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HEALTH CARE NEWS

THE MONTHLY NEWSPAPER FOR HEALTH CARE REFORM

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Vol. 16 No. 7 ~ August 2015

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Vermont residents now have to pay 6 percent more for soft drinks under a new sales tax that began in July.

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Medical Device Tax Repeal

The U.S. House passed a bill to repeal a tax estimated to cost medical device manufacturers about \$194 million per month and the loss of 43,000 jobs.

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The U.S. Food and Drug Administration is tightening its approval process for imports from India's \$15 billion a year drug industry.

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Obamacare Repeal Effects

Repealing Obamacare would increase U.S. gross domestic product by about 0.7 percent between 2021 and 2025.

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Supreme Court Ruling Doesn't Stop Efforts to Repeal, Replace Obamacare

By S.T. Karnick

In June, the U.S. Supreme Court ruled in favor of the Obama administration's move to make federal tax subsidies available to all Americans, regardless of whether they purchased health insurance in a state-established or federal health insurance exchange.

Rather than end the political battle over the unpopular program, the court's 6-3 ruling in *King v. Burwell* appears to have strengthened the motivation of Obamacare's strongest critics by making it clear only Congress can repeal and replace Obamacare.

The Court's decision, which the plaintiffs argued directly contradicted the wording of the Affordable Care Act, averted a change that both proponents and critics agreed would have made the system completely unworkable.

Now both sides are gearing up for resumption of the political fight over Republicans' promises to repeal and replace the law, which had previously been muted by the pending Court decision.

Budget Reconciliation Option

Peter Ferrara, a senior fellow for entitlement and budget policy at The Heartland Institute, which

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After Ruling, States May Close Exchanges

By Kenneth Artz

In the wake of the U.S. Supreme Court's decision in *King v. Burwell*, Republican legislators in states that established state health insurance exchanges during the implementation of Obamacare are actively seeking to transfer those operations to the federal government.

With federal contributions for states' implementation of Obamacare begin-

ning to run out, these lawmakers argue operating a state health insurance exchange is a luxury their taxpayers can't afford.

No more federal grants were awarded after January 1, 2015, so all state health insurance exchanges will bear the full cost beginning January 1, 2016.

The combined impact of the Supreme

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GAO: Half of All Medicaid Money Is Spent on Only 5% of Enrollees

By Bruce Edward Walker

A small percentage of Medicaid-only enrollees—those who are not also eligible for Medicare—account for a large percentage of total Medicaid expenditures for Medicaid-only enrollees, according to a new report from the U.S. Government Accountability Office (GAO).

In “Medicaid: A Small Share of Enrollees Consistently Accounted for a Large Share of Expenditures,” GAO analyzed data collected between 2009 and 2011, finding in each fiscal year the most expensive 5 percent of Medicaid-only enrollees accounted for almost half of the expenditures for all such enrollees. The least expensive 50 percent of Medicaid-only enrollees accounted for less than 8 percent of the expenditures for these enrollees.

According to GAO, the most expensive 5 percent of beneficiaries were disabled, children, mentally ill, or had diabetes. In 2013 there were about 72 million Medicaid enrollees whose expenditures totaled about \$460 billion in fiscal year 2013.

Does Not Work Well for the Poor

Peter Ferrara, a senior fellow for The Heartland Institute, which publishes *Health Care News*, says Medicaid is not well-run by the federal government. Ferrara says the states should run Medicaid instead.

“First, the Constitution does not give the power to provide welfare and perform income redistributionist policies to the federal government,” Ferrara said. “The feds are given the power to promote the general welfare, which means perform functions that benefit everyone. Examples include the national defense, foreign relations, the administration of justice, the national highway system, [and] the national post office. The Constitution envisioned welfare to be a domain of the states.”

Each state should be given the freedom to experiment as to how to best provide health care for the poor, says Ferrara.

“Fifty states could then try 50 experiments as to what works best, and the states could then learn from each other,” said Ferrara. “Moreover, the same answer may not be right for all 50 states. Some states have higher incomes and higher health care costs; others have lower incomes and lower costs. With power and control devolved to the states, the voters of each state

“The current trajectory of Medicaid spending is unsustainable. If we are to truly care for the neediest among us, we need to look at wholesale program reforms, such as ending categorical eligibility for most federal welfare programs and imposing cost-sharing and/or time limits for able-bodied recipients.”

NAOMI LOPEZ-BAUMAN
DIRECTOR OF HEALTH CARE POLICY
GOLDWATER INSTITUTE



know who to hold accountable for the program, and they can better exercise democratic control over the program to enact their own state preferences.”

Medicaid is a very troubled, poorly functioning program not working well for the poor, Ferrara says, noting the failures are due to shared responsibilities between state and federal governments. The program does not pay doctors and hospitals enough to provide first-rate health care because of overlapping authority and a poor program design.

If states provided impoverished Americans with health insurance vouchers they could use to buy the health insurance they prefer, says Ferrara, everyone would be much better served. Impoverished people would have the same health care as many middle-income earners, because they would have the same health insurance offered to middle-income Americans.

“Private health insurance has to pay doctors and hospitals enough so their insured can get health care,” Ferrara said. “Otherwise, they would have no customers. Each state could then also determine what work requirement their Medicaid assistance should be subject to. This worked fabulously in the 1996 reforms of just one federal welfare program. That should be expanded to all.”

Block-Grants are Necessary

Jack McHugh, a policy analyst for the Mackinac Center for Public Policy, says the problems found in the GAO study exemplify the major deficiencies of federal health care programs, and he argues for devolving those respon-

sibilities to the states.

“This is another good reason to block-grant Medicaid to the states and let them tailor programs to meet the needs of their own unique populations, rather than having to follow one-size-fits-none diktats from Washington, DC,” McHugh said. “States could then establish reasonable rules to eliminate some of the perverse and destructive incentives that currently dominate today’s medical welfare state.”

Spending Is ‘Unsustainable’

“The current trajectory of Medicaid spending is unsustainable,” said Naomi Lopez-Bauman, director of health care policy at the Arizona-based Goldwater Institute. “If we are to truly care for the neediest among us, we need to look at wholesale program reforms, such as ending categorical eligibility for most federal welfare programs and imposing cost-sharing and/or time limits for able-bodied recipients.”

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Supreme Court Ruling Doesn't Slow Opposition

Continued from page 1

publishes *Health Care News*, says the Republican majorities in the U.S. House and Senate can pass legislation repealing Obamacare and enacting free-market health care reforms to replace it using the budget reconciliation process, which is not subject to a Senate filibuster.

"That would be entirely fair game, because Obamacare was passed using reconciliation," Ferrara said.

Republicans are considering plans for a complete repeal-and-replace law based on freedom of choice, market incentives, and competition, which would assure essential health care for all, with no individual mandate, no employer mandate, and trillions of dollars in reduced government spending, taxes, and regulatory cost burdens, says Ferrara.

"Obama would still veto the repeal and replace passed by reconciliation," he said. "But in the process, the public would be educated about what the alternative to Obamacare is, and I am confident large majorities would be con-

"Obviously the ACA will not go away while Obama is president and has the veto to protect it, but ... [Republicans] do need to show some progress toward the goal of repeal."

**TEVI D. TROY, PRESIDENT
AMERICAN HEALTH POLICY INSTITUTE**



vinced that the free-market approach would be much better for them than Obamacare's government-controlled and -dictated medicine.

"I am sure the Democrats would consequently suffer a grievous price in next year's elections for Obama's ideological stubbornness and extremism on

the issue," he said.

Republicans are in a holding pattern right now, says Tevi D. Troy, president of the American Health Policy Institute, as they try to figure out what can be done without a veto-proof 60 votes in the Senate and facing a president who has promised to veto any real reform of his signature law, despite its obvious flaws and public discontent toward it.

"Obviously the ACA will not go away while Obama is president and has the veto to protect it, but ... [Republicans] do need to show some progress toward the goal of repeal," he said.

Troy says it's important for Congress to go on the record soon as offering a way to repeal and replace Obamacare, because there is a limited time before the public will come to accept the sys-

tem as established, regardless of any flaws.

"Let's say there's a law passed and nobody does anything about it for 10 years, with no votes for disapproval, and suddenly you decide to vote now to repeal it. I don't think that would have much of a chance," he said.

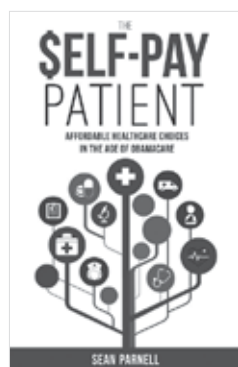
There are positive steps the Republicans can take while Obama is still president, Troy says. Potential reforms with current bipartisan support include repeal of the medical device tax and the "Cadillac Tax," an excise tax that increasingly affects non-wealthy taxpayers with high-end employer-based health plans.

S. T. Karnick (skarnick@heartland.org) is research director for The Heartland Institute.

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Black Market for Salt in Ind. School Cafeteria

By Kenneth Artz

A black market for salt packets has developed among schoolchildren at a district in Indiana to help the students flavor their bland, unappetizing lunches.

The salt reduction is the result of a federal mandate initiated by the Healthy, Hunger-Free Kids Act (HFKA), legislation championed by First Lady Michelle Obama. The guidelines are designed to force children to eat healthier by forbidding them from consuming items they enjoy, but it has not achieved the desired results.

