says.

“The more you disconnect workers from being able to decide whether a dollar of medical care is worth it, the more wasteful it becomes,” Herrick said.

Skin in the Game

This “sky is the limit” mentality eventually became too costly, and employers responded by offering insurance with higher deductibles, Herrick says.

“Since on average most employees don’t spend the $1,200 or $1,500 or whatever their deductibles are, they’re more price-conscious, and they’re more apt, in theory, to ask questions, like, ‘Do I really need that?’ What’s that going to cost?” or ‘Is that drug available in a generic?’” Herrick said. That’s the reason for the higher cost-sharing, Herrick says.

Recent premium increases have a different cause, Herrick says.

“The reason for the higher premiums is the perversive programs like Obamacare that mandate the benefit package, drug coverage, and unlimited benefits,” Herrick said. Consumers have to pay more because they are forced to take more coverage than they want.

Power to the Consumer

The tax code is what led to the health care system now comprising one-sixth of U.S. gross domestic product, says Avik Roy, president of the Foundation for Research on Equal Opportunity and author of Bringing Private Health Insurance Into the 21st Century.

“We’ve become dependent on and addicted to this ‘drug’ of overly expensive health care, of which the employer base is a major driver,” Roy told Health Care News.

Roy says consumer control is the key to the solution.

“A lot of things need to be changed,” Roy said. “But the most important thing we have to do is to put the control of health insurance in the consumer’s hands.”

Employers tend to pick insurance plans that serve their own interests, not necessarily those of the employees, Roy says.

“We need to give that money, that compensation, over to the worker to buy the coverage that the worker thinks is best for her or him,” Roy said.

Preexisting Problem

One reason for the popularity of employer plans is the lack of cost penalties for preexisting conditions.

“In terms of standardizing some things around preexisting conditions, Obamacare did make it possible to go back and forth from the employer market to the individual market in ways that are smoother than they were before,” Roy said.

“The individual market didn’t work so well because the premiums were very high for preexisting conditions,” Roy said. “The way Obamacare solved it, unfortunately, was not the best way to solve it, but the flipside is that by trying to address that problem, it makes the argument against being wedded to the employer-provided health care plans weaker, while making the argument for consumer control over their health care stronger.”

Employees Feel the Pinch

The Commonwealth Fund analysis, “How Much U.S. Households with Insurance Spend on Premiums and Out-of-Pocket Costs: A State-by-State Look,” was an attempt to look more closely at employer-based coverage, on which there has been “less attention” than the public debate over plans on the Obamacare exchanges, the report states.

Some 158 million Americans get health insurance through employer plans, and “faced with rising premiums, U.S. employers are sharing more of the costs with workers,” the report states.

While the employer-paid percentage of health care has remained relatively steady over time, the rapidly increasing costs of premiums and deductibles are causing many employees to spend an ever-greater share of their income on health care.

“Employees face much higher insurance premium costs and out-of-pocket medical costs than they did in the past. The portion of the insurance premium that employers pay has been pretty steady over time: about 80 percent for single plans and 77 percent for family plans. But because the costs of the insurance plans are going up, employees pay more in absolute dollars.”

DAVID RADLEY

SENIOR SCIENTIST

THE COMMONWEALTH FUND

INTERNET INFO


Avik Roy, Bringing Private Health Insurance Into the 21st Century, April 21, 2019: https://freopp.org/bringing-private-health-insurance-into-the-21st-century-d1df138f1f0c

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Leo Pusateri (psycheistr@fastmail.fm) writes from St. Cloud, Minnesota.
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California Increases Telemedicine Payments to Reduce Medicaid Costs

By Bonner Cohen

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di-Cal, California’s sprawling Medicaid program, is working under new rules expanding reimbursement for telemedicine.

Medi-Cal currently serves more than 13.5 million residents. Telemedicine is increasingly seen as a way to help the hard-pressed program carry out its mission while the state struggles with a growing shortage of doctors. The new rules offer pay parity for telemedicine visits versus in-office consultations.

Medi-Cal defines telemedicine as “the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care while the patient is at the originating site, and the health care provider is at a distant site,” as stated in an announcement laying out the new guidelines.

