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# HEALTH CARE NEWS

THE MONTHLY NEWSPAPER FOR HEALTH CARE REFORM

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## The Pulse

### Patients Avoiding Needed Care

Many lower- and middle-income Americans who purchased insurance on government-run health insurance exchanges are skipping needed tests and doctor's visits because of the expense. **Page 4**

### Obamacare Insurance Hikes

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### Medicaid Fraud Persists

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### Cost-Saving Move Hindered

Companies are providing telephone consultations with doctors to millions of patients, but government regulations impede use of this cost-saving option. **Page 18**

### Obamacare Death Spiral Begins

John R. Graham argues the proposed hefty rate boosts for plans sold in Obamacare health insurance exchanges indicate the fiscal collapse of the program is rapidly approaching. **Page 16**

## House Republicans Release Plan to Repeal, Replace Obamacare



By Kenneth Artz

A group of House Republicans released a proposed health care plan that would replace Obamacare with patient-centered reforms and free-market solutions.

The 192-page American Health Care Reform Act (AHCRA) was written by Reps. Phil Roe (R-TN) and Austin Scott (R-GA). The authors describe it as an “aspirational model” of American health care and say it’s open for amendments.

Highlights include fully repealing President Barack Obama’s health care law, eliminating billions of dollars in taxes and thousands of pages of unworkable regulations and mandates that drive up health care costs, expanding federal funding for state high-risk pools, allowing health insurance plan purchases across state lines, reforming medical liability laws, and investing in research for the most common causes of death in the United States.

**REPEAL, p. 12**

## Calif. Exchange Running out of Money

By Loren Heal

After spending more than \$1 billion on startup costs, California’s state-run Obamacare health insurance exchange has failed to produce the expected returns and is rapidly running out of money.

Covered California signed up fewer people than was required for it to become self-sufficient, Lanhee Chen of the Hoover Institution says.

“Even spending all of the money they did on advertising, they still managed to sign up far fewer Californians than they expected,” Chen said. “In fact, they’ve signed up about 1.27 million people, when they expected to enroll 1.8 million.”

“Covered California receives \$13.95 for each enrollee into the program, so

**CALIFORNIA, p. 14**

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# Right to Try Passes Calif. Senate

By Katie Clancy

The California Senate unanimously passed The Right to Try Act, which effectively nullifies certain Food and Drug Administration (FDA) rules preventing terminally ill patients from accessing experimental treatments.

State Sens. Jeff Stone (R-Palm Desert) and Joel Anderson (R-Alpine) introduced Senate Bill 149 in January. The bill gives terminally ill patients access to medicines that have not been given final approval by FDA.

California's Right to Try (RTT) bill follows the lead of 18 other states that have already enacted similar legislation. Twenty-one other states are also now considering such laws.

Under the Federal Food, Drug, and Cosmetic Act, general access to experimental drugs is prohibited, but under the expanded access provision of the act, patients with serious or immediately life-threatening diseases may access experimental drugs once they receive express FDA approval.

California's Right to Try Act bypasses FDA's expanded access program, allowing patients to obtain experimental drugs from manufacturers without first obtaining FDA approval.

Stone, who is also a pharmacist, says he was motivated to introduce his bill because he had seen firsthand the frustration of people and families who are battling not only horrible, life-threatening illnesses but also the

**"At this point in the illness, the patient has exhausted any other treatment options and simply does not have the time to wait for the FDA's approval for the drugs and treatments, which can prolong for months or years."**

JEFF STONE, STATE SENATOR, PALM DESERT, CALIFORNIA



government bureaucracy that prevents needed treatments.

"At this point in the illness, the patient has exhausted any other treatment options and simply does not have the time to wait for the FDA's approval for the drugs and treatments, which can prolong for months or years," Stone said.

FDA does have a process, known as "compassionate use," allowing individuals to request permission to use unapproved drugs, but it takes countless hours and paperwork to be of use for the patient in the short amount of time they have left, Stone says.

## Providing Legal Protection

Right to try laws protect doctors and drug makers who administer the experimental drugs from lawsuits filed when the treatment harms the individual. Under right to try, patients agree-

ing to experimental treatments sign a legal form of consent, acknowledging the risks involved and their understanding the treatment has no guarantee of success.

The Goldwater Institute, a pro-liberty think tank, has been a major advocate of right to try legislation in states across the country. Kurt Altman, a national policy advisor for Goldwater, says his organization developed the model legislation for RTT after conducting significant research into the FDA drug approval process.

"Once the data was collected, Goldwater identified ... the lack of access terminal patients had to investigational new drugs [as a significant problem that, if resolved,] could potentially help them," Altman said.

"We believe right to try will enable more terminally ill patients to access investigational medications that could potentially benefit them," Altman said.

## Concerns, But Also Hope

Those skeptical of right to try say it could produce false hope for patients or even worsen their condition. Altman acknowledges those concerns but remains hopeful.

"We have no illusions that this will save millions or even thousands, but we are certain it will help many," Altman said.

"Right to try gives control over medical decisions back to the patient and doctor, where it rightly belongs," Altman said. "So far, the bill in California has received bipartisan support. This common-sense bill has gained positive momentum, and we believe that momentum will continue."

FDA has not commented on the right to try issue. Altman and other proponents hope the movement behind this legislation will prompt FDA to change some of its requirements right to try supporters believe to be outdated.

Katie Clancy ([kmclancy.heartland@gmail.com](mailto:kmclancy.heartland@gmail.com)) is a government relations intern for The Heartland Institute.

## Obamacare Exchange Poses Cap on Specialty Drugs

Californians worried about the high cost of drugs took their concerns to Covered California, the state's Obamacare health insurance exchange. The agency agreed, capping the monthly out-of-pocket costs for specialty drugs. Starting in 2016, most people will have to pay a maximum of only \$150 or \$250 per prescription per month.

Drug expenditures rose by about 13 percent in 2014, due largely to specialty drugs such as those used to treat hepatitis C, says Devon Herrick, a senior fellow and health care researcher for the National Center for Policy Analysis.

"State Medicaid programs and insurers are balking at the high price and are looking for ways to limit their costs," Herrick said.

— Staff Reports

# Excessive Obamacare Costs Cause Many to Avoid Needed Care

By Bruce Walker and Jim Waters

Many lower- and middle-income Americans who purchased insurance on government-run health insurance exchanges are skipping needed tests and doctor's visits, a new study has found.

The study, conducted by Families USA and titled "Non-Group Health Insurance: Many Insured Americans with High Out-of-Pocket Costs Forgo Needed Health Care," indicates high deductibles required by many health insurance plans offered through government health insurance exchanges discouraged one in four exchange customers from keeping doctor's appointments or getting important medical tests. The ratio was nearly one-in-three for middle- and lower-income adults.

More than half of plans offered in government exchanges have deductibles of at least \$1,500.

"This is a clear example of how people can be very casual in their thoughts and language about rhetoric coming from the government about public programs," said D. Eric Schansberg, an economics professor at Indiana University Southeast.

Schansberg says trust in government promises can result in people thinking they can get the care they need when they can't.

## Results Don't Match Rhetoric

"Simply having health insurance is no guarantee that a consumer can afford to

pay for health care," wrote the authors of the Families USA report.

Although the study's results don't prove these patients have worse access to care than before signing up for Obamacare, they certainly show the results don't match the government's rhetoric, Schansberg says.

"When government jumps in like it did with Obamacare, the benefits tend to be overstated, often by a significant amount," Schansberg said. "The rhetoric surrounding implementation of the Affordable Care Act led these people to believe things would get better, but they haven't."

## Millions Can't Afford Care

Families USA received \$1.1 million from the Robert Wood Johnson Foundation after passage of Obamacare to encourage the newly insured to tell how President Barack Obama's health care law personally benefited them.

The Families USA study ended up confirming millions of lower- and middle-income Americans who purchased plans on the exchange still can't afford care, despite promises the subsidies and tax credits in the law would assist customers not only to purchase insurance but also to gain access to care.