A school administrator from Hartford City, Indiana told a U.S. House of Representatives subcommittee a “contraband economy” in food flavoring packets had arisen in response to HFKA. He says the kids have been caught bringing and even selling salt, pepper, and sugar in school to add taste to bland and tasteless cafeteria food.

Says Diet Is Unhealthy

Julie Kelly, a cooking teacher and writer, humorously says this phenomenon should be counted as a win for the district because the new federal school lunch program has kids smuggling in salt and pepper instead of other illegal substances.

“In all seriousness, the new nutrition guidelines are not just unrealistic but could have the effect of repelling kids from healthy foods for a lifetime,” Kelly said. “The goals are admirable, but the approach is questionable. The truth is that you can still eat healthy food that contains reasonable levels of salt, sugar, and fat. Removing these ingredients from food not only strips flavor from every meal but denies children the vital nutrients that are crucial to their development.”

Kelly says the salt smuggling will only get worse over the next several years as HFKA requires schools to cut sodium levels in half by 2022, when meals for grade-schoolers will be limited to only about a one-fourth teaspoon of sodium.

“There is no evidence to suggest this is a healthy approach to feeding kids,” Kelly said.

Protecting Kids from ... Pickles

At a congressional hearing in June, one lawmaker told Tom Vilsack, the U.S. secretary of agriculture, a teacher at a local school had to ration pickles during lunchtime. The students were

allowed only three pickles instead of four because the extra pickle would exceed salt limits, Kelly says.

“Is this really how educators should be spending their time, protecting 3rd graders from pickles?” Kelly asked.

Jeff Stier, a senior fellow at the National Center for Public Policy Research, says the problems result from a nanny-state mentality in which government doesn’t trust citizens to make sensible decisions. Stier says the premise behind HFKA is scientifically unsound, as it falsely assumes if something is unhealthy at high levels it is proportionately unhealthy at lower levels, and if something is unhealthy for some people it is harmful to all.

“Just because very high levels of salt are a problem for some, does not mean bringing levels down from moderate to low will add any gains,” Stier said.

‘Tastes Like Prison Food’

“I’ve heard critics of the school lunch program say it tastes like prison food,” Stier said.

“We’re creating a prison-like environment of trading contraband ingredients in school,” Stier said. “Look what we’re doing to our children. I think the best way is to give kids access to salty foods, sugary foods, and all the foods they want to ban. Give kids access to these products and, under supervision, let them learn how to consume them appropriately.”

Right now schools are teaching the exact opposite lesson, he says.

“I don’t want kids to grow up that way,” Stier said. “I want them to say, ‘Salt and sugar, I learned in school, it’s OK to eat in moderation.’ Otherwise it’s going to be, ‘Salt and sugar, oh my gosh, I can’t wait to get my hands on it when there are no adults looking.’”

“By criticizing these government regulatory programs, I’m not saying kids should have unlimited, unfettered access to [these foods],” Stier said. “Instead, I’m saying this is a learning opportunity.”

Kenneth Artz (iamkenartz@hotmail.com) is managing editor of Health Care News.

“There is no evidence to suggest this is a healthy approach to feeding kids.”

**JULIE KELLY
POLICY ADVISOR
THE HEARTLAND INSTITUTE**

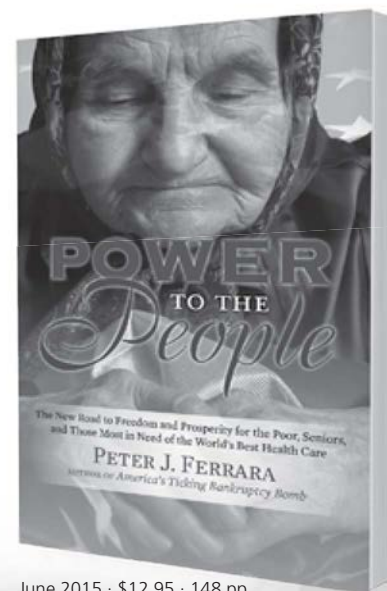


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After Ruling, States Reconsidering Exchanges

Continued from page 1

Court decision and funding termination on state-run exchanges is likely to be profound, especially with so many of them already being in financial trouble, says Dr. Doug Perednia, author of *Overhauling America's Healthcare Machine*.

"As of May 2015, roughly half of the 17 exchanges established by states were in financial trouble," Perednia said. "With the subsidies removed, there is little or no reason for states to continue operating their own exchanges, and we will see many, if not all of them, disappear over time."

'Wise States' Stayed Out

Twila Brase, president of the Citizens' Council for Health Freedom, says citizens in the states that did not set up health insurance exchanges will be able to get premium subsidies from the federal government through Healthcare.gov because of the Supreme Court decision.

"These states dodged the bullet," says Brase. "They were the wise states. They saw the expensive trap. They saw the federal control over the state exchange and said no."

States without exchanges have no doubt seen how difficult it was for those with state exchanges, Brase says.

Brase cites several examples. Oregon spent \$300 million, never got its exchange running, and switched to Healthcare.gov. Hawaii started shutting down its state exchange before the Supreme Court ruled. Nevada switched to the federal exchange. Colorado added new fees to try to cover the cost.

"No state, no legislature, and no gov-



"As of May 2015, roughly half of the 17 exchanges established by states were in financial trouble. With the subsidies removed, there is little or no reason for states to continue operating their own exchanges, and we will see many, if not all of them, disappear over time."

DR. DOUG PEREDNIA, AUTHOR OF OVERHAULING AMERICA'S HEALTHCARE MACHINE

ernor will likely even consider the idea [of opening a state exchange now,] Brase said. "Not creating an exchange improves the state budget, lets the state use those dollars for more pressing priorities, and prevents the lawsuits, technological snafus, bad press, and defeat other states have faced. I expect many states will terminate their state exchanges."

Minnesota Exchange Disaster

The Minnesota exchange recently reported a backlog of 180,000 reenroll-

ments caused by technical problems, Brase says.

"This may be the end of MNsure, the state's health insurance exchange," Brase said. "Come next session, I expect Minnesota to consider a repeal of the MNsure exchange and a switch to Healthcare.gov."

"I expect much or all of the entire exchange enterprise will be on the shoulders of the federal government until the law is repealed," Brase said. "Democrats in the U.S. House wanted a national exchange. It appears that's what they're going to get, although it's still not fully functional and the funding for it may become a political football as a way to impede continued implementation of the law."

Defaulting to Federal Exchange

The ruling in *Burwell* puts many of the remaining state-based exchanges on a death watch, says Josh Archambault, a senior fellow at the Foundation for Government Accountability.

"Many of the state-based exchanges have had low enrollment, so they are unlikely to be sustainable on their own," Archambault said. "With federal taxpayer money drying up, it is likely state legislatures will eventually follow the lead of Hawaii, Nevada, and Oregon and default to Healthcare.gov. It may take a few years in a handful of states to make this move, due to ideological or political reasons, but most states are

not likely to spend \$50 to \$100 million a year keeping a state-based exchange afloat at the expense of education programs, public safety, or road projects."

Some states have already started to discuss using even more state funds to keep their state-based exchange open, while others are considering assessing a fee on all insurance plans sold in their state. Some are even considering taxing plans not sold on the exchange in addition to those that are, Archambault says.

"If small businesses and state lawmakers wise up, this proposal will be challenged, as it raises the expense of insurance for everyone in the state unnecessarily and is in direct contradiction to the name and stated goal of the Affordable Care Act," Archambault said.

Kenneth Artz (iamkenartz@hotmail.com) is managing editor of Health Care News.

Va. Committee to Look at Repeal of State's CON Laws

Critics of Virginia's Certificate of Need (CON) laws say they create artificial monopolies on health care services, stifle competition, and prevent communities from receiving vital medical services. During the past Virginia legislative session, a bill was passed to assemble a working group to develop a set of recommendations for reforming Virginia's CON law.

Mike Thompson, chairman and president of the Thomas Jefferson Institute for Public Policy in Virginia, says it's high time the legislature abolish this clunky, outdated set of rules.

"If a hospital has done its marketing and research and wants to purchase a new MRI machine or some other expensive piece of equipment, why does it have to defend that decision to some state bureaucracy?" Thompson asked.

"They didn't make the decision to invest bazillions of dollars into their new equipment if they didn't think it would be beneficial to them, the patients, etc.," Thompson said. "It makes about as much sense as the 7-Eleven having to go before the state commerce department entity to say: I want to start a new 7-Eleven down the street."

— Kenneth Artz

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Vt. Soda Tax Fizzles with Businesses, Retailers

By Sean Parnell

Vermont residents now have to pay 6 percent more for soft drinks under a new sales tax that began in July.

The tax is part of a \$30 million package of tax increases intended to help close a \$113 million gap between projected state spending and revenue. The sales tax on soft drinks is estimated to generate \$7.9 million annually.

One especially unpopular provision in the new law exempts customers who

use food stamps from the sales tax on soft drinks. Critics say the exemption for those who use food stamps removes the incentive to make healthier beverage choices, which the tax's proponents argued was the primary benefit of the soft drink tax.

Soda Tax Is a Money Grab

This measure is nothing more than another tax grab in the guise of government discouraging use of a disfavored food product, says Dr. Gilbert Ross, executive director of the American Council on Science and Health.