The policies began to go into effect on July 1. The California Department of Health Care Services released its final policy in August.

Sweeping Rule Changes

In a major departure from previous Medicare policy in California, there are no restrictions on where the consultation must begin. Patients will not have to go to a center, for example, to receive a telehealth service. The visit can originate from home. To be reimbursed, services must be covered by Medi-Cal, meet policies and guidelines, and be appropriate for telehealth.

The provider must be licensed in California and enrolled as a Medi-Cal provider. Nonphysician medical practitioners are covered.

Providers using telehealth no longer have to document a barrier to an in-person visit, nor are they required to document the cost-effectiveness of the telehealth option. Patients, however, must consent to the telehealth services, and the providers must be licensed under California law.

Medi-Cal does not embrace all forms of telemedicine. The new guidelines do not allow payment for remote patient monitoring that collects health data from the individual’s home through devices and mobile health platforms. Medi-Cal also does not pay for telehealth equipment purchases or compensate providers for phone calls or emails.

Increasing Doctor Shortage

Medi-Cal’s embrace of telemedicine arrives at a time of an acute shortage of health care providers throughout the state, including doctors, nurses, and home care workers. Putting further strains on the system, Gov. Gavin Newsom proposes extending Medicaid coverage to young adults who are in the country illegally and providing more subsidies for health care for middle-class families.

A February 2019 report by the California Future Health Workforce Commission found the state will need 4,100 more doctors and 600,000 additional home care workers over the next decade. More than one-third of the state’s doctors and nurse practitioners are reaching retirement age, the Los Angeles Times reported on February 5.

“A lot of people don’t have that luxury. They can’t walk away from work when they want to, or they’re going to lose their wages. Telemedicine offers a way to offer immediate help, anywhere you are, any hour of the day. That is an extraordinary capability.”

ROBERT GRABOYES
SENIOR RESEARCH FELLOW, MERCATUS CENTER

Growing Trend

California’s decision to offer pay parity for telemedicine visits is a significant reform, says Robert Graboyes, a senior research fellow at the Mercatus Center who focuses on technological innovation on health care.

“California is a pretty significant chunk of the U.S. population,” Graboyes said. “It offers ways to potentially cut some costs, but also ways to deliver better health care.

“The good news is they are paying for it,” Graboyes said. “The bad news is, potentially, one of the advantages of telehealth is it can be delivered less expensively. And now we’re saying we are going to have to pay you the same as an office visit. You may be undermining one of its biggest advantages: saving money.”

Graboyes says telemedicine will be especially helpful to people who can’t easily take time off from work to see a doctor.

“A lot of people don’t have that luxury,” Graboyes said. “They can’t walk away from work when they want to, or they’re going to lose their wages.

“Telemedicine offers a way to offer immediate help, anywhere you are, any hour of the day,” Graboyes said. “That is an extraordinary capability.”

Slipping Down

The Mercatus Center publishes a periodic report on states’ openness to new health care technologies and delivery models that can save consumers money. In the June 2018 report, “Healthcare Openness and Access Project: Mapping the Frontier for the Next Generation of American Healthcare,” California was ranked 39th in the nation, down from 34th in 2016. The state scored a three out of five on the telemedicine subindex, putting it in the middle of the pack.

Maine, Mississippi and Washington had the highest score, at 4.5. Pennsylvania was ranked last with a 1.75 score.

Scores are based in part on how state Medicaid programs reimburse for telehealth.

“States place varying restrictions on this type of telemedicine, in some cases limiting its use to the treatment of certain conditions or limiting the type of devices that can be used or the information that can be collected,” the report stated. “For this indicator, states with fewer restrictions received higher scores.”

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INTERNET INFO

The Trump administration is launching a plan to require hospitals to disclose publicly the prices they negotiate with insurance companies for certain medical services. Currently, these prices are not available to the public or competing providers and insurers.

The rule would require hospitals to disclose the negotiated rates with specific insurers for at least 300 medical services considered shoppable.

The plan will take effect in January 2020 if it receives final approval by the administration.