"It is odd a group that lobbied for Obamacare claims Obamacare has delivered on its promise of making health care less expensive, despite evidence to the contrary, and then demonstrates that we cannot tax, subsidize,

**"When government jumps in like it did with Obamacare, the benefits tend to be overstated, often by a significant amount. The rhetoric surrounding implementation of the Affordable Care Act led these people to believe things would get better, but they haven't."**

D. ERIC SCHANSBERG  
INDIANA UNIVERSITY SOUTHEAST



and mandate our way to affordable health care for everyone," said Nathan A. Benefield, vice president of policy analysis at the Commonwealth Foundation, a think tank in Harrisburg, Pennsylvania.

## Calling for More Subsidies

To fix the problem, Family USA recommends reducing deductibles and copayments for lower- and middle-income Obamacare Silver Plan consumers.

"It is not surprising that they go on to advocate for still more government mandates and taxpayer subsidies," said Benefield. "Government policy can expand the pool of Americans with health insurance cards, but it cannot guarantee lower costs. In fact, most government intervention into the health care field directly results in higher prices."

The reality is the Affordable Care Act has not made health care any more affordable or accessible, Benefield says.

"The only way to achieve that is through actually having choice and competition in the health care industry," Benefield said. "Choosing not to pay for additional medical services should be part of that. Simply asking taxpayers to pay more and taking choices out of the hands of patients will add to the total cost of health care and fail to address the underlying problems families struggle with."

## Doomed From the Start

The very existence of subsidies ensured failure from the beginning, says David Adams, president of Kentucky Citizens Judicial and a plaintiff in an ongoing legal battle to shut down the commonwealth's state-based exchange.

"The fact that they have to throw federal dollars to ameliorate what they've done to the pricing is your first clue that it's a failure," Adams said.

The reality for the lower- and middle-income Americans caught between the cracks of Medicaid and lacking the resources to cover much higher deductibles is Obamacare has blurred the distinction between insurance and actual access to care, says Adams.

"Of what benefit is it to have lower premiums if they have a \$13,000 deductible and can't afford basic treatment?" Adams asked. "You used to be able to go in to the doctor's office and write a check for \$50 to get a prescription. But now the price of everything is so distorted because of Obamacare so that even routine visits are out of reach for many of these people."

*Bruce Edward Walker (bwalker@heartland.org) is a policy advisor for The Heartland Institute. Jim Waters (jwaters@freedomkentucky.com) is president of the Bluegrass Institute, Kentucky's free-market think tank.*

## House Votes to Repeal Medical Device Tax

The U.S. House of Representatives voted to repeal a tax on medical devices in the Affordable Care Act, despite President Barack Obama's threat to veto the bill.

"If Republicans can't defund all of Obamacare, then we should do the next best thing, which is to defund it piecemeal," said Seton Motley, president of Less Government, a nonprofit organization dedicated to reducing the power of government and protecting First Amendment rights.

— Staff Reports

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# Florida Fights Administration over Medicaid

By Jehadu Abshiro

Florida Gov. Rick Scott (R) announced his administration will file a lawsuit against the federal government for threatening to withhold more than \$1 billion in Low Income Pool (LIP) funding for hospitals if the state fails to expand Medicaid.

LIP was created to replace supplemental hospital payments when the state moved from a fee-for-service system to reformed Medicaid managed care. Florida officials agreed to move \$1.2 billion in other Medicaid funding into LIP as part of waiver negotiations with the federal government in 2014. According to state data, Medicaid payments cover 62 percent of hospital costs, and with LIP funding, 95 percent of costs are covered.

"What the Washington[,DC] officials and Centers for Medicare and Medicaid Services are saying is if you expanded Medicaid, then you would have less of a need for low-income pool funding," said Thomas Miller, a resident fellow at the American Enterprise Institute. "But

that's questionable because it's not typically good care and it's not particularly well funded."

## Obama Leveraging States

A Florida Senate bill would require the state to cover 10 percent of the Medicaid expansion cost, or \$5 billion.

Scott and most of the Florida House are resisting any legislation that expands Medicaid since the U.S. Supreme Court decision in *National Federation of Independent Business v. Sebelius* made expansion optional, Miller says. In this 2012 Affordable Care Act (ACA) case, Chief Justice John Roberts and Justices Samuel Alito, Stephen Breyer, Elena Kagan, Anthony Kennedy, Antonin Scalia, and Clarence Thomas found the Medicaid expansion provisions were written unconstitutionally. They concluded Congress does not have authority to threaten a state with complete loss of federal funding of Medicaid if the state refuses the expansion.

"Politically, this suggests that [although] there are some limits in resisting Medicaid expansion by states, it doesn't work that well for the Obama administration to use this type of money to leverage and coerce ... the states to this type of expansion," Miller said.

Twenty-one states have rejected the expansion, and the Obama administration is sending a clear signal to other non-expansion states they're willing to bully and basically blackmail state

**"The costs are unsustainable and unpredictable."**

NICHOLAS HORTON, POLICY IMPACT SPECIALIST  
FOUNDATION FOR GOVERNMENT ACCOUNTABILITY

lawmakers to get what they want, says Nicholas Horton, a policy impact specialist at the Foundation for Government Accountability.

"All the while, they're telling these same state lawmakers how much 'flexibility' they'll give them if they'll just agree to expand," Horton said.

## Costs 'a Nightmare'

If Florida were to expand Medicaid, nearly 1.3 million people would enroll, according to the National Center for Policy Analysis. Horton says he considers this a low estimate based on the experience of other expansion states.

"The costs are unsustainable and unpredictable," Horton said. "It's just a nightmare all the way around for taxpayers, for the needy, and for state lawmakers."

The Obama administration's push to

force Medicaid expansion may hit Kansas and Texas later this year, when their LIP funding waivers will be up for reauthorization.

Miller says LIP funding represents a significant amount of the resources available to provide assistance to low-income individuals not covered under Medicaid.

"There's a lot of pressure and angst over the [potential] loss of those resources, which people had assumed would continue in the future for a number of years," Miller said. "Both sides are probably moving closer to finding some common ground, but there is a short amount of time and a lot of polarized atmosphere surrounding this."

Jehadu Abshiro ([jabshiro@gmail.com](mailto:jabshiro@gmail.com)) writes from Dallas, Texas.

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## South Dakota Mental Health Court Proposed

A Sioux Falls, South Dakota judge is proposing an alternative court system that would focus on rehabilitating mentally ill defendants instead of putting them in prison. Second Circuit Judge Doug Hoffman says a mental health court could produce better results for taxpayers and society and help lower the state's prison population.

Dr. John Dale Dunn, an emergency physician and policy advisor to The Heartland Institute, which publishes *Health Care News*, urges caution in considering such ideas. Dunn says mental health is often a way for progressives to say people are not responsible for their actions.

In the overwhelming majority of cases, "people commit crimes because they choose to commit crimes, not because of mental health," Dunn said.

— Staff Reports

## Power to the People!

Obamacare can and must be replaced by free-market, patient-centered health care reforms that expand patient power, ensure health care for all without an employer mandate or an individual mandate, and reduce taxes, federal spending, and regulation.

Learn more about these patient-centered health care strategies in "Power to the People: Repealing and Replacing Obamacare with Patient Power," a *Policy Brief* by Peter Ferrara, senior fellow at The Heartland Institute. Request your copy by calling 312/377-4000 or going online at [heartland.org](http://heartland.org).



# Medicaid Set to Overwhelm New Mexico Budget

By Matthew Glans

New Mexico is one of 28 states that expanded Medicaid coverage for impoverished adults as part of the implementation of Obamacare, resulting in more than 216,000 people joining the state's Medicaid roster and pushing the total to nearly 800,000 enrollees.