"Look, if they're going to tax sugary sodas as well as nonalcoholic drinks with either natural or artificial sweeteners, then clearly the intent of the law is not to combat obesity, as artificial sweeteners have zero to do with promoting obesity," Ross said.

Even taxing actual sugary beverages does nothing to combat obesity, no matter what the sponsors of such laws say, Ross says. In addition to being a tax grab, the law will turn out to be a bureaucratic nightmare for many store-owners and shopkeepers in Vermont, he says.

"I feel sorry for them," Ross said. "They should make their feelings known to the misguided lawmakers who instituted this inane measure."

Compliance Nightmare Seen

Another big problem with this tax is it applies to everything with sugar or sweetener in it, making it difficult for small businessmen to comply with, says Seton Motley, president of the public policy organization Less Government.

"For Vermont's legislators to come up with this tax on sodas is laughable and proves they don't have enough experience to even run a lemonade stand," Motley said.

'Will Do Nothing to Ease Obesity'

In an attempt to punish soda drinkers, the government ends up punishing small business owners and retailers, says Julie Kelly, a food writer and policy advisor to The Heartland Institute, which publishes *Health Care News*.

"One can only imagine the amount of time used to research, debate, lobby, and implement this law that will do nothing to ease obesity or the state's budget gap," Kelly said.

"For Vermont's legislators to come up with this tax on sodas is laughable."

SETON MOTLEY
PRESIDENT
LESS GOVERNMENT

"It's always funny to read how state legislators, whose lack of fiscal discipline has basically bankrupted their state government, like to 'tsk-tsk' people about 'bad' habits," Kelly said. "Dumb laws like this might make them feel better, but they're totally ineffective at accomplishing anything but frustrating consumers and business owners."

Sean Parnell (sean@impactpolicymanagment.com) is a policy advisor to The Heartland Institute and president of Impact Policy Management, LLC.

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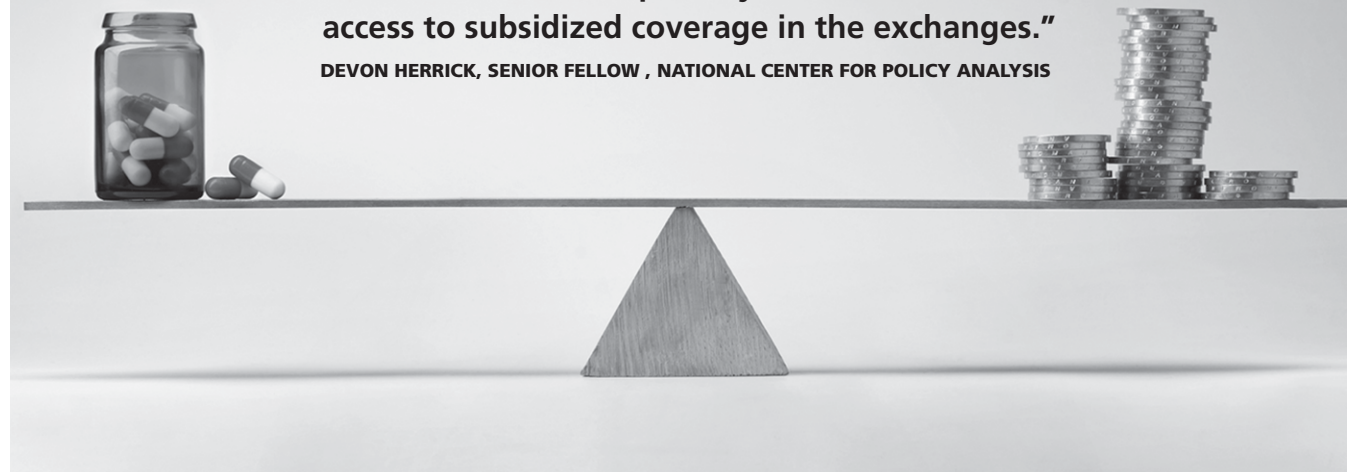
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HHS Coercing States to Expand Medicaid, Ten States Say

"States would be foolish to expand Medicaid eligibility above the poverty level because poor individuals at the poverty level would lose access to subsidized coverage in the exchanges."

DEVON HERRICK, SENIOR FELLOW, NATIONAL CENTER FOR POLICY ANALYSIS



By Danni Ondraskova

According to a mid-July tally by the Kaiser Family Foundation, 21 states have not expanded their Medicaid programs as urged by the Obama administration and incentivized under Obamacare.

Holdouts include most Southern states and half of the Midwestern states.

HHS has taken steps to nudge reluctant states, allowing them to use Medicaid funds to pay for private insurance and require some enrollees to make health insurance premium payments. Arkansas, Indiana, and Iowa included such provisions in their Medicaid expansion programs.

On June 23, attorneys general from Florida, Kansas, Texas, and seven other states sent a joint letter to Rep. Fred Upton (R-MI), chairman of the House Committee on Energy and Commerce, asking for an investigation of allegedly coercive actions by HHS to force states to expand Medicaid.

CMS Actions Are Coercive

One grievance listed in the letter involves the Centers for Medicare and Medicaid Services (CMS), an agency run by HHS. CMS had announced unless Florida expanded its Medicaid coverage, the state would not receive \$1 billion in federal funding to support its Section 1115 program, an initiative supported by the Social Security Act

allowing states to fund health care providers serving underserved populations who would otherwise not have access to Medicaid.

Devon Herrick, a senior fellow at the National Center for Policy Analysis, says CMS's actions are coercive.

"The Obama administration's stated reason, [which is] that health coverage is more efficient than charity care, is meant to effectively deprive states of federal help for charity care unless states expand their Medicaid programs," Herrick said.

It's an important issue because expanding Medicaid to cover families above the poverty level moves people from private insurance into Medicaid, which provides inferior coverage, Herrick says.

"Families at the poverty level already have access to subsidized coverage in the [health insurance] exchange," Herrick said. "States would be foolish to expand Medicaid eligibility above the poverty level because poor individuals at the poverty level would lose access to subsidized coverage in the exchanges."

States Should Promote Innovation

Matthew Glans, a senior policy analyst at The Heartland Institute, which publishes *Health Care News*, says the Obama administration is sacrificing the best interests of states in favor of an agenda for expanding dependency on federal government programs.

"Since the introduction of Obamacare, the federal government has used Medicaid dollars as a carrot to entice state governments to undergo reforms against their best interests," Glans said. "States should hold fast against Medicaid expansion and follow Florida's lead in pushing innovative reforms such as its 'Medicaid Cure.'"

Danni Ondraskova (danni.heartland@gmail.com) writes from Chicago, Illinois.

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Georgia Certificate of Need Law Faces Legal Challenge

The Goldwater Institute has filed a lawsuit on behalf of two Georgia OB/GYN doctors challenging the state's medical certificate of need (CON) law. The plaintiffs argue the law is unconstitutional because it is "a restraint on competition, economic liberty, and consumer choice."

CON regulations prevent health care providers from entering new markets and increasing existing capacity without first gaining approval from state regulators, such as the Georgia Department of Community Health (DCH). When a company applies to enter a new market, competitors can use the CON process to block them, which means CON regulations can allow a few large hospital chains to control the market and keep prices high.

Entrenched special interests justify CON regulations by claiming they keep health care costs down by preventing overinvestment in facilities and equipment. States also justify CON programs as a way of cross-subsidizing health care for the poor. A 2014 study by the Mercatus Center at George Mason University rendered those claims dubious; it found no relationship between CON regulations and increased access to health care for the poor.

Jim Manley, a senior attorney for the Goldwater Institute's Scharf-Norton Center for Constitutional Litigation, is the lead attorney on the lawsuit filed in the Fulton County Superior Court on behalf of the two doctors against officials at DCH.

"We're representing two OB/GYNs who went to the Georgia Department of Community Health to ask for a slight modification to their situation so that other OB/GYN doctors could use their state-of-the-art facilities to perform procedures," Manley said.

The CON application and review process is quite extensive in Georgia, so the doctors hired a consultant and spent tens of thousands of dollars of their own money, only to be turned away, and the appeals process is just as arduous, says Manley.

"We view the fight against CON laws as a way to expand access to health care," Manley said.

— Kenneth Artz

FDA Tightens Curbs on Drug Imports from Firms in India

By D. Brady Nelson

The U.S. Food and Drug Administration (FDA) has tightened checks on its approval process for India's \$15 billion-a-year drug industry, which is still rebuilding its image in its largest market, the United States, following a high-profile case in which the U.S. Department of Justice fined Indian firm Ranbaxy \$500 million for drug safety violations.

The Central Drug Standards Control Organization (CDSCO), India's version of FDA, announced it will appoint 147 drug inspectors by the end of 2015. An additional 1,195 posts have been authorized under the 12th Five Year Plan of the Government of India.

India's pharmaceutical industry supplies approximately 40 percent of the over-the-counter and generic prescription drugs consumed in the United States. The increased scrutiny could have profound implications for Indian pharmaceutical companies and U.S. consumers.

Could Increase Prices

An increase in manpower for India's national drug regulatory agency may appear to be an efficient and practical method to ensure the quality of drugs manufactured for use in India and for export to world markets is on par with global standards. But the reforms could also lead to increased health care expenses if proper protocols are not developed, says D. Dhanuraj, chairman of the Centre for Public Policy Research (CPPR) in India.