The administration is basing its authority on an Affordable Care Act provision that requires hospitals to make public a list of standard charges for services provided.

**Forced Transparency**

The rule is based on the assumption transparency will provide patients more control over health care decisions. In a phone call with reporters on July 29 when the proposed federal rule was announced, CMS Administrator Seema Verma explained, “Patients have the right to know the price of health care services so they can shop around for the best deal.”

Whether the rule can accomplish that goal is debatable, says John Goodman, president of the Goodman Institute for Public Policy Research and a policy advisor to The Heartland Institute, which publishes Health Care News.

“Transparency may backfire,” Goodman said. “The reason is almost every patient in a hospital is going to exceed his [insurance] deductible. So, patients are unaffected financially by the information.”

In addition, consumers may not be the best judges of published prices, Goodman says.

“There is a tendency across all markets to associate higher cost with higher quality,” Goodman said. “So, patients may choose the higher-priced facility because they assume the care will be better.”

For transparency to achieve real value, consumers have to be in the driver’s seat, Goodman says.

“Transparency without patient empowerment gets the cart before the horse,” Goodman said. “Transparency is never a problem for Canadians who come to this country for hip and knee replacements. That’s because they control the marginal dollars.

“If employers would give their employees the money and let them shop for surgery the way Canadians do, transparency would never be a problem,” Goodman said.

**Better Than Nothing?**

Price disclosure can have some benefit in a market otherwise stripped of normal forces, as is the case with health care, says Dr. Chad Savage, founder of Your Choice Direct Care and a policy advisor to The Heartland Institute.

“Knowledge of these rates merely acts as a guard against exploitation of low-information health care consumers who, without this information, would have no knowledge that they were being fleeced,” Savage said.

**Concerns About Bidding Wars**

Hospitals and insurance companies oppose mandated price disclosure and could mount a legal challenge to the federal rule if it goes into effect. They express concern that disclosure of privately agreed-upon rates would create bidding wars that drive prices below unsustainable levels.

Savage says that belief has little basis.

“The argument goes that the negotiated prices are so low that the person selling the service could not provide them at this rate to the other buyers and, with them now public, would be less likely to offer them at all to any buyer,” Savage said. That idea, Savage says, “suggests that sellers of services are pricing their services below the cost of providing them. If they are doing that, it would indicate that there is substantial price-shifting to other customers—which those customers would have a right to know—to prop up the inappropriately low negotiated prices.

“Alternatively, the provider of the service, pricing below cost, would be in an untenable financial situation and go out of business,” Savage said. “Assuming neither of these is true, it would mean that other people could likely access the negotiated prices without harm to the seller, because they are selling at a profit.”

Compliance will be discretionary, but failure to participate could be costly, Goodman says.

“The way most health regulations are enforced is by tying them to participation in Medicare,” Goodman said. “So, if a hospital refuses to go along, it can lose its right to treat Medicare patients. Regulations can also be tied to Medicaid and other entitlement spending.”

**Kelsey E. Hackem** (khackem@gmail.com) writes from Washington state.
Editors Note: With health insurance prices expected to rise again in 2020 (see related story, page 13), Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons and a policy advisor to The Heartland Institute, which publishes Health Care News, shared her views on consumer-driven health plans (CDHP) and how they reduce costs and lead to better care.

Orient’s views are bolstered by a Health Care Cost Institute study released in May which showed consumers respond to market forces when they have a plan that allows them to do so. The study examined more than 10 million people in CDHP plans with lower premiums but higher deductibles and a health savings or health reimbursement account. It found those consumers spent an average of 13 percent less than those in a traditional plan on inpatient care, 7 percent less on outpatient care, 8 percent less on professional health care services, and 26 percent less on prescription drugs.

Health Care News: How does paying more up-front lead to lower health care costs?

Orient: It’s a whole lot less expensive just to pay directly. A lot of so-called health plans are just a very, very expensive check-writing service. Before we got all of this unaffordable health care, courtesy of the Obama administration, the best thing to do was to have a high-deductible insurance plan that you hoped never to use, much the same as you hope never to use your fire insurance or car insurance.