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

The federal government currently pays 100 percent of the cost of the expansion, but that percentage will decrease beginning in 2017 to 90 percent, resulting in New Mexico having to pay about \$120 million of the expansion's expenses. By 2020, more than 895,000 people could be on the rolls, including 257,000 who will be covered by 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, including \$268 million caused by the expansion.

David Abbey, director of the state's Legislative Finance Committee, says

**"Because of the politics in the state, Republican Gov. Susana Martinez [right] faced a very difficult decision to expand the program. I'm sure she felt like she had no choice and she had to do it, but it's a bit ironic a government program designed to alleviate poverty is going to spread it widely."**

**PAUL J. GESSING**  
PRESIDENT  
RIO GRANDE FOUNDATION



other parts of the budget are going to have to shrink to accommodate the rapidly expanding Medicaid spending.

## Behind the Eight Ball

Paul J. Gessing, president of the Rio Grande Foundation, a think tank based

in Albuquerque, New Mexico, says New Mexico's budget is always in doubt because it is highly reliant on oil and gas tax revenues and the state's economy is not very diversified.

"It's been described as a two-legged stool with one leg being the federal government and the other being oil and gas," Gessing said.

"We have not recovered like many other states have from the 2008 economic recession," Gessing said. "Another thing is New Mexico's population declined during that period. Population loss is unheard of in a Western state."

The state's chronically bad economy makes it difficult to imagine how the state can find a way to pay for the huge expenses of the Medicaid expansion, Gessing says.

"Because of the politics in the state, Republican Gov. Susana Martinez faced a very difficult decision to expand the program," Gessing said. "I'm sure she felt like she had no choice and she had to do it, but it's a bit ironic a government program designed to alleviate poverty is going to spread it widely."

## Tax Burden Will Grow

Michael Cannon, director of health policy studies at the Cato Institute, says New Mexico's officials should have listened to critics who warned the state's motto, "It grows as it goes," applies to the tax burden Obamacare's Medicaid expansion is imposing on New Mexicans.

"That tax burden will grow further still, because both Congress and President Obama have proposed to renege on the federal government's commitment to pay 90 percent of the cost," Cannon said.

Meanwhile, the expansion creates a

huge incentive for officials to protect able-bodied, childless adults at the expense of pregnant women and children, Cannon says.

Medicaid delivers only 40 cents of benefits to enrollees for every dollar spent, and it appears to have little if any impact on enrollees' health, Cannon says. Under Medicaid expansion, the federal government pays 90 percent of the cost and the state pays 10 percent. New Mexico's regular Medicaid match is about 70 percent, so the federal government pays two-thirds of the cost, and the state pays one-third.

Facing a budget gap, New Mexico officials want to reduce Medicaid outlays. Cannon notes they have many options for doing that. Cutting services to pregnant women and children gives the state "much more bang for their buck" than cutting services to able-bodied, childless adults, he says.

"New Mexico needs to opt out of the Medicaid expansion and enact real reforms that bring quality health care within the reach of more low-income residents," Cannon said.

*Matthew Glans (mglans@heartland.org) is a senior policy analyst at The Heartland Institute.*

## SAVE MEDICARE PART D

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Millions of seniors rely on Medicare Part D for affordable drugs. It has reduced spending on hospitalization and it costs less than originally budgeted. But some politicians want to destroy Part D by breaking its market-driven approach to price negotiation or by imposing taxes on drugs sold to seniors. Stand up for Medicare Part D! Don't let politicians destroy a program that is working!

Go to [SaveMedicarePartD.com](http://SaveMedicarePartD.com) for information about what you can do to save Medicare Part D!



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# GAO Study Details Medicaid Payment Fraud

By **Jehadu Abshiro**

**M**edicaid, the national government health care program meant to help provide health care for the impoverished, is riddled with fraud, according to a Government Accountability Office (GAO) study that analyzed Medicaid payment data from the year 2011 in four states: Arizona, Florida, Michigan, and New Jersey.

The agency found about 8,600 Medicaid beneficiaries received payments in two or more of the four states that year, in violation of federal law, totaling at least \$18.3 million. It also discovered Medicaid payouts to approximately 200 deceased beneficiaries, totaling about \$9.6 million.

GAO also found approximately 50 health care providers billed Medicaid even though they were excluded from the program for patient abuse and fraud. Those bills amounted to approximately \$60,000.

GAO recommends the Centers for Medicare and Medicaid Services (CMS) do more to prevent fraud by providers and patients by providing new guidance to states about screening Medicaid beneficiaries more thoroughly and

giving the states full access to the federal government's records on Medicaid providers.

"Every dollar [stolen] is committing a crime," said Mara Mellstrom, legislative manager at the Foundation for Government Accountability. "This is no different from stealing from your neighbor."

## Amount of Fraud Unknown

Almost 70 million Americans are currently enrolled in Medicaid, according to a report released by the U.S. Department of Health and Human Services in February. The report states Medicaid spending grew by 6.1 percent in 2013, to \$449.4 billion, and constituted 15 percent of national health expenditures.

CMS projects health care expenditures financed by federal, state, and local governments will account for 48 percent of national health care spending and a total of \$2.5 trillion by 2023. This is a 44 percent increase from 2012, when total government health care spending was approximately \$1.2 trillion.

"Ultimately, due to the nature of

the enrollment program, it is difficult to tackle the fraud," Mellstrom said. "The depth of Medicaid fraud is truly unknown, since so many states do the minimum in addressing the issue from the get-go."

If states used a better screening approach or took a more active role in catching scammers, they could achieve a 2 to 5 percent savings in Medicaid spending, Mellstrom says.

"It's about bringing welfare programs into the twenty-first century, and it's really [about] making use of your resources," Mellstrom said. "We need to backtrack and see how we got here."

## Misplaced Incentives Cited

States don't have much incentive to flush out waste, fraud, and abuse in programs like Medicaid, and this leads to misallocated resources, says Thomas Miller, a resident fellow at the American Enterprise Institute.

"Improvised coverage doesn't provide the care promised and it's not particularly well-administered, and therefore some of that money gets diverted into other places," Miller said.

Some states are moving toward a

private-sector managed-care approach that enables slightly better policing of fraud, Miller says.

"There's been mixed results in that," Miller said. "It's probably a little bit better, but it doesn't mean the problem has been solved."

*Jehadu Abshiro (jabshiro@gmail.com) writes from Dallas, Texas.*

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## California Court Strikes Down 'Pay to Delay'

By **Katie Clancy**

**T**he California Supreme Court has ruled pay-to-delay agreements among pharmaceutical companies violate state antitrust laws.

The decision in the case *In Re Cipro Cases I & II* follows a 2013 U.S. Supreme Court ruling that determined these deals are subject to antitrust scrutiny and is the first such decision made since the ruling.

The case came about after a brand name pharmaceutical company, Bayer, maker of the blockbuster antibiotic Cipro, paid Barr, a maker of generic drugs, to delay sales of a biosimilar generic drug, thus forestalling competition against Bayer.

Bayer paid Barr \$398.1 million between 1997 and 2003, and Bayer's profits on Cipro exceeded \$1 billion during that period. The court ruled this delay of release extended a monopoly for the drug manufacturer and hurt consumers by removing choice and keeping prices artificially high.

## Costs to Consumers Estimated

Michael Carrier, a law professor at Rutgers University who specializes in antitrust law and has submitted *amicus* briefs on behalf of consumer and antitrust organizations in various cases, says the decision will set a precedent for deciding the legality of such transactions not just in California but throughout the country.

"The ruling shows state antitrust laws can play an important role in challenges to these [troublesome] agreements," Carrier said.

Mark Lemley, a lawyer and law professor at Stanford University, says the court's decision will be seen as an important victory for consumers.

"The decision will make pay-for-delay settlements much harder, not only in California but nationwide, as companies that enter into those settlements will

**"The decision will make pay-for-delay settlements much harder, not only in California but nationwide, as companies that enter into those settlements will likely be violating California law if they do so."**

**MARK LEMLEY**  
STANFORD UNIVERSITY

likely be violating California law if they do so," Lemley said.