It could also lead to harassment and arbitrary decisions by government bureaucrats and prohibitive investment costs that deter smaller players from entering the sector, Dhanuraj says.

"CDSCO should be an independent agency, detached from political and bureaucratic controls," Dhanuraj said. "The policy decisions of the government should not be the job of CDSCO."

Picking Winners and Losers

One need only look to the threat FDA poses to U.S. businesses to see why expanding CDSCO's regulatory authority is a bad idea for Indians, said Ritu-parna Basu, an analyst for the Ayn Rand Institute.

"Both agencies exist fundamentally to decide which medical drugs and

treatments individuals are allowed to take and which they are not," said Basu. "But this is a decision that properly should be left to individuals to make with their physicians."

"The government's only role should be to define and prosecute real cases of medical fraud, malpractice, and criminal negligence," Basu said.

Regulatory System Is Outmoded

Drug inspectors are a nineteenth century method to deal with a twenty-first century challenge of quality assurance, says Parth Shah, president of the Centre for Civil Society, a pro-free-market think tank in India.

"The government does not send meter readers every month to prepare bills for water and electricity consumption anymore," Shah said. "It's time the government used India's IT power to design a non-intrusive, more accurate, and timely method of collecting drug quality data. Technology allows government or any other third party to monitor quality in real time. Let's bring the governance of the pharmaceutical industry into the twenty-first century."

Says Cooperation a Welcome Step

Joint FDA-CDSCO workshops were held in four Indian cities in May 2014, covering topics relevant to FDA regulatory requirements, such as process validation, enforcement, and computer system validation. More than 60 pharmaceutical companies participated in the workshops.

"The cooperation between CDSCO and FDA is a very welcome step," said Barun Mitra, founder and director of the Liberty Institute of India. "It is perhaps a reflection of the seriousness with which the regulator and the industry in India have begun to take note of quality issues that have dogged some of the major Indian companies lately,

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"Technology allows government or any other third party to monitor quality in real time. Let's bring the governance of the pharmaceutical industry into the twenty-first century."

PARTH SHAH, PRESIDENT, CENTRE FOR CIVIL SOCIETY

particularly those who are seeking to export to large lucrative markets in the developed countries.

"Apart from regulations and policing, what is also needed is a huge shakeup in the Indian domestic pharmaceutical sector that allows a degree of rational-

ization, greatly reducing the number of manufacturers while increasing competition and incentivizing research and development," Mitra said.

D. Brady Nelson (darren.nelson@me.com) is a columnist with Townhall.

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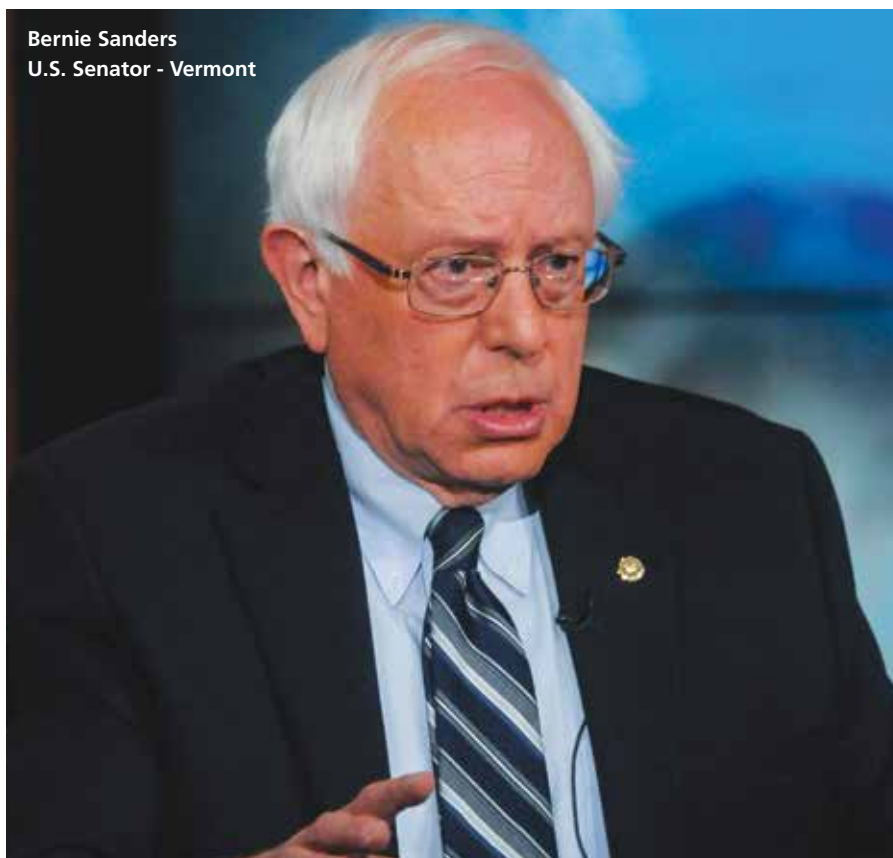


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Sen. Bernie Sanders Calls for Single-Payer

Bernie Sanders
U.S. Senator - Vermont



By Sean Parnell

Sen. Bernie Sanders (I-VT), a candidate for the Democratic presidential nomination, is calling for the United States to adopt a “Medicare-for-all” single-payer health care system similar to those in Canada and the United Kingdom.

A single-payer model would empower the government to be the primary health insurance provider and allow government agencies to decide who gets life-saving treatments and who does not.

During a June interview on ABC’s *This Week*, Sanders said, “We need to join the rest of the industrialized world” by adopting a Medicare-for-all health care system.

Many public policy experts say it would be a grave mistake for the United States to adopt a single-payer system.

Rationing or Trillions in New Debt

Sanders is a true zealot for single-payer, says Roger Stark, a health care policy analyst at the Washington Policy Center and a retired physician.

“Of note is the fact that Gov. Shumlin of Vermont campaigned for office [on the issue] and has been a strong proponent of a single-payer system for years,” Stark said.

“When it came right down to implementing it for Vermont, however, he realized the tremendous cost and backed away from the plan,” Stark said. “Sanders’ Medicare-for-everyone should be a nonstarter unless he wants the Independent Payment Advisory Board to severely ration health care or he intends to add trillions to the national debt.”

Obama’s ‘Ultimate Goal’ Too

Greg Scandlen, an independent health care analyst, says he’s not at all surprised single-payer is in the news again.

“After all, President Obama said some time ago that single-payer is his ultimate goal,” Scandlen said. “Many people suspect he created a very flawed health care ‘reform’ bill in order to crash what was a reasonably well-functioning system and leave single-payer as the only road forward. Whether or not that was his intention, it is certainly the result.”

There is in fact only one true single-payer system among all the industrialized countries, and that is in Canada, Scandlen says. The rest all have a mix of public and private programs, as the United States does. But the idea of a government program for everybody residing in the country is a longstanding fixation on the political left, he says.

“Sanders’ Medicare-for-everyone should be a nonstarter unless he wants the Independent Payment Advisory Board to severely ration health care or he intends to add trillions to the national debt.”

ROGER STARK, POLICY ANALYST
WASHINGTON POLICY CENTER

“They often call it ‘Medicare for All,’ but in fact Medicare is a very poor insurance program that has many gaps of coverage and no limit whatsoever on out-of-pocket spending,” said Scandlen. “[It’s such a poor system that it effectively] forces people ... to buy another plan [called MediGap] to supplement it. Medicare is completely unsustainable and is [quickly] running out of money and has made promises to the elderly that can never be kept. Single-payer would be the fastest way imaginable to bankrupt the country and leave us like Greece.”

Government-Imposed System

A true free market health care system would be best at ensuring high quality at the lowest possible cost, which is far from what we now have, says Merrill Matthews, a resident scholar with the Institute for Policy Innovation.

“We have a convoluted, government-imposed system under Obamacare that will be expensive and inefficient and may be unworkable,” said Matthews. “If we can’t repeal Obamacare, the country may be forced into a debate over whether a single-payer system ... is more efficient than Obamacare, and we may conclude it is.”

Sean Parnell (sean@impactpolicymanagement.com) is a policy advisor to The Heartland Institute and president of Impact Policy Management, LLC.

Illegals Should Receive Obamacare, says JAMA

Obamacare leaves behind approximately 11 million undocumented immigrants, according to a July online viewpoint in the *Journal of the American Medical Association* (JAMA).

“Not only are they excluded from premium tax credits and Medicaid—with narrow exceptions—they cannot even purchase health insurance on [the Affordable Care Act] exchanges at full price,” wrote the author of the JAMA article.

Illegal aliens are “very likely to be uninsured,” the article reports.

Between 1999 and 2007, more than half of the illegal aliens in the nation are believed to have gone without insurance.

“Uninsured and undocumented immigrants, however, are still able to access limited care through emergency services—a highly cost-inefficient method,” said JAMA.

JAMA says since there is no “humane federal policy,” state and local governments can take on the cost of providing services.

“In California, for example, 47 of the state’s 58 counties provide some low-cost health care to undocumented immigrants,” said JAMA. “However, national action is needed to guarantee universal health coverage.”

If illegal aliens do not receive subsidized health insurance, the whole concept of affordable health care in the U.S. may “unravel,” the article warns.