Over the years, health plans became a far different product. Traditionally, you would pay directly for all services, place receipts in a shoe box, and if receipts approached the deductible you could take them out and send them in.

Now insurance plans require a claim for every expense. Insurers decide whether or not it applies to the deductible. Then they may or may not write a check and/or audit it to see whether the doctor did what they think should have been done. All of these processes add costs—it probably at least triples the cost of routine medical services. What we need is medical insurance that acts like other types of casualty insurance.

Health Care News: Having a third party scrutinize claims seems like a way to control costs. Does it?

Orient: No. Fraud is sort of inevitable when you take a huge amount of money from people up front and dole it out afterward. Everybody’s got the incentive to try to get as much out of it as possible. Whereas if the patient is paying the bill at the time of service, if it isn’t worthwhile, the patient is probably not going to spend the money.

It reminds me of the time I could buy an insurance plan with a $25,000 deductible. It cost me about $250 per year. And I hoped I would never use it, and indeed I never did. I was very sorry to see that they added a requirement that I had to have some basic policy that would be vastly more expensive that would cover day-to-day things that I had been previously paying for myself at a much lower cost.

Patients don’t go to the doctor for a lot of reasons. But knowing that they are going to have to pay up front when they already paid a huge amount for their insurance premiums might be a deterrent.

Health Care News: The antithesis of CDHPs is Medicare and Medicaid, with government administrators determining cost and coverage. What is wrong with that approach?

Orient: I would say CDHPs are a way out of these bankrupt government programs that are placing both patients and doctors in a vise. We need to open all the escape hatches to allow patients to get out of these programs now, because these programs are bankrupt, and they are increasingly becoming stingy and intrusive.

They [Medicare/Medicaid] are going to crash and burn, eventually. The demographics and huge unfunded liabilities already accumulated guarantee that.

Health Care News: It seems that we need an entire paradigm shift in the way we think about health care.

Orient: I don’t know why consumer-directed health plans are a problem, because we have consumer-directed everything else, including grocery shopping, rent, computers, cars, and so on, where customers decide what they want and whether things are valuable and worth it or not.

Medicine is not like that at all. They ask you all kinds of questions about your private life, insurance coverage, and so on. It’s often very difficult to get into the doctor’s office, and they act like they’re doing you a favor just letting you through the door.

INTERNET INFO

Kidney Patients Die Despite Plenty of Donated Organs Available, Study Finds

By Ashley Herzog

About 10,000 patients with kidney disease die from renal failure each year in the United States, and a new study shows it’s not for lack of organ donors. These patients receive an average of 16 donation offers, but transplant teams reject them, states the study published on August 30 in JAMA Network Open.

The researchers reviewed a list of 280,041 patients on an organ wait list and found those who died while waiting for a kidney had received an average of 16 offers of kidneys over 651 days. Those who had successful transplants received an average of 17 offers over 422 days.

Misaligned Incentives

Concern about failure rates may cause transplant teams to reject organs that could save patients’ lives, says John Dale Dunn, an emergency physician in Brownwood, Texas and a policy advisor to The Heartland Institute, which publishes Health Care News.

“The transplant teams are rejecting kidneys that were possibly injured at death or in the final illness, or maybe the organs were from donors who were unhealthy,” Dunn said. “The motive for transplant teams is they don’t want to go on the list of bad transplant teams with unacceptable failure rates.

“As long as transplant teams are under the gun, there won’t be any loosening of acceptance levels for donor kidneys,” Dunn said. “The downside is too much to ignore.”

The physicians’ incentives are not aligned with those of their patients, says Alex Tabarrok, director of the Center for Study of Public Choice.

“Physicians may want perfect organs to keep up their track record of successful transplants,” Tabarrok said. “Physicians look bad when transplants do not go well, but not when a patient is removed from the transplant list while under their care. Patients are more concerned with getting off the waiting list.

“With the waiting list for transplants long and lengthening, we should use more of the organs that are available and not make the perfect the enemy of the good,” Tabarrok said.

Respecting Patients

Patients should have more of a voice in the process, says Paul Conway, chair of policy and global affairs for the American Association of Kidney Patients.