## Alternative to Litigation

Despite the California court's decision, there may be times when pay-for-delay makes sense, and a blanket ban may harm consumers, says Devon Herrick, a senior fellow at the National Center for Policy Analysis.

"Drug makers view pay-for-delay settlements as an alternative to litigation," Herrick said. "However, the Federal Trade Commission disagrees, arguing consumers lose when firms collude to keep drug prices high."

*Katie Clancy (kmclancy.heartland@gmail.com) is a government relations intern for The Heartland Institute.*

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# Hep C Drug Lawsuits Filed, Challenging Insurer Decisions

By Matthew Glans

Consumers across the nation are starting to file lawsuits against insurers who deny them access to expensive new hepatitis C treatments.

Harvoni, the new treatment sold by Gilead Science and AbbVie, cures more than 90 percent of those infected with hepatitis C and costs \$63,000 to \$94,500, before any discounts, in the United States.

Two lawsuits allege Anthem Blue Cross refused to pay for individual women's Harvoni treatments because the treatments were not deemed "medically necessary."

Dr. John Dale Dunn, an emergency physician and policy advisor to The Heartland Institute, which publishes *Health Care News*, says hepatitis C causes liver failure and liver cancer, resulting in a slow, painful death.

"Some people don't show any symptoms for a long time, and it can be acquired innocently, so you can say innocent people are suffering," Dunn said.

"Interferon was painful, but the new medications are supposed to be effective," Dunn said. "However, there are the costs. The financial barriers to access medical care are always going to have to be considered."

## Cheaper than Liver Transplants

Sally Pipes, president of the Pacific Research Insti-

tute, says health insurers like Anthem Blue Cross are being short-sighted in denying payment for drugs effective at curing hepatitis C.

"While Sovaldi, [another drug manufactured by Gilead to treat chronic hep C,] is expensive, costing about \$94,000, it is inexpensive compared to the cost of covering a liver transplant, which runs in the range of \$500,000, assuming a match is available," Pipes said. There are also nonmonetary costs for a patient undergoing major surgery, such as time away from work during recovery.

The price of new drugs is high due in part to the cost of research and development for a drug company to develop innovative drugs such as Sovaldi, which run to approximately \$1.2 billion, Pipes says.

Most new drugs never make it through the lengthy FDA approval process and clinical trials, so in order to continue developing new treatments, pharmaceutical and biotech firms have to be able to recover their costs from those that do finally reach the public.

"It is short-sighted of insurers to deny such treatments," Pipes said.

## Short-Term Thinking

The hard lesson for many Americans to learn is coverage is not care, particularly since Obamacare handed

**"Interferon was painful, but the new medications are supposed to be effective. However, there are the costs. The financial barriers to access medical care are always going to have to be considered."**

**JOHN DALE DUNN**  
EMERGENCY PHYSICIAN

the entire health care system over to managed-care plans, which by federal law are allowed to make "medical necessity" decisions in conflict with the interests and health of the patient, says Twila Brase, president of the Citizens' Council for Health Freedom.

Because patients no longer pay most medical bills, they and their doctors have little power over treatment decisions, Brase says. Insurers are more likely to deny expensive treatment requests because the enrollee may not be in the system next year, and hence they may never realize the cost benefits of that decision over the patient's lifetime.

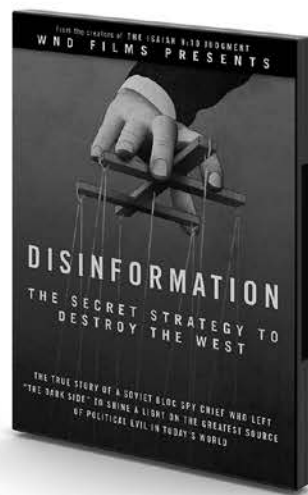
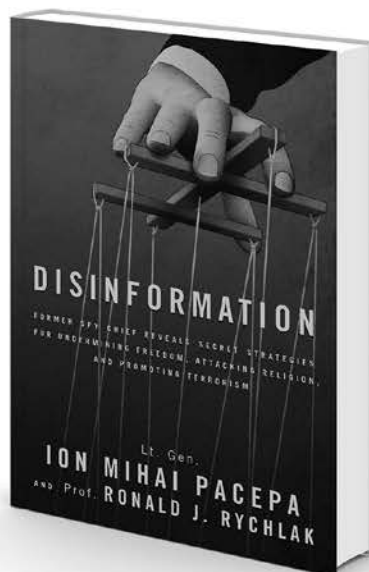
"Fortunately, many Americans are finding and joining health-sharing organizations, which have far fewer barriers to care," Brase said.

Matthew Glans ([mglans@heartland.org](mailto:mglans@heartland.org)) is a senior policy analyst at The Heartland Institute.

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—R. JAMES WOOLSEY, former Director of Central Intelligence

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# Obamacare Spurs Double-Digit Rate Increases

By Jim Waters

Health insurers are seeking double-digit rate increases in 2016 to continue covering enrollees in the Obamacare health insurance exchanges.

They report two factors are causing the increases: Fewer-than-expected younger, healthy Americans are purchasing insurance and costs are rising to treat previously uninsured older, sicker patients who are now seeking care for preexisting and often serious conditions.

Having now experienced the first full year of Obamacare, insurers are finding out the big-government approach to health care costs more than many of the Affordable Care Act's (ACA) supporters initially believed was possible, says John Garen, an economics

professor at the University of Kentucky.

"Health care is not free, and neither is health insurance," Garen said. "There is no such thing as a free lunch."

Not only is health insurance purchased on a government exchange far from free, it's about to get a lot more expensive if insurers have their way, Garen says.

BlueCross BlueShield is requesting a 36 percent rate increase in Tennessee after losing \$141 million in 2014 on plans it sold on the state's government-run exchange.

Exchange market leaders in other states want even steeper rate hikes. New Mexico's Health Care Service Corporation says it needs a 52 percent increase

in order to continue offering subsidized plans.

Under Obamacare, insurers must make public on the federal government's website any proposed rate increases of 10 percent or more. Insurers still have to go through the process of negotiating with state insurance regulators before any rates can be finalized.

Prior to ACA's passage, while it was being debated, the U.S. Department of Health and Human Services (HHS) indicated the law would keep premiums down by spreading out the cost of medical care. HHS's estimate was based on the prediction at least 40 percent of policyholders on the insurance exchanges would be between 18 and 35 years old, because this group is generally the healthiest population.

Instead, barely one-in-four purchasers in both 2014 and 2015 were in that age group. In Arizona and West Virginia, only 17 percent of policyholders are young adults.

During debate over ACA, Obamacare proponents said higher penalties for not purchasing insurance would force younger people onto the exchanges and stabilize premium rates. H&R Block reports the median penalty during 2014 for those without coverage was just \$178, less than one month's payment for individuals purchasing a bronze plan, Obamacare's lowest coverage level.

*Jim Waters (jwaters@freedomkentucky.com) is president of the Bluegrass Institute, Kentucky's free-market think tank.*

## New Mexico Rushing to Expand Medicaid Population

A new law will allow inmates at New Mexico prisons to apply for Medicaid and receive services once they're released.

Some states, including New Mexico, are rushing to expand their Medicaid populations to take advantage of the federal government's 100 percent financing promise, but that pile of federal money won't continue, says Nicole Kaeding, a budget analyst who focuses on federal and state

spending policy for the Cato Institute.

"The federal government will start decreasing its share in 2017," Kaeding said. "It's also quite possible that Congress will further cut the federal share as Congress confronts the realities of the federal budget. Those actions will leave New Mexico holding the bag."