Gene Koprowski, director of marketing for The Heartland Institute, which publishes *Health Care News*, says Obamacare opponents feared it would be used to cover illegal aliens.

“Though the White House denied this was true, the Democrats in the statehouse in Sacramento, California, are moving forward with plans to make that happen,” Koprowski said.

“I do not doubt that the administration would approve of this if a waiver is requested for compliance with the Affordable Care Act,” Koprowski said. “The administration always gives waivers to the liberal states, while it denies them for conservative states on Medicare.”

— Kenneth Artz

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Pope's Encyclical Ignores Health Benefits of Modern Technology

By Kenneth Artz

The Vatican released Pope Francis's encyclical letter, "Laudato Si," which translates to "Praise be to You," on June 18.

The highly anticipated letter to the global Catholic community focuses on how mankind must be a better steward of Earth, which the pope says includes reducing the world's emissions of carbon dioxide.

The pope wrote, "People may well have a growing ecological sensitivity, but it has not succeeded in changing their harmful habits of consumption, which, rather than decreasing, appear to be growing all the more. A simple example is the increasing use and power of air conditioning. The markets, which immediately benefit from sales, stimulate ever-greater demand. An outsider looking at our world would be amazed at such behavior, which at times appears self-destructive."

As Francis released his encyclical, Chicago marked the 20th anniversary of the great heat wave that caused the deaths of nearly 800 people in the city in July 1995. Many of those who died were elderly, poor, and did not have air conditioning in their homes.

The role of air conditioning in preventing heat-related deaths cannot be overestimated, says H. Sterling Burnett, a research fellow for The Heartland Institute, which publishes *Health Care News*.

Prevents Premature Deaths

Air conditioning has been a boon to public health in the United States and other developed countries where it has become widespread, Burnett says.

Since its invention and installation in peoples' homes and businesses, air conditioning has prevented thousands of premature deaths due to heat-related illnesses each year and millions of lives over the decades, Burnett says.

"One of the quickest and surest ways to reduce millions of unnecessary, premature deaths in developing countries is the widespread, reliable, electrification of those countries, which requires the use of either fossil fuels or nuclear power and the rapid adoption of air conditioning," Burnett said.

Alarmed About Future

By condemning air conditioning and the use of fossil fuels, which are responsible for helping to extend lifespans and improve overall health, the pope is missing the forest for the trees, Burnett says. Fossil-fuel-powered technology allows people to remain active and productive as they reach their 70s, 80s, and 90s, all while reducing hunger and malnutrition.

"Pope Francis is worried about preventing speculative future harms from an unlikely catastrophic climate change decades from now, based on predictions of deeply flawed computer models, and is ignoring the effect of that alarmism on the very real needs of those still living in poverty, hunger, and want today," Burnett said.

Expanding the use of fossil fuels and air conditioning will save lives today, tomorrow, and into the next half-century. It will increase educational opportunities, improve economic conditions today and into the future, and ease adaptation to environmental changes, Burnett says.



PHOTO COURTESY JEFFREY BRUNOWIKIMEDIA COMMONS

"The wealth created using these tools and technologies now will allow future, wealthier generations to adapt to and/or reduce harms from climate change, whatever the changes and for whatever reasons they occur," Burnett said.

Much More Than a Luxury

The air conditioning remark exemplifies the encyclical's uninformed attack on modern industrial civilization, which owes a lot to air conditioning and fossil fuels, says Myron Ebell, director of the Center for Energy and Environment at the Competitive Enterprise Institute.

Ebell notes air conditioning's many uses, which include physical comfort, protection from dangerous outdoor temperatures, applications in chemical and biological laboratories, and keeping data centers and mainframe computers operational. Air condition-

ing also cools food cooking and processing areas, hospital operating rooms, industrial environments, mining areas, nuclear power facilities, physical testing facilities, plants and farm growing areas, and textile manufacturing facilities.

The tenor of the whole encyclical is that there are too many rich people enjoying the benefits of modern technology and energy, and therefore we need to get rid of them and spend those resources on whatever the pope considers to be the real necessities of life, Ebell says.

"In other words, we don't need to raise poor people up, we need to bring rich people down and level everyone [into poverty,]" Ebell said.

Kenneth Artz (iamkenartz@hotmail.com) is managing editor of *Health Care News*.

Senate Bill Would Allow Over-the-Counter Sale of Birth Control Without Prescription

Sens. Kelly Ayotte (R-NH) and Cory Gardner (R-CO) are sponsoring Senate Bill 1438, the Allowing Greater Access to Safe and Effective Contraception Act. The bill would allow the sale of hormonal contraceptives over the counter without a prescription.

Since Obamacare was passed and mandated private health insurance plans cover prescription contraceptives at no cost, the average out-of-pocket spending on birth control pills has dropped significantly. Devon Herrick, a senior fellow at the National Center for Policy Analysis, points out mandated benefits are not free but come with costs more efficiently borne by individuals.

"Providing contraceptive coverage without cost-sharing doesn't make contraceptives cheaper; it merely shifts the cost from the enrollees to the health plan, which charge enrollees higher premiums to compensate," Herrick said.

A new U.S. Senate bill would make contraceptives more affordable by allowing birth control pills to be sold over the counter without a doctor's prescription, he says.

"History shows that when a prescription drug is allowed to be sold over the counter, the price soon falls by 90 percent," Herrick said.

— Kenneth Artz

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Bipartisan Support to Repeal Medical Device Tax

By Danni Ondraskova

The House of Representatives passed HR 160, the Protect Medical Innovation Act of 2015 in June and is now waiting for the Senate to act. The bill would repeal the 2.3 percent excise tax on manufacturing and importing medical devices.

The tax, which took effect in January, was implemented through the Affordable Care Act and has proven to be highly unpopular. Some Democratic lawmakers are wondering whether they should heed constituents' concerns the tax kills jobs or remain loyal to party strategists who say removal of the tax could ultimately bring down Obamacare.

The tax is expected to bring in \$3.2 billion in tax revenue each year over the next 10 years to help fund Obamacare.

President Barack Obama has promised to veto the repeal bill if it passes the Senate, but there may be enough bipartisan support in Congress to secure the two-thirds majority needed to override the president, says Devon Herrick, a senior fellow with the National Center for Policy Analysis.

According to the Advanced Medi-

"The [medical technology] industry has had to tighten its belt to absorb the tax. Because the medical device tax is calculated on gross revenue, rather than on taxable income, the device makers have not been able to raise prices enough to recoup the lost profits."

DEVON HERRICK, SENIOR FELLOW, NATIONAL CENTER FOR POLICY ANALYSIS

cal Technology Association, the tax is expected to cost medical device manufacturers approximately \$194 million per month and cause the loss of up to 43,000 jobs in the medical device industry.

Adverse Effects on Producers

Herrick says the bill's bipartisan support is the result of both parties recognizing the tax's adverse effect on medical device producers. The tax causes increased prices and decreased availability of needed medical items.

"The [medical technology] industry has had to tighten its belt to absorb the tax," Herrick said. "Because the medical device tax is calculated on gross rev-

enue, rather than on taxable income, the device makers have not been able to raise prices enough to recoup the lost profits."

The tax also disproportionately harms certain medical technology companies. "A startup may suffer losses before turning a profit," Herrick said. "For instance, some medical device firms produce consumable supplies that have razor-thin margins between net profit and revenue, yet pay the same gross revenue tax as implant makers with a margin of 75 percent."

Harm to Consumers Cited

Herrick says the medical devices tax

also harms consumers and workers.

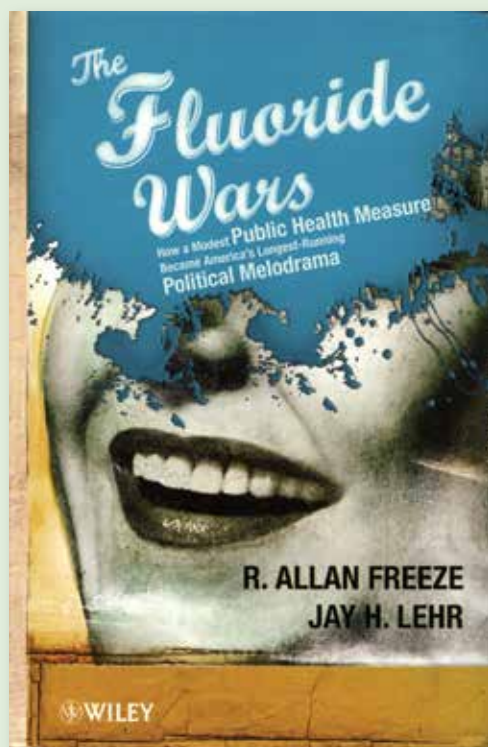
"When cash flow is tight, firms are tempted to cut research and development and quality compliance," Herrick said. "Adding the tax encourages medical device producers to move jobs offshore."

Matthew Glans, a senior policy analyst at The Heartland Institute, which publishes *Health Care News*, says the tax has the additional problem of being hidden from consumers.

"Consumers are not aware of the cost the tax adds to the product, because providers integrate the cost into the product price," Glans said. "Coverage often comes through an insurance company, and consumers are unable to see the real costs of care, which means it might as well be a 'phantom tax.'"

"The will to repeal this burdensome tax already exists, and several votes have been taken supporting repeal," Glans said. "Now is the time to finish the job."