“Transparency around discarded organs is badly needed,” Conway said. “We need to know why so many donated kidneys are going to waste.”

The study authors note an additional reason why the issue of rejection of organs deserves scrutiny.

“This study suggests that a large number of deceased donor kidney offers are received by candidates but are declined on their behalf, resulting in what appears to be many missed opportunities for a transplant before death or removal from the waiting list,” the article stated.

In July, the Trump administration issued an executive order on end-stage kidney care which called for, among other things, “modernizing” the kidney donation process and creating incentives for organ donation in order to allow patients to end dialysis. The executive order also called for greater transparency throughout the donation process.

Conway says the president’s order should increase patients’ input into these decisions.

“A patient who is dying of kidney failure may, understandably, be willing to accept a higher-risk kidney than their transplant team will allow, and the patient’s voice should be respected,” Conway said.

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

MI Considers Tax Break for Live Organ Donors

By Ashley Herzog

The Michigan Legislature is considering granting a $5,000 tax credit to those who donate a kidney or part of their liver to a patient in need.

Michigan state Sen. Jeff Irwin (D-Ann Arbor) introduced Senate Bill 0456, which has received bipartisan support.

Irwin says the credit is more than a reward for a good deed.

“Live organ donors are giving an irreplaceable gift: the gift of life,” Irwin told Health Care News. “By choosing to donate a kidney or part of their liver, they also rack up many expenses that aren’t covered by insurance. Medicare might cover the cost of the actual operation, but a donor’s expenses will far exceed just one procedure.”

Cash for Organs

A financial incentive for live organ donations raises ethical issues, says David Gortler, a former pharmacology professor at the Yale University School of Medicine who served at the Yale Interdisciplinary Center for Bioethics.

“Along with many other bioethicists, I believe that offering money for organs is wrong,” Gortler said. “Offering any type of direct or indirect economic benefits in exchange for organ donation is inconsistent with American values.”

Although there is a critical shortage of organs, offering potential donors a tax credit is not the solution, Gortler says.

“Offering money for organs can be viewed as an attempt to coerce economically disadvantaged Americans to participate in organ donation,” Gortler said. “Furthermore, since the economically disadvantaged have been shown to be less likely to be organ transplant candidates, financial incentives for organ donation could be characterized as exploitation.”

More Than Financial Sacrifice

Gortler says he understands why lawmakers are driven to consider such measures.

“[Live organ donation] is a huge time indeniture, inconvenient, expensive, and has a high medical complication rate,” Gortler says.

That’s exactly why live donors should receive a tax credit, Irwin says.

“Live organ donors have to spend a considerable time away from work,” Irwin said. “Because America isn’t great about offering paid time off for medical leave, I believe live organ donors should be able to recoup at least some of their lost wages with a tax credit.”

The National Kidney Foundations says 19 states currently offer tax breaks to living organ donors.

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

INTERNET INFO

The Louisiana Department of Health (LDH) is expected to release a study (see related article, page 7) by Louisiana State University (LSU) researchers claiming Medicaid expansion created tens of thousands of jobs in the state.

The study’s underlying premise that higher taxes and government spending will create economic growth has raised questions among the state’s free-market and conservative circles. However, LDH and LSU face an even more fundamental problem: last year’s version of this report made inflated claims.

Last month, a similar study covering the potential impacts of Medicaid expansion in North Carolina highlighted the problems with the 2018 LSU report. While calculating the federal dollars attributable to Medicaid expansion, the North Carolina researchers subtracted “the federal tax credits that otherwise would have been paid for individuals with incomes between 100% and 138% of poverty for” coverage on the health insurance exchange.

Inflating the Numbers
After months of public records requests by the Pelican Institute, the LSU researchers acknowledged they, unlike their counterparts on the North Carolina study, did not subtract these foregone exchange subsidies when calculating the “net new federal dollars” attributable to Medicaid expansion.