— Staff Reports

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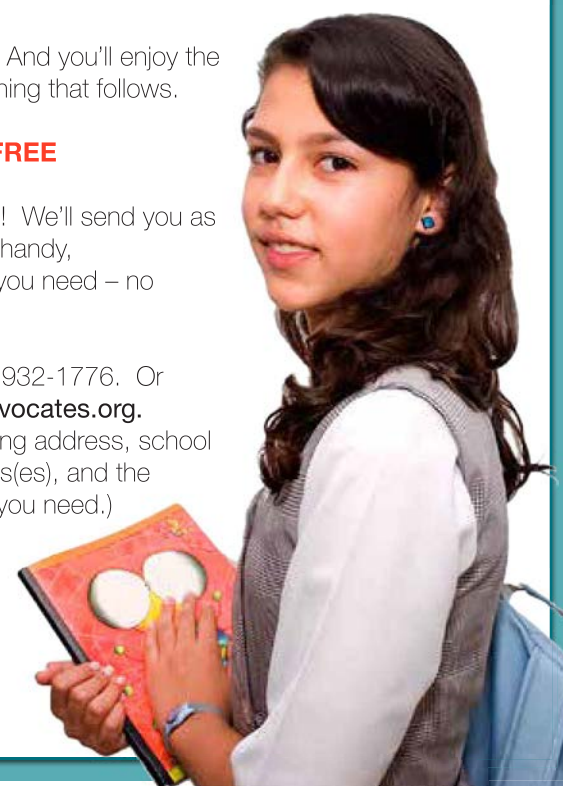
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# Kynect Insurers Request Double-Digit Premium Increases

By Jim Waters

The Kentucky Health Cooperative, the largest insurer on Kynect, Kentucky's Obamacare health insurance exchange, proposed a 25.1 percent health insurance premium rate increase for 2016.

Kentucky Gov. Steve Beshear (D) is unconcerned about the double-digit rate increase in his administration's signature policy.

"System-wide averages don't give a good picture of what an individual's out-of-pocket costs may be," Beshear said.

Beshear bypassed the legislature and created Kynect, the nation's first state-run health insurance exchange, through an executive order.

"The rates for private health plans on Kynect have been filed but have not yet been approved or certified, so we don't yet know what the final numbers will be," Beshear said. "Changes still may occur, and rates should be finalized sometime in mid-July, but we do expect that some plan rates will go down, some will go up, and some will stay close to the same as last year."

## Financial Problems Loom

In May, Standard and Poor's (S&P) reported Kynect is in serious financial trouble, especially because no federal bailout money will be provided after 2016, when Obamacare's risk corridor program ends.

S&P's report indicates the Kentucky Health Cooperative booked an amount of risk corridor receivables, which is money from a risk pool paid out in varying degrees to insurers who collected significantly less in premiums than the cost of providing benefits, equal to 117 percent of its capital. Kentucky had the second highest number of risk corridor receivables in the nation in 2014.

## Rate Hikes Will Vary

Beshear says rate changes will impact enrollees differently depending on their region, age, household income, and smoking status, and he argues the average numbers don't specify how much those rate fluctuations may affect individual policyholders.

Despite Beshear's assurances, all enrollees will pay significantly higher premiums in 2016.

BlueCross BlueShield of Tennessee's 36.3 percent average premium rate increase will result in increased premiums ranging from 19.5 percent to 59.5 percent. The top end of premium increases in New Mexico, where exchange market leader Health Care Service Corporation is asking for an average hike of 51.6 percent, would be even steeper.

The current 25 percent increase sought by the Kentucky Health Cooperative would mean the cooperative will have increased rates by 45 percent in Kynect's first two years of existence.

## Unintended Consequences Cited

The announcement of proposed premium increases arrived at the same time as a recently released report from Families USA, which found one in four people with health insurance plans purchased on government-operated exchanges skip doctor's visits and important medical tests because of high deductibles. The number is closer to one in three among poorer enrollees, the report says.

John Garen, an economist at the University of Kentucky, says the massive regulatory agenda of Obamacare is doing great damage to the health insurance and health care markets.

"It's frustrating, because it's like sticking your thumb in a leak—you stick it in and five more leaks pop up," Garen said.

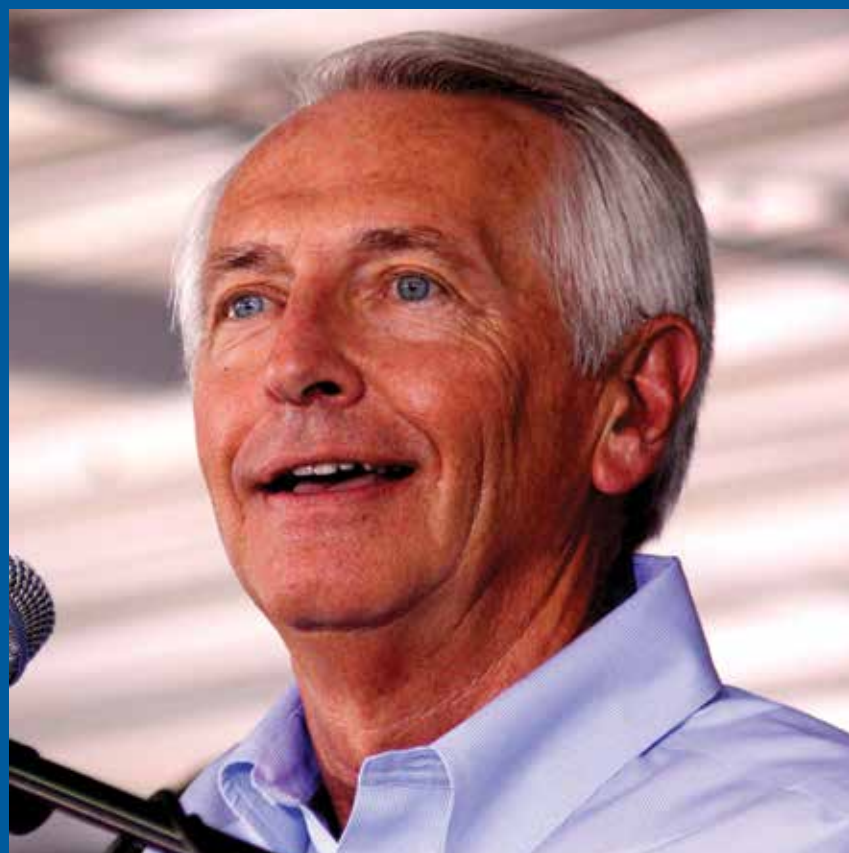
"If you want to help people who are poor and sick, ruining the market, as the Affordable Care Act threatens to do, isn't the way to do it," Garen said.

Garen says targeted policies are needed, such as funding for high-risk pools or vouchers that serve as private insurance for those in need of a safety net without ensnaring the whole population.

"Such an approach puts individuals back in charge of their own health care and reduces costs, which is one of the most important steps we can take to get back on the tracks toward a viable and affordable health care policy," Garen said.

## Political Battle over Kynect

Kynect's viability has been a hot topic during Kentucky's 2015 gubernatorial campaign, which will replace Beshear,



**"The rates for private health plans on Kynect have been filed but have not yet been approved or certified, so we don't yet know what the final numbers will be. Changes still may occur, and rates should be finalized sometime in mid-July, but we do expect that some plan rates will go down, some will go up, and some will stay close to the same as last year."**

STEVE BESHEAR, GOVERNOR, KENTUCKY

who is constitutionally barred from seeking a third term.

Jack Conway, the Democratic nominee, is backed by Beshear and supports Kynect. Republican nominee Matt Bevin proposes eliminating Kynect and moving its enrollees to the federal exchange. State Senator Jimmy Higdon (R-Lebanon), who serves on the state Senate's Health and Welfare Committee, also supports ending Kynect.

"I don't think we need it, and we can't afford it," Higdon said. "I think that it could be handled through the federal government. The state would save around \$30 million a year by not having to operate its own exchange, and it's not an overwhelming number of people we're talking about—about 100,000. The federal government, in taking them on, would barely notice, but it would greatly help our state budget."

Higdon says he supports plans to hold hearings by the state Senate's Health and Budget Committees in the fall before the legislature begins working on its biennial budget in January.