Danni Ondraskova (danni.heartland@gmail.com) writes from Chicago, Illinois.



A LIVELY ACCOUNT OF FLUORIDATION AND ITS DISCONTENTS

Since its first implementation in Grand Rapids, Michigan, in 1945, public drinking water fluoridation and its attendant conflicts, controversies, and conspiracy theories serve as an object lesson in American science, public health, and policymaking. In addition to the arguments on the issue still raging today, the tale of fluoridation and its discontents also resonates with such present concerns as genetically modified foods, global warming response, nuclear power, and environmental regulation.

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- ✓ Fluorophobia and popular conspiracy theories involving fluoride
- ✓ The colorful characters in the debate including activists, scientists, magicians, and politicians

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A richly and considerably told tale of American science and public life, *The Fluoride Wars* offers an engrossing history to both interested general readers and specialists in public health, dentistry, policymaking, and related fields.

Medicaid Expansion Threatens N.M. Budget

By Kenneth Artz

High health care costs in government programs and other expenses have New Mexico on its way to becoming the Greece of the United States.

A July editorial in the *Albuquerque Journal* noted Greece is becoming “a textbook example of what happens when politicians hand out too much to people more than willing to take it, with nothing required in return.”

“The United States, and New Mexico, should take note,” the editorial continued.

One out of every 2.5 New Mexico residents is enrolled in Medicaid, compared to the national average of one out of every 4.5 Americans, according to the U.S. Census Bureau.

New Mexico will need to come up with \$1.1 billion annually to cover its base Medicaid program and the expansion by 2020, when almost half of all state residents will be on the newly expanded Medicaid program, the *Journal* notes. That’s with the federal government still paying 90 percent of the cost. The federal government currently pays 100 percent of the expansion cost.

Huge Enrollment Expansion

New Mexico was one of 28 states that expanded Medicaid coverage for low-income adults under Obamacare, resulting in more than 216,000 people joining the state’s Medicaid rolls, pushing the total to nearly 800,000 enrollees.

INTERNET INFO

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Combined with the loss of federal funds used to pay for the expansion in 2016, the state will soon face a serious budget crunch, says an Associated Press report.

The reduction of the federal government’s share of the expansion payments from 100 percent to 90 percent, beginning in 2017, will result in New Mexico having to pay about \$120 million of the expansion’s expenses in that year. By 2020, more than 895,000 people could be on the rolls, including 257,000 who will be covered under the expansion. Based on current projections, total general fund dollars needed to cover the state’s Medicaid program by fiscal year 2020 will be \$1.1 billion annually, including \$268 million caused by the expansion.

“In the near term, Medicaid expansion is certainly affordable, but starting in fiscal year 2018–19, it will start to present some challenges for appropriators,” said Charles Sallee, deputy director of New Mexico’s Legislative Finance Committee.

Not Limited to the Needy

Costs of government-funded health care have continually grown in recent years because of eligibility expansions, says Linda Gorman, director of the Health Care Policy Center at the Independence Institute, a free-market think tank.

“For starters, it is no longer accurate to characterize Medicaid as a health care program for the poor,” Gorman said. “It is true the program was designed for the seriously ill who cannot help themselves, but enrollment by the seriously ill is now far outnumbered by enrollment by healthy children and able-bodied adults.”

Gorman says with spending increasing rapidly because of the surge in enrollment, governments see only two ways to contain costs: cut payments to the people who provide medical services or ration the services they provide. Both courses lead to a reduction in the quality of care for the needy.

Calls for Federal Block Grants

Under the current design, spending rises continually because state governments get more money the more people they add to the program, Gorman says.

“This is one reason why one solution to out-of-control Medicaid, aside from returning it to being a program that covers only people who are seriously ill or disabled and cannot [get health care]



“In the near term, Medicaid expansion is certainly affordable, but starting in fiscal year 2018–19, it will start to present some challenges for appropriators.”

**CHARLES SALLEE, DEPUTY DIRECTOR
NEW MEXICO LEGISLATIVE FINANCE COMMITTEE**

without public help, is to start fixing the incentives by moving to [a system that offers] federal block grants to the states,” Gorman said. “After all, there is little evidence that Medicaid expansions improve [low-income people’s] health.”

A study of Oregon’s Medicaid program found expansions “increase utilization, increasing state and federal expenditures, without noticeably improving on health,” Gorman said.

Gorman says there is considerable evidence Medicaid does a poor job of helping people who are seriously ill, and its low payments ensure poor quality of care for those enrolled in the program.

That’s a bitter pill for those forced into the program to swallow, she says.

“Remember that before Obamacare they had other choices, such as mini-med coverage through part-time jobs, relatively cheap catastrophic coverage, and student health plans in college,” Gorman said.

“It’s time for a serious reform of the program, but as a practical matter this will require an Obamacare repeal,” Gorman said. “A major prob-

lem is that Obamacare’s insurance requirements seem designed to make coverage a very poor deal for people with low incomes.”

Costs Roll Downhill

Paul Gessing, president of the Rio Grande Institute, says Medicaid is going to become an increasing burden on New Mexico’s budget in the years ahead as the state is forced to fund an ever-greater portion of the expanded program’s costs because of budget pressures at the federal level.

“Medicare is becoming an increasingly heavy burden on the federal taxpayer,” Gessing said. “Entitlements are crowding out other traditional federal priorities.”

Gessing says it will be very difficult for New Mexico to assume that responsibility because the state has long suffered from a culture of dependency.

“Like Greece, too few New Mexicans are working to support those who are not involved in the workforce,” Gessing said.

Kenneth Artz (iamkenartz@hotmail.com) is managing editor of Health Care News.

Obamacare Mandate May Spark Rise in For-Profit Diet Clinics

By Sean Parnell

It's a very lucrative time to operate a for-profit diet clinic overseen by doctors because of a provision in Obamacare requiring insurers to pay for nutrition and obesity screening.

Medical weight loss programs, including those run by hospitals and clinics, bring in an estimated \$1 billion annually and are expected to grow by approximately 5 percent a year through 2019, according to John LaRosa, research director at Marketdata Enterprises, who has studied the weight loss industry for more than 20 years.

LaRosa says a get-rich-now mentality fed by insurance payments is fueling the temptation to offer ineffective quick fixes for treating obesity.

Ambition Versus Ethics

Dr. Gilbert Ross, executive director of

the American Council on Science and Health, says there may be a lot more going on in many of these clinics than obesity screening and nutritional counseling.

"It doesn't take much to screen for obesity," said Ross. "Height, weight, and, if you're ambitious, a fat-caliper to estimate adiposity is all that is needed. Nutritional counseling is complex when it's done well."

Ross says there may be too great a temptation for doctors to exploit the system by selling useless vitamins and supplements and other quick fixes to vulnerable patients, but he remains optimistic about the profession as a whole.

"Well, it happens, and it can happen with any doctor and indeed with any professional who holds a position of trust," Ross said. "To point out some



"If a responsible clinician wants to help long-term obese patients lose weight and keep it off, a combination of approaches is needed with regular follow-up."

**DR. GILBERT ROSS, EXECUTIVE DIRECTOR
AMERICAN COUNCIL ON SCIENCE AND HEALTH**

examples of doctors who game the system is not the same as saying the whole field is rife with such behavior."

Ross says it's difficult to get obese patients to lose weight utilizing a long-term lifestyle approach, and there are some pharmaceuticals that do somewhat improve weight loss safely.

"If a responsible clinician wants to help long-term obese patients lose weight and keep it off, a combination of approaches is needed with regular follow-up," Ross said. "Drugs included, even bariatric surgery when appropriate. [Simply] giving out phentermine and vitamins and supplements on sale in one's office is unprofessional and unethical."

Government Helped Cause Problem

The war on obesity will be complex, costly, and probably lost in the end, says Julie Kelly, a cooking writer and teacher.

"It's hard not to make the connection between government's overreach in how and what we eat during the last few decades and the rise in overweight and obesity rates," Kelly said. "And now the health care law will incentivize the use of diet clinics that have little hope of making any progress against obesity."

Since obesity is considered a disease, we are spending an enormous amount of resources to combat it, with little in the way of personal accountability, Kelly says.

"Some doctors acknowledge 90 percent of their patients who use diet clinics are unsuccessful," Kelly said. "Why? Because people are looking for a quick fix, a crash diet, or products that do the hard work [for them]. This will be an even easier sell for people desperate to

lose weight if taxpayers and insurers will pick up part of their tab at a diet clinic."

There are many reasons for the obesity crisis, Kelly says, including cultural, socioeconomic, and heredity factors. But the government must also accept blame for promoting policies that have contributed to the problem.

"From giving bad advice such as the high-carb, low-fat recommendations over the past few decades to supporting poor food choices for folks on [the Supplemental Nutrition Assistance Program], to now the misguided nutritional standards in the school lunch program, the federal government has largely been a failed messenger," Kelly said.

Sean Parnell (sean@impactpolicymanagment.com) is a policy advisor to The Heartland Institute and president of Impact Policy Management, LLC.

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LEGISLATIVE PULSE: OREGON

Averting Oregon's Billion-Dollar Medicare Hole

Oregon State Rep. Julie Parrish (R-Tualatin) serves on the Human Services and Housing, Veterans, Emergency Preparedness, and Natural Resources Committees. In this interview with Managing Editor Kenneth Artz, she discusses the Obamacare "Cadillac Tax," Medicare expansion, and an innovative proposal to redesign public employee benefits.