The university stated that although the researchers “indicated the desire to analyze other data” regarding exchange subsidies, they ultimately “did not do so.” Because the researchers did not subtract the federal exchange subsidies forfeited by new Medicaid recipients, they inflated the “net new federal dollars” attributable to expansion. Additionally, the study inflated the number of jobs supposedly associated with Medicaid expansion by a sizable amount.

According to the federal Centers for Medicare and Medicaid Services, subsidized enrollment on Louisiana’s exchange fell by nearly half, from 170,806 in March 2016 to 93,865 in March 2018. More than 96 percent of that decline came from the narrow sliver of the population that moved to Medicaid from the exchange and now qualifies for expansion. Multiplying these tens of thousands of individuals by the average exchange subsidy provided to them means last year’s study overstated the “net new federal dollars” attributable to expansion by hundreds of millions of dollars, plus thousands of jobs.

Oversight or Intentional?
On three occasions, the Pelican Institute asked the researchers to retract the flawed study. The researchers failed to acknowledge these requests. The Pelican Institute also pointed out the flaws in last year’s study to LDH. According to the public records requests, the lead LSU researcher sent Louisiana Department of Health Secretary Rebekah Gee and Medicaid Director Jen Steele a copy of the Pelican Institute’s rebuttal—which prominently noted its inaccuracy—on April 25, 2018.

As the officials responsible for a $12 billion Medicaid program, Gee and Steele undoubtedly know federal law made individuals who qualified for Medicaid expansion ineligible for exchange subsidies once expansion took effect. Therefore, they should also know that by failing to subtract the foregone exchange subsidies in its calculations the study inflated the impact of Medicaid expansion. Despite these facts, LDH is spending even more taxpayer dollars to produce a predictably flawed follow-up report.

With so much conflicting information circulating around Medicaid expansion, the people of Louisiana deserve the truth, not more inflated claims from flawed studies. Coming on the heels of stories about Medicaid recipients with six-figure incomes and tens of thousands of individuals dropping private insurance to enroll in expansion, this study is the latest instance of LDH failing to disclose important facts to the public.

Lawmakers should increase their oversight of the Medicaid program, and taking a close look at this study is a good place to start.

Chris Jacob (info@pelicaninstitute.org) is a senior fellow with the Pelican Institute and founder and CEO of Juniper Research Group, a policy consulting firm. An earlier version of this article was published in the Houma Courier on July 27.
Health Insurance Participation Rates Show Federal Reforms Are Working

By Brian Blase

The latest U.S. Census Bureau survey shows a sizable increase in the number of Americans without health insurance. The number of uninsured climbed from 25.6 million in 2017 to 27.5 million in 2018. Only two demographic groups experienced significant declines in coverage: people in Medicaid-expansion states with incomes below the poverty line (about $25,000 for a family of four) and people with incomes above 400 percent of the poverty line (about $100,000 for a family of four).

Democrats were quick to argue the Trump administration is sabotaging Obamacare. The truth is that the administration has worked aggressively to increase options for affordable health care and address Obamacare’s failings. In fact, the Census Bureau numbers are further proof that the administration has taken the correct actions to date.

Obamacare Effect

Just before Obamacare took effect, government experts projected it would lead to nearly 30 million people being insured in the individual market by now. The new exchanges were supposed to offer attractive coverage. At the time, there were around 11 million people covered in the individual market, so the projected increase was substantial.

Obamacare, however, pushed up costs dramatically and caused insurers to leave markets. Rather than 30 million enrollees, only about 14 million enrolled — many of them shoved out of plans they liked. Nearly 70 percent of those enrolled now receive huge subsidies, and millions of middle-income Americans who don’t qualify for subsidies have been priced out of the market. Federal taxpayers now are paying more than $50 billion a year in Obamacare subsidies, and new individual-market enrollment is up by only about three million people.

Obamacare has created a major incentive for people to wait until they need health care to purchase coverage. People can buy insurance after they are sick and still get the same rates as healthy people. Others stop paying premiums in the fall and, because of Obamacare’s design, can stay covered for the rest of the year. As they’ve learned more about how Obamacare works, it should not be surprising that more people have figured out how to game the system, causing higher premiums for others.