"Getting information on Kynect from this administration is like pulling teeth," Higdon said. "I think we would be surprised at what we find this administration has really spent on marketing, advertising, and operating this plan."

*Jim Waters (jwaters@freedomkentucky.com) is president of the Bluegrass Institute, Kentucky's free-market think tank.*

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# Medicaid Rolls Expanding Rapidly in Indiana

By Kenneth Artz

**H**IP 2.0, a plan proposed by Gov. Mike Pence (R-IN) to expand Medicaid in Indiana, has embarked on a \$2 million ad campaign to sign up more Hoosiers, despite criticism the plan's benefits are too generous and they disincentivize people from leaving the program.

Since February 1, HIP 2.0 has signed up some 177,000 Hoosiers, and the statewide ad campaign is projected to help increase enrollment by 357,000 by the end of 2015.

Pence's plan injects Medicaid with elements of a consumer-driven health plan developed under his predecessor as governor, Mitch Daniels (R), in which enrollees are encouraged to act more like cost-conscious consumers by paying attention to prices, using the emergency room only for emergencies, and keeping their appointments.

More than 71 percent of enrolled HIP 2.0 members are participating in the HIP Plus program, which provides vision and dental benefits as well as health insurance. It also allows mem-

bers to avoid copayments because they pay monthly payments into a type of health savings account (HSA). An individual with an annual income of \$10,000, for example, would pay about \$16 a month, and a family of four making \$32,000 would pay more than \$50 a month.

HIP Basic does not require a monthly premium, but it offers fewer benefits, and users have copays.

## Big Differences from Daniels' HIP

HIP 2.0 expands the Healthy Indiana Plan, a program first introduced in 2008 that expanded Medicaid eligibility to 200 percent of the federal poverty level—about \$44,000 a year for a family of four in 2008. It offered limited health benefits with a health savings account, much like the high-deductible, consumer-driven plans available on the private market.

The Healthy Indiana Plan under Daniels provided health savings accounts that required enrollees to meet a \$1,100 deductible, mostly funded with Medicaid dollars, before coverage kicked in, and they had to contribute monthly to their health savings account based on income—no more than 2 percent of household income for those below the poverty line. Those who stopped contributing would be kicked out of the program for a year, and enrollment would be capped based on available funding.

John Davidson, director of the Center for Health Care Policy at the Texas Public Policy Foundation, describes



Mike Pence  
Governor - IN



Mitch Daniels  
Former governor - IN

**"[It is] also possible that the HIP plan will curtail costs provided that people have some ownership over the HSA money."**

**GREG SCANDLEN**  
SENIOR FELLOW  
THE HEARTLAND  
INSTITUTE



HIP 2.0 as a long-term financial liability for Indiana. HIP 2.0 goes far beyond what the original HIP plan included, dragging the entire non-disabled Medicaid population into the expansion scheme, not just those above the poverty line, Davidson says.

HIP 2.0 offers enrollees a choice between a HIP Basic and a HIP Plus plan. Some can also choose a plan that supplements employer coverage, a longstanding feature of traditional Medicaid. The HIP Plus and HIP Basic plans feature a health savings account with a \$2,500 deductible, funded almost entirely by taxpayers.

## Consequences Removed

Davidson says the basic plan requires nothing of enrollees because they get a health savings account and can either pay into it or not, and the state will still cover the entire cost of the deductible and limit copayments to 5 percent of income, as they are for all Medicaid programs everywhere.

The HIP Plus plan also includes vision and dental coverage and comprehensive prescription drug coverage, and it requires no cost-sharing as long as an enrollee keeps up with the monthly contributions to their account, which range from \$3 to \$25 a month, Davidson says. An enrollee who stops paying into the account won't be kicked out of the program but simply gets put on the basic plan.

If you want to have HSAs built into Medicaid in order for enrollees to behave like people who actually have HSAs, then they need some kind of stake, or skin in the game, Davidson says.

## Criticized as Redundant

Devon Herrick, a senior fellow at the

National Center for Policy Analysis, says it makes no sense for Indiana to expand its HIP program to 200 percent of the poverty line because low-income individuals earning above the poverty line already have access to sliding-scale subsidies for private coverage in the Obamacare exchange.

"They would lose this under Pence's plan," Herrick said.

Greg Scandlen, a senior fellow at The Heartland Institute, which publishes *Health Care News*, says any income-based welfare program discourages individual initiative among recipients.

"That is axiomatic," Scandlen said. "But it is also possible that the HIP plan will curtail costs provided that people have some ownership over the HSA money."

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

## New York Mayor Goes After Salt

New York City could become the first U.S. city to require warning labels on restaurant chain menu items deemed too high in sodium.

The labels proposed by Mayor Bill de Blasio won't have much impact, says Jeff Stier, a senior fellow at the National Center for Public Policy Research.

"Those with high blood pressure who are salt-sensitive make up a small portion of the entire population, and they need to limit their salt intake from all sources anyway," Stier said. "For the rest of us, we actually can have a moderate amount of salt, which is actually above the current federal guidelines de Blasio relies on for his McLabel."

— *Staff Reports*

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John Davidson, "Indiana Gov. Mike Pence's 'Alternative' Medicaid Expansion Is the Worst One Yet," Texas Public Policy Foundation, January 28, 2015: <http://www.texaspolicy.com/blog/detail/indiana-gov-mike-pences-alternative-medicaid-expansion-is-the-worst-one-yet>

# House GOP Reveals Repeal-and-Replace Plan

Continued from page 1

AHCRA covers four broad areas: It encourages competition in the health care market, improves health care access for vulnerable Americans, supports medical breakthroughs, and reforms medical liability laws, according to its authors.

## Flexibility Praised

Josh Archambault, a senior fellow at the Foundation for Government Accountability, says AHCRA lays a solid foundation for greater access to insurance for more people than Obamacare provides, unlocks greater competition between health insurers, and helps lower the cost of insurance for most people.

"The bill is right to focus on health savings accounts as a tool to engage consumers in their health care," Archambault said. "These tools need to be more flexible, and this bill would help significantly in that effort."

Archambault expresses concerns about the provisions for high-risk pools for those with preexisting conditions. He says these pools had mixed records before Obamacare was enacted in 2010 and can be very expensive. Archambault suggests the federal government should instead seek state-based solutions, such as the pre-Obamacare high-risk reinsurance systems in Idaho and Maine, which cover individuals with preexisting conditions but keep them in the market with everyone else to keep premium costs down.

Archambault is also concerned AHCRA contains some questionable provisions that may violate constitutional provisions.

"There remain constitutional questions about doing medical malpractice reform at the federal level," said Archambault. "This would be better handled at the state level."

It is unlikely Obama would sign a law that repeals 100 percent of his signature law, but many ideas in the bill could end up in a replacement plan from Congress that gets signed by the president if the plaintiffs win the upcoming U.S. Supreme Court decision in *King v. Burwell*, Archambault says.

"The other political obstacle would be a move away from employer-based insurance to this standard deduction, but it is worth starting the conversation about such a change, as it has caused many of the dysfunctions we are dealing with today in health care," said Archambault.