By Kenneth Artz

Artz: What is the "Cadillac tax," and how would it affect public employees in your state?

Parrish: The Cadillac tax is an excise tax on health care plans the federal government deems as being too generous. The tax goes into effect on January 1, 2018, and it will affect individual plans costing more than \$10,200 and family plans costing more than \$27,500. The tax is assessed on the insurance companies, who will most certainly pass the tax through to the [policy holder's] employer, including public employers.

In a state such as Oregon, where public employee health care plans are very generous, public employers at all levels of government will likely be subject to this tax in 2018 if they do nothing.

Artz: What are some of the budget holes Oregon is already facing in the 2017–19 biennium and how does the Cadillac tax affect this problem?

Parrish: Oregon was already set to face significant budget holes in its 2017–19 biennium. In 2013, the legislature attempted to reform the Public Employees Retirement System to help bring down the unfunded liability. The bulk of the reforms were deemed to be unconstitutional. Public employers, who avoided some of that liability for the past few years, will be faced with a huge payment in the next biennium, estimated to be close to a billion dollars.

As part of former Gov. John Kitzhaber's (D) plan to get people health care access under the Affordable Care Act, Oregon expanded its Medicaid population. In 2017, the federal government will be reducing the amount of the federal match they'll send our state to continue coverage for some 600,000 Oregonians. Oregon is already a donor state in that we send Uncle Sam \$1 of federal income tax and get less than \$1

back. So the loss of the Medicaid match will be significant. Next biennium, we're also looking at the possibility of a budget hole of \$1 billion or more for the Medicaid expansion we passed in 2011.

Now, overlay a new cost of a Cadillac tax on public employee health care costs. This could cost our state, at every level of government, millions of dollars in the form of a tax, but it also creates disparities in total compensation to public employees and will likely become a collective bargaining issue in the future.

Artz: Can you explain what your bill, House Bill 3564, does and how much it could save Oregon's taxpayers?

Parrish: House Bill 3564 represents over a year of research into how public employers in our state can redesign public employee benefits. It recognizes employees based on their individual needs, rather than offering a one-size-fits-all health care plan some may not be using. HB 3564 allows a benefit contribution to the employee in the amount of the single cap set forth in the [Affordable Care Act]. It moves public employers away from being self-insured and into an exchange. It then gives the employee the choice of how to spend the benefit amount. The allocation could go to cover the cost of health care. Or for a family with health care through a spouse, the money could instead go to a pre-tax retirement account or into a flex spending account to pay for child-care.

The bill also has a savings mechanism in the legislation; half of the realized savings would be banked by the employer to pay for future health care [cost] increases. When the Affordable Care Act cost caps go up, the employer would increase the amount to the employee automatically. The rest of the savings could be used to pay down the Public Employ-



"Next biennium, we're also looking at the possibility of a budget hole of \$1 billion or more for the Medicaid expansion we passed in 2011."

JULIE PARRISH, STATE REPRESENTATIVE, TUALATIN, OREGON

ee Retirement System liability or for other non-health-care-related collective bargaining.

In theory, the bill could not only cover quality health care and benefit options for employees but also help create long-term solvency in public employer budgets. This bill also has applicability for private employer benefits and self-insured private union plans as well.

Artz: What happens if Oregon is unable to avert the Cadillac tax?

Parrish: I believe if we don't solve this issue by 2016, the tax is going to be unavoidable. Congress is offering no repeal. Its unwillingness to repeal this provision of the ACA stems from the Medicaid expansion being, in part, predicated on the ability to collect the Cadillac tax as a new revenue stream.

I believe 2016 is our drop-dead date, because our state would first need to pass legislation. In and of itself, that

will be difficult. Then we would need to go through a public bid process, followed by an open-enrollment period for employees. Without swift legislative change, the timeline is almost too tight to make such a substantive change and roll that out to thousands of public employees across state government, which is composed of 197 school districts, 240 cities, 36 counties, and dozens of other governmental organizations.

Yet the cost of doing nothing could be astronomical and crippling to budgets already strapped for cash with no way to raise the revenue to pay for it. Oregon's taxpayers shouldn't have to be saddled with this cost, particularly when there is no new value being received by the employee or the constituencies those employees were hired to serve.

Kenneth Artz (iamkenartz@hotmail.com) is managing editor of Health Care News.

New York Regulations Put Fresh Sushi on Ice

By Sean Parnell

New York's sushi restaurants have long boasted the freshest fish in the city, but new regulations taking effect in August will remove that distinction.

The New York City Department of Health and Mental Hygiene regulations will require fish served raw, undercooked, or marinated raw in dishes such as ceviche must first be frozen to guard against parasites.

By the end of summer, all fish used in sushi, sashimi, tartare, and other popular raw dishes must be kept in the freezer for one hour before it can be served to customers.

Freezing Doesn't Eliminate Risks

Although there are benefits to freezing fish before serving it in a raw preparation, this process doesn't eliminate the risk of eating uncooked fish, says Julie Kelly, a cooking teacher and writer.

Kelly says one problem is freezers must remain at a certain temperature.

"If you're a large-scale sushi chain that can afford commercial-grade freezers, that's great," Kelly said. "But smaller vendors will have a tough time calibrating and maintaining that temperature for up to 15 hours, not to mention the space burden it imposes. And there is some evidence freezing doesn't completely kill off all dangerous microorganisms."

Defrosting the fish must also be done properly, Kelly says. It's not a quick process, and if a timely system isn't in place, it can be quite laborious and



time-consuming for small restaurants.

Food handling is the main problem in restaurants, Kelly says. Preparers must take care when handling any raw ingredient, from fish to fruits to vegetables, as improper food handling is the source of most food-borne illnesses. Providing guidance about how to handle raw fish is a better approach than mandating a costly, laborious, imperfect, and largely unnecessary freezing process.

"The bottom line is people who love sushi—and I'm one of them—realize the small risk involved in eat-

ing it," Kelly said. "But the taste and enjoyment are worth it."

Another Nanny State Intrusion

The whole point of sushi is it's supposed to be fresh, not frozen, says Seton Motley, president of the public policy organization Less Government.

"I don't know how this helps or improves the ability of sushi restaurants to protect their customers, because it's in their best interest to always serve the freshest product," Motley said. "Otherwise, word gets out and the business will eventually fail."

Motley says the nanny state is intruding once again where it has no business.

"This goes all the way back to the Constitution, which is supposed to be a shield to protect us from this sort of bureaucratic nonsense," Motley said.

Dr. Gilbert Ross, executive director of the American Council on Science and Health, says the restaurateurs and chefs seem blithely unconcerned about these new regulations for freezing raw seafood.

"I was perturbed by the 'better safe than sorry' justification for the mandate, given the lack of either data or concern for the actual risk of parasitic diseases via raw seafood," Ross said. "Therefore, I do wonder why these regulations are necessary."

Sean Parnell (sean@impactpolicymanagement.com) is a policy advisor to The Heartland Institute and president of Impact Policy Management, LLC.

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COMMENTARY

Repealing Obamacare Would Grow Economy, Cut Uninsured by 10 Million

By John R. Graham

I have asked, and the Congressional Budget Office (CBO) has answered.

I have been urging CBO to do a comprehensive estimate of all the effects of the Affordable Care Act, effectively for the first time since 2012. It did so in June. The main takeaway from CBO is “repealing the ACA would increase Gross Domestic Product (GDP) by about 0.7 percent in the 2021–2025 period, mostly because provisions of the law that are expected to reduce the supply of labor would be repealed.”

Changing Estimates

CBO concludes repeal would increase federal budget deficits. This effect is much smaller than previous estimates, because this is the first time CBO has used so-called “dynamic scoring,” tak-

ing macroeconomic effects of repeal into account, instead of just a simple static bookkeeping type of estimate.

Under old “static” scoring techniques, which exclude the effects of macroeconomic feedback, CBO and the Joint Committee on Taxation (JCT) estimate federal deficits would increase by \$353 billion over the 2016–25 period if ACA is repealed.

By contrast, new “dynamic” scoring techniques find repeal of ACA would boost economic output. Federal deficits would still increase over the 2016–25 period, but by significantly less, \$137 billion, CBO and JCT estimate.

Repeal Would Shrink Deficits

Charles Blahous of the Mercatus Center says CBO’s conclusion is incorrect, because what it is using as “current law” is not actually the current law. He says federal budget deficits would actually shrink if ACA is repealed.

CBO also misreports the number of people who would become uninsured as 24 million. Actually, it would be 10 million, because CBO includes as losing health insurance 14 million who are on Medicaid as a result of Obamacare. In fact, they would lose access to a welfare program. It is wrong to count them as currently having health insurance.

Overstated Challenge

CBO is not entirely to blame for these two errors. It measures things as the Congress tells it to. Nevertheless, there is one paragraph in the new estimate that is remarkable for a different reason: “Implementing a repeal of the ACA would present major challenges. In the five years since its enactment, nearly

“Repeal of ACA would raise economic output mainly by boosting the supply of labor, and the resulting increase in GDP is projected to average about 0.7 percent 2021 to 2025.”

every key provision of the law has taken effect and has been incorporated into final rules and other administrative actions. Undoing the ACA would thus be quite complicated.”