Four Market Solutions

Last year, the Trump administration reversed an Obama-era policy that severely restricted the ability of people to purchase short-term insurance coverage. The new rule gives Americans the ability to purchase more-affordable plans that allow their families to get insurance if they, say, lack workplace coverage, decide to further their education, or retire early.”

Democratic attorneys general are leading a lawsuit against this rule change, but the administration is fighting back in the courts.

Reversing another Obama-era policy, the Trump administration is allowing employers to make tax-free contributions to reimburse workers who purchase policies in the individual market. The administration estimates in five years, 800,000 employers, nearly 90 percent of them with fewer than 20 workers, will offer these Health Reimbursement Arrangements, covering more than 11 million people. Far from sabotaging the individual market, this will increase its size by an estimated 50 percent and reduce the number of uninsured by nearly one million.

Finally, the administration has approved several waivers allowing states to redirect money to finance care for those with expensive health conditions. The states that received these waivers had an average premium reduction of nearly 8 percent, compared to an average premium increase of 3 percent in other states.

Medicaid Smoke and Mirrors

The vast majority of Obamacare’s coverage gains have been achieved by putting able-bodied adults on Medicaid—traditionally a welfare program for the disabled and lower-income children, pregnant women, and some seniors.

States that adopted the law’s Medicaid expansion have experienced a surge in enrollment. Unfortunately, many enrollees have incomes well above the eligibility thresholds. Recent research shows two and a half to four million people may have been wrongly enrolled in Medicaid in 2017. Since 2017, states have had to bear a small but growing share of the expansion cost. Some are finally checking eligibility and removing people who are ineligible, which likely contributed to the two million person decline in Medicaid enrollment from 2017 to 2018.

It is especially notable that coverage among people below the poverty line in Medicaid-expansion states declined by 1.5 percent. Americans in this group are eligible for what is essentially “free” coverage through Medicaid, but a growing number of them are not enrolling, indicating the low value they place on the coverage. These individuals should not be thought of as uninsured in a practical sense, because they can generally enroll for coverage in the program after they receive services.

The Trump administration has expanded affordable options that will significantly increase the number of people with insurance, including individual-market Obamacare coverage. Far from proving the administration has “sabotaged” the law, the Census Bureau’s new data provide compelling support for the president’s actions.

Brian Blase, Ph.D. (brian@blasepolicy.org) is president of Blase Policy Strategies, a senior fellow at the Galen Institute, and served on the White House’s National Economic Council. An earlier version of this article was published at National Review Online, September 11, 2019. Reprinted with permission.
Michigan’s CON Laws Undermine Cancer Treatment

By Matthew Glans

MICHIGAN is one of 35 states that have certificate of need (CON) laws, which are intended to decrease duplication and promote health care consolidation. Unfortunately, CON laws increase health care costs and limit patients’ access to treatments by reducing competition and innovation and forcing providers to use older facilities and equipment.

Although most CON law disputes involve the construction or expansion of physical facilities, they also apply to new treatments and services clinics and hospitals want to provide. In Michigan, a controversy has emerged over a recent vote by the Michigan Certificate of Need Commission to impose new accreditation requirements on health care providers that want to offer new immunotherapy cancer treatments.

Simple Blood Transfusion

These promising treatments work within the body’s immune system to attack and kill cancer cells. At the center of the debate is a process known as Chimeric Antigen Receptors Therapy (CAR-T) where T cells within a person’s immune system are bioengineered to attack cancer cells. Under Michigan’s CON rules, hospitals seeking to provide CAR-T services will have to go through an additional accreditation process via the Foundation for the Accreditation of Cellular Therapy. This is in addition to the lengthy and costly CON approval process.

Anna Parsons, a policy coordinator with the American Legislative Exchange Council, told Reason.com, “The safe administration of CAR-T cell therapy does not require hospitals to make new capital investments—which is the only time CON laws should apply. Literally any FDA-certified hospital should be capable of offering these treatments, since all the high-tech bioengineering is done at other locations. The only thing that happens at the hospital is a simple blood transfusion.”

These new rules were proposed at the urging of the University of Michigan Health System, the state’s largest hospital system, which argues the measures are necessary to ensure patient safety. Although CAR-T is still under development for most types of cancers, it has been approved for children suffering from leukemia and for adults with advanced lymphoma.