## 'More Freedom and Control'

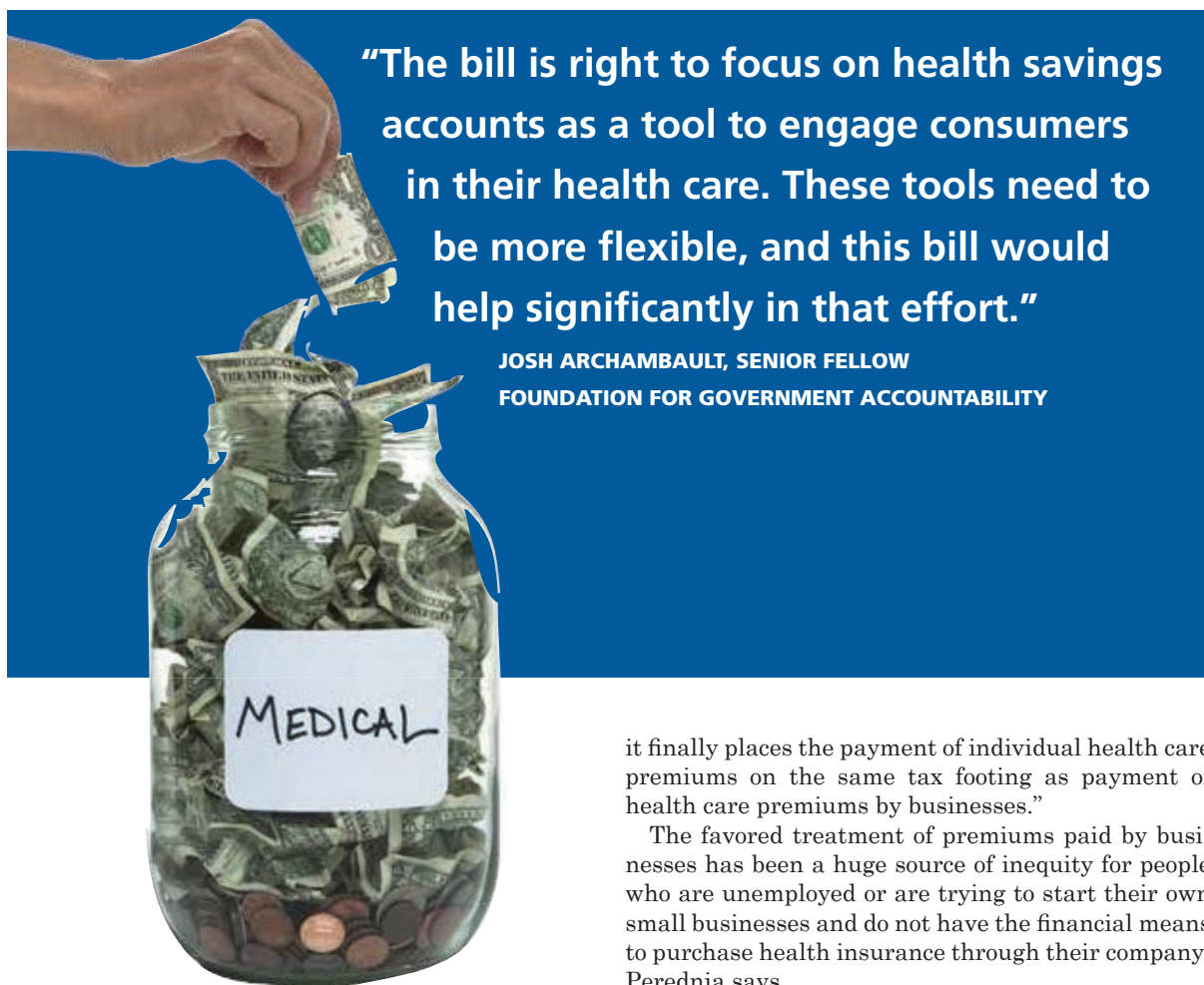
Twila Brase, president of the Citizens' Council for



**Phil Roe**  
Representative - TN



**Austin Scott**  
Representative - GA



**"The bill is right to focus on health savings accounts as a tool to engage consumers in their health care. These tools need to be more flexible, and this bill would help significantly in that effort."**

**JOSH ARCHAMBAULT, SENIOR FELLOW  
FOUNDATION FOR GOVERNMENT ACCOUNTABILITY**

Health Freedom, says the proposed bill would go a long way toward restoring health care freedom in America.

"[This] bill would not only expand choices for private health insurance, it would also give citizens more freedom and control over their health care dollars in health savings accounts and repeal a controversial comparative effectiveness council that could be used to ration care," Brase said.

Brase says the tax incentives for individuals would move people toward privately purchasing and individually owning health insurance policies, which is a necessity for reducing health care costs and avoiding preexisting condition exclusions.

"Given our organization's support for moving health care away from the federal level and to the states, we're pleased that this bill would remove many of the federal controls now in place as a result of Obamacare and other restrictive federal laws and regulations," Brase said.

## Reintroducing Competition

The bill does not eliminate federal health insurance subsidies but makes them fairer, says Dr. Doug Perednia, author of *Overhauling America's Health-care Machine*.

"They are substituting subsidies in the form of tax deductions for actual payments to individuals or insurers on the part of the government," said Perednia. "While the ultimate impact on federal deficits may be similar, this is a huge improvement because

it finally places the payment of individual health care premiums on the same tax footing as payment of health care premiums by businesses."

The favored treatment of premiums paid by businesses has been a huge source of inequity for people who are unemployed or are trying to start their own small businesses and do not have the financial means to purchase health insurance through their company, Perednia says.

"Obamacare advocates should be overjoyed at this, because it directly removes the insurance-based 'job lock' that prevents people from leaving their current jobs in order to follow their artistic, familial, or entrepreneurial tendencies," Perednia said.

## Praises Freedom to Choose

The bill's plan to provide everyone with a standard deduction for health insurance—\$7,500 per individual or \$20,500 per family—would be a great improvement over the current system, says Devon Herrick, a senior fellow at the National Center for Policy Analysis.

"This is far better than relegating Americans to coverage they must obtain in malfunctioning exchanges with convoluted subsidies," Herrick said. "Moreover, Americans would be free to choose the type of coverage that best meets their needs rather than being forced to enroll in a plan that's not of their own choosing."

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

## INTERNET INFO

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# FDA Bans Trans Fats

By Kenneth Artz

The U.S. Food and Drug Administration (FDA) has banned trans fats, demanding food companies remove the ingredient from their products, such as frostings, microwave popcorn, packaged pies, frozen pizzas, margarine, and coffee creamers, within the next three years.

FDA's rule says hydrogenated oils—the primary source of artificial trans fats in processed foods—are no longer generally recognized as safe for use in food. FDA says banning trans fats will help to reduce heart disease, the

nation's number one killer.

Jeff Stier, a senior fellow at the National Center for Public Policy Research, says such food policing by the federal government has unintended negative consequences. FDA's decision is wrongheaded and will force food makers to find more expensive and environmentally harmful alternatives to trans fats, he says.

## Concerns About Replacement

Stier says the most likely replacement for trans fats will be palm oil, which is more expensive because it comes from palm trees in Malaysia.

Stier says FDA's ban on trans fats could lead to deforestation in that country.

"Food companies will respond by switching to 'sustainable' palm oil, which will have to come from areas not as environmentally sensitive, and [will] thus cost more to produce," Stier said.

FDA estimates the ban will cost the food industry \$6.2 billion over 20 years as it reformulates products and substitutes ingredients.

"Food bans are a regressive tax that harm the people who can least afford it,

**"[The ban is] more 'window dressing' or 'intellectual placebo' than anything truly useful."**

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

because they will have to pay more for food," Stier said.

## Ross: Benefits Greatly Exaggerated

Dr. Gilbert Ross, executive director of the American Council on Science and Health, did not take any specific position for or against the ban, but he says FDA's estimate of the expected public health benefits of the regulation is greatly exaggerated given the relatively low levels of trans fatty acids now present in the nation's food supply as a result of the gradual removal of the ingredient by the food industry.

"While they posit the ban as a major boon to public health, in fact it's more 'window dressing' or 'intellectual placebo' than anything truly beneficial," Ross said.

Michelle Minton, a Competitive Enterprise Institute fellow specializing in consumer policy and FDA regulation of non-pharmaceuticals, says there was no need for the ban because the

nation's public had already educated themselves through labeling and public service announcements, which shows the free-market system works.

"Americans have almost completely eliminated trans fats from their diets voluntarily, so this proves the market works," Minton said. "The additive was generally recognized as safe, but this administration believes any amount is harmful. We know large amounts are not good for you, but none of the research has looked at the effects of low intake of trans fats.