Why would undoing ACA be complicated? The law and its regulations are harmful and frustrating. Suppose the government passed a law requiring us to wear cardboard tricorne hats, speak Latin on odd-numbered days of the month, and hop on one leg on even-numbered days. If that law were

repealed, we would simply stop doing those things, no matter what regulations had been emitted to enforce them.

John R. Graham (john.graham@ncpa.org) is a senior fellow at The National Center for Policy Analysis and The Independent Institute. An earlier version of this commentary originally appeared at the websites of the National Center for Policy Analysis and the Independent Institute. Reprinted with permission.

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Millions Choose Obamacare Fine Over Insurance

Approximately 7.5 million Americans paid an average penalty of \$200 for not having health insurance in 2014, the first year most Americans were required to have coverage under the Affordable Care Act, according to the Internal Revenue Service.

Seton Motley, president of Less Government, a DC-based nonprofit organization, says it still vexes him that a majority of the Supreme Court found in the Constitution an “emanation from a penumbra” empowering the federal government to fine someone simply for existing.

The fine is “for not purchasing something, over which the Constitution grants the federal government exactly zero authority,” Motley said. “Something the Constitution in fact never even mentions.”

— Kenneth Artz

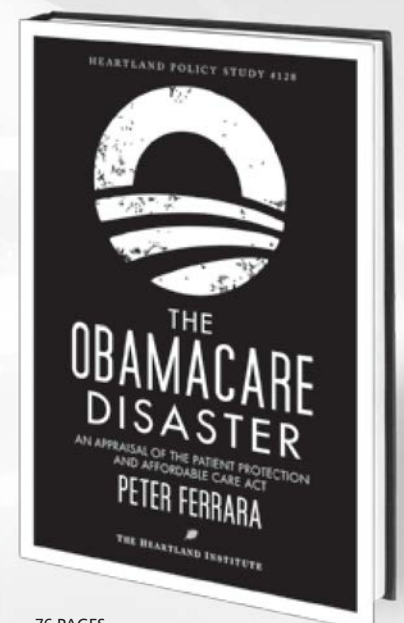
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COMMENTARY

How Much Is Medicaid Really Worth to Beneficiaries and Taxpayers?

By John C. Goodman

One of the most important components of Obamacare is its expansion of Medicaid.

In those states that have done it, the additional cost to taxpayers has totaled billions of dollars. Is this expenditure worthwhile? What if instead of giving people Medicaid insurance, we offered them cash?

A new study says beneficiaries prefer the cash. In fact, if you offered the Medicaid population a little more than 20 cents on the dollar, the average enrollee would take the cash.

In their study, researchers Amy Finkelstein, Nathaniel Hendren, and Erzo F.P. Luttner, three of the nation's premier health economists, examine the new evidence from the Oregon Medicaid expansion, an event that has provided social scientists with a wealth of data not previously available.

The authors conclude the uninsured are not really uninsured. Instead, they are insured "implicitly." When they get medical care, they don't pay the full price. Several previous studies estimate the uninsured pay about 20 percent of the cost of their care. But if this is generally true and if the uninsured

"One finding that has already been widely reported is even though Medicaid expansion led to more consumption of health care, the additional care appears to have had little effect on the enrollees' physical health. A finding that was not widely reported is 40 percent of those who were offered Medicaid coverage didn't bother to enroll."



know it is true, they know the cost to them when they seek medical care will be 20 percent.

Value, Cost-Determined Consumption

Put another way, the uninsured have an implicit insurance contract with a 20 percent copayment. A general economic principle that covers all insurance is patients will tend to consume care until its value to them is worth its cost to them. So if health care costs a patient 20 cents on the dollar, the patient will tend to consume it until it

is worth 20 cents on the dollar.

In the Oregon Medicaid expansion, those who remained uninsured spent about \$2,700 per person each year on medical care. Those newly enrolled in Medicaid spent about \$3,600, or \$900 more. This is consistent with economic theory. When \$1 of care becomes free instead of costing 20 cents, people obtain more of it. But the value of this additional care is likely to be less than 20 cents on the dollar.

There were 75,000 people on the waiting list for Medicaid coverage in Oregon. Of these, about 35,000 were selected by lottery. Since the enrollees were selected randomly, those with Medicaid and those who remained uninsured were separated only by chance. This created an ideal experiment in which social scientists were able to study the effects of Medicaid.

Additional Care Has Little Effect

One finding that has already been widely reported is even though Medicaid expansion led to more consumption of health care, the additional care appears to have had little effect on the enrollees' physical health. A finding that was not widely reported is 40 percent of those who were offered Medicaid coverage didn't bother to enroll.

That is consistent with national, pre-Obamacare data that show one-third of those eligible for Medicaid nationwide don't enroll. It is also another indication the value of Medicaid to the recipients is well below its taxpayer cost.

This is not the whole of the story. If the uninsured are paying only

20 percent of the cost of their care, somebody else must be paying the other 80 percent. The study by Finkelstein and her colleagues found 60 cents of every dollar of Medicaid spending benefitted "somebody else."

However, the study did not identify who benefited from the 60 cents.

There is lengthy literature in health economics that tries to pin this down. A common belief is the cost of unpaid medical bills is shifted to other patients. But if other patients don't bear the costs, who does? Taxpayers? Providers? This is obviously a question that needs to be answered.

In any event, it appears these unidentified non-impoveryished people get three times as much benefit from Medicaid as the enrollees themselves.

John Goodman (johngoodman@goodmaninstitute.org) is a senior fellow at the Independent Institute. An earlier version of this commentary originally appeared at Forbes. Reprinted with permission.

Vitter Bill Would End Obamacare Subsidies for Congress

Sen. David Vitter (R-LA) introduced a bill in July to eliminate an Obamacare exemption allowing members of Congress to avoid purchasing insurance through the health insurance exchanges. The bill would also prevent members of Congress from receiving taxpayer-funded subsidies to pay for their insurance.

The legislation was prompted by an ethics complaint filed by a coalition of watchdog groups who called for an investigation into whether Congress committed fraud on applications submitted to the Washington, DC health insurance exchange.

Vitter's bill would require President Barack Obama, Vice President Joe Biden, political appointees, and members of Congress to purchase their health insurance through an exchange. The legislation would also prevent them from receiving a federal subsidy.

Dr. Roger Stark, a senior fellow of the Washington Policy Center, says he believes members of Congress and employees receive their health insurance through the Washington, DC exchange, but it is virtually all paid for by the employer, meaning the taxpayers. The reasoning, he says, was the government supposedly needed to continue to provide health care benefits to attract the best and brightest employees.

"There is a definite trend among Americans that our elected officials should play by the same rules and laws that they pass," Stark said. "Congress seems to be split on this issue, and not along party lines."

— Kenneth Artz

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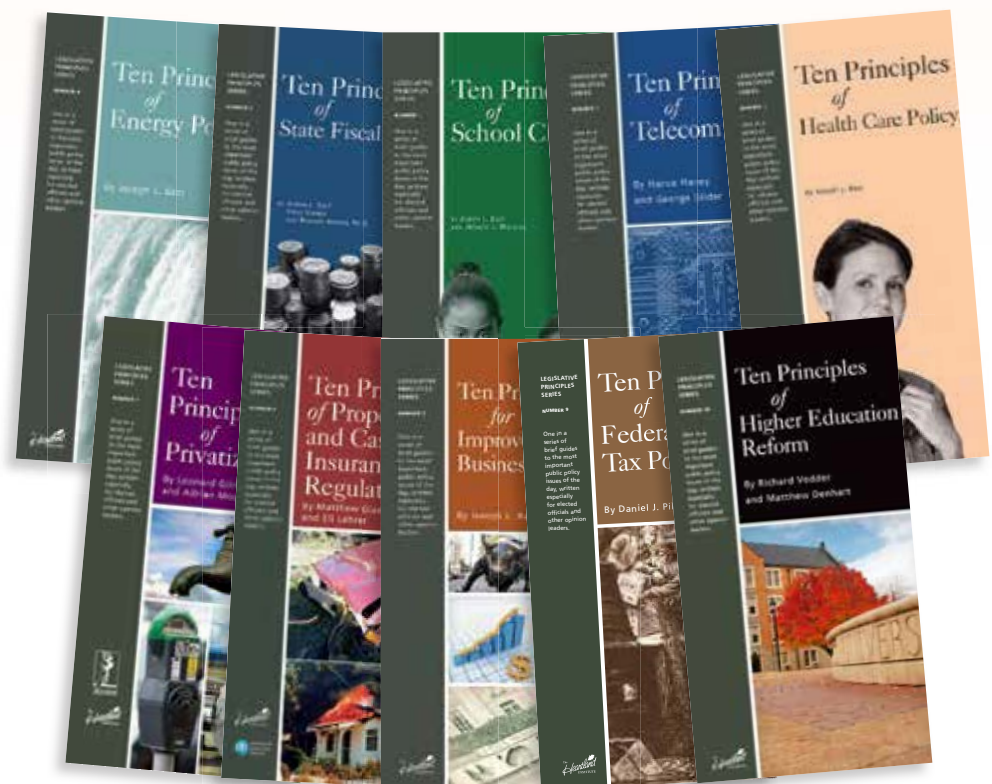
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