“Like all industries, when the U.S. health care system has improved, it has been because of competition and innovations born in the free market, not because of government regulation. If health care providers have the means to expand and innovate, they should be encouraged to do so.”

Suppressing Innovation, Raising Prices

CON laws are outdated and obtrusive regulations that hold back health care innovation. According to a profile of Michigan’s CON laws by the Mercatus Center at George Mason University, health care spending in Michigan would drop by $215 per person if CON laws were repealed.

In addition to lowering health care costs, eliminating CON laws would improve health care quality and access for all Michiganders. Michigan could have 72 more hospitals if it eliminated its CON laws, according to Mercatus. Furthermore, patients could have access to more imaging tests (such as MRIs and X-rays) outside the hospital setting, resulting in less travel, lower costs, and more consumer choice.

CON laws also raise the price of health care services. The Kaiser Family Foundation found a positive correlation between the number of CON law restrictions in a state and the cost of health care. States with CON laws on 10 or more services averaged per capita health care costs 8 percent higher than the $6,837 average for states requiring CON for fewer than 10 services.

Blocking Access to Care

In addition to the effect on health care outcomes and prices, CON laws also give undue influence to existing providers during vetting processes. When a health care company applies to enter a new market, existing providers often use CON laws to block the potential competition. As a result, CON laws raise health care costs by preventing new medical providers from competing with existing hospitals.

Placing CON restrictions on CAR-T would severely curtail the number of hospital-based cancer centers allowed to offer these potentially lifesaving treatments. Like all industries, when the U.S. health care system has improved, it has been because of competition and innovations born in the free market, not because of government regulation.

If health care providers have the means to expand and innovate, they should be encouraged to do so. Unfortunately, far too many states unnecessarily limit the expansion of health care providers and services because of outdated and unnecessary CON laws, which lack transparency and political accountability.

Michigan policymakers should repeal these monopolistic, misguided laws.

Matthew Glans (mglans@heartland.org) is a senior policy analyst at The Heartland Institute, publisher of Health Care News.

Medicare for All Could End Bernie’s Chance for Stents

By Jane Orient, M.D.

Democrat presidential contender Sen. Bernie Sanders (I-VT) had to cancel some campaign events because of chest pain and treatment for clogged arteries. He received two coronary artery stents.

At press time, he was reported to be doing well. We physicians are very pleased when medical technology and physicians’ skills can stave off a heart attack and prevent disability and premature death.

But what would Bernie’s Medicare for All mean for you if you get chest pain—especially at age 78 or older, like Bernie?

Too Old to Matter?

Remember the famous article by Obamacare architect Zeke Emanuel: “Why I Hope to Die at Age 75: An argument that society and families—and you—will be better off if nature takes its course swiftly and promptly.”

Emanuel stated what he plans to do after age 75.

“If I develop cancer, I will refuse treatment,” Emanuel wrote. “Similarly, no cardiac stress test. No pacemaker and certainly no implantable defibrillator. No heart-valve replacement or bypass surgery.”

Maybe he would accept a stent. What about those who want to choose otherwise? From the standpoint of “population health” and bioethics, with its focus on “limited resources,” what is the correct answer when an older patient presents with chest pain?

We might say, “Sorry, there are 40-year-olds who need drugs for HIV; babies who need a well-baby check; migrants with multiple-drug-resistant tuberculosis; pregnant women without prenatal care; teenagers seeking abortions. How can we justify cardiac catheterization labs in every hospital when there are so many unmet needs? And an elderly patient with bad arteries is likely to have future emergencies also.”

Emanuel and others outlined the “complete lives system” in The Lancet in 2009. Societal resources, it holds, are best allocated to persons between the ages of 15 and 40. Bernie’s fans might ask whether this should apply to their favored candidate—or to themselves and their loved ones.

Medicare for All will clearly reallocate resources now used for the elderly.

Jane M. Orient, M.D. (jane@napsonline.org) is executive director of the Association of American Physicians and Surgeons.
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