"People should be able to make their own dietary decisions, not [coerced by] government and biased scientists," Minton said. "Government has shown time and time again that when it meddles in food choices, it makes the wrong decisions."

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

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# California Exchange Is Running out of Money

Continued from page 1

falling half a million enrollees short will mean financial strain for the exchange," Chen said.

Covered California's 2015–16 budget proposal outlines possible consequences of such a shortfall.

"If enrollment is larger than anticipated, we will look to lower the assessment we charge health plans," the proposal states. "If enrollment were to be lower, we would look at reducing costs, reduce our reserves or raise the assessment we charge health plans."

## Federal Money Drying Up

All the federal money given to help start the exchanges is gone, so Covered California will begin cutting its budget and drawing down on the approximate-

ly \$200 million it set aside during the startup period, Chen says.

In addition to the revenue shortfalls, Covered California is not an effective way to help Californians obtain health insurance, Chen says.

"Consider that even before the passage of Obamacare, California had a robust individual insurance marketplace where folks could buy insurance from many different places," Chen said. "For example, you had web brokerages like Ehealthinsurance.com that were revolutionizing the way that people bought health insurance."

Bureaucracy clearly played a role in the downfall of Covered California, Chen says.

"Covered California required Californians who wanted to buy subsidized coverage to complete their enrollments by telephone, even where a Web-based option was available," Chen said. "This added layer of bureaucracy is demonstrative of why Obamacare is driving up costs in our health care system and ultimately making it more difficult for people to get access to quality, affordable health coverage."

## INTERNET INFO

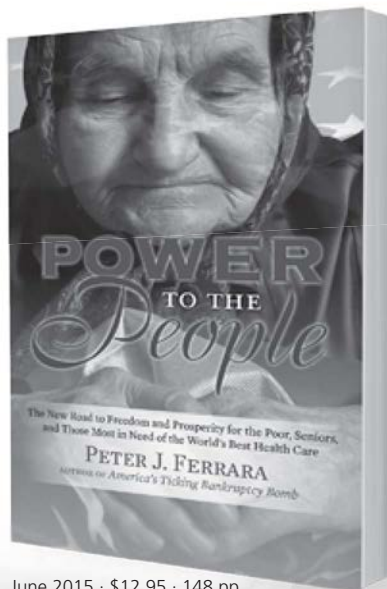
"Financial Reports," California Health Benefits Exchange: <http://hbex.coveredca.com/financial-reports/>

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**"Even spending all of the money they did on advertising, they still managed to sign up far fewer Californians than they expected. In fact, they've signed up about 1.27 million people, when they expected to enroll 1.8 million."**

LANHEE CHEN  
HOOVER INSTITUTION

## Unrealistic Estimates

The revenue and spending estimates used in setting the Covered California budget were unrealistic, Chen says.

"They expected to bring in \$242 million in revenues, but they are going to fall far short of that number, and it is unlikely they will remain sustainable in the long run without federal funding, which goes away next year," Chen said.

Chen says there have been countless media stories about the failure or impending failure of state-operated health insurance exchanges, and although California's exchange isn't quite there yet, it demonstrates the folly of trying to create organizations that are both regulators and marketplaces.

"Ultimately, what's needed is a system where people can get access to a wide variety of plans and can choose the one that suits them best, rather than being forced to shop in a constrained marketplace where only certain plans are offered and people are forced into buying potentially much more coverage than they need," Chen said.

"That's what is helping to drive up costs under Obamacare, and why citizens in some states are sure to experience even more rate shock when they try to buy Obamacare plans next year," Chen said.

Loren Heal ([loren.heal@gmail.com](mailto:loren.heal@gmail.com))  
writes from Neoga, Illinois.

## Connecticut Cuts Medicaid Budget

Some 23,700 low-income parents in Connecticut will lose Medicaid coverage under the new state budget. This reduction comes less than two years after a much-touted expansion of coverage under the federal health care law.

Merrill Matthews, a resident scholar with the Institute for Policy Innovation, compares Obamacare's Medicaid expansion to the drug dealer who provides an addictive substance for little or no cost to lure the victim in until hooked.

"Democrats and the Obama administration, like the drug dealer, knew exactly what they were doing when they made Medicaid expansion free for a few years," Matthews said. "Soon many of those states that took the bait will have to make significant budget cuts in other places to pay for its addiction."

— Staff Reports

# Sanders Bill Would Make Generic Drug Firms Pay Rebate

By Kenneth Artz

A bill aimed at lowering the cost of generic drug prices by forcing generic drug manufacturers to pay a rebate to Medicaid when their drug prices rise faster than inflation has been introduced in the Senate by Sen. Bernie Sanders (I-VT), the ranking member of the Senate Budget Committee, and in the House by Rep. Elijah Cummings (D-MD).

Sanders says the health care system is overly costly and that reining in high drug prices using the regulatory authority of the government is the best way to control consumer costs. Sanders is an avowed socialist and has pushed for a government-run single-payer health insurance system in the United States.

Generic drugs have long been seen as a way to keep drug costs lower by boosting competition, but both Sanders and Cummings say they are troubled by price spikes in the generic market and are offering the Medicaid Generic Drug Price Fairness Act as their solution.

A study published in *The New England Journal of Medicine* in 2014 found the price of the generic antibiotic doxycycline increased from 6.3 cents per pill to \$3.36 per pill in the course of just one year.

Sanders and Cummings say extending rebates to generic drugs will save taxpayers \$1 billion over 10 years.

## Drug Application Backlog

Sanders and Cummings missed the boat with their proposal, says Devon Herrick, a senior fellow at the National Center for Policy Analysis.

"Generic drug prices can only rise when there isn't enough competition to hold the prices in check," Herrick said.

"Rather than demand generic drug rebates, they should propose ways to help the U.S. Food and Drug Administration process the backlog of 4,000 drug applications from firms applying to manufacture generic drugs," Herrick said.

## Price Controls and Shortages

John C. Goodman, a senior fellow at the Independent Institute and president of the Goodman Institute for Public Policy Research, says Sanders' proposed price controls will lead to shortages, black markets, and patients being unable to

get the drugs they need.

"This would not be something negotiated," Goodman said. "It will be imposed, and manufacturers will find it is not profitable to sell in this market, so we will get shortages. Then we will get a black market, and the hospitals will take advantage of the situation because they get to buy the drugs cheaply due to the price controls. [They can then] resell those drugs to non-poor patients, which they have been doing with brand-name drugs."

The bill would affect all generics sold in the United States, no matter where they are produced, but the United States already has the lowest-priced generic drugs in the world, Goodman says.

"They produce generic drugs in Canada, so they protect them [through import controls]," said Goodman. "They produce generics and import their brand-name drugs while keeping the price up on their generics and discriminating against U.S. imports. Then on the brand drugs, it's the other way around: They squeeze the brand producer with price controls."

Dr. Roger Stark, a health care policy analyst at the Washington Policy Center and a retired physician, says artificial controls on the prices of goods inevitably create shortages of those items.

"This is economics 101," Stark said. "In fact, [such a policy approach] turns economics upside down."

## Bill Promotes Class Warfare

Dr. John Dale Dunn, an emergency physician and policy advisor to The Heartland Institute, which publishes *Health Care News*, says Sanders is a perfect example of a utopian socialist who promises the world but can't deliver anything except economic contraction.

"His bill is just a formalized effort to promote class warfare by pitting himself against big corporations—you know, the ones that provide us with a pretty darn good quality of life by delivering goods and services like medicines, electricity, automobiles, and food," Dunn said.

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



**"Rather than demand generic drug rebates, they should propose ways to help the U.S. Food and Drug Administration process the backlog of 4,000 drug applications from firms applying to manufacture generic drugs."**

DEVON HERRICK, SENIOR FELLOW, NATIONAL CENTER FOR POLICY ANALYSIS

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## FIXING PUBLIC PENSIONS

Pensions: Securing retirement benefits for current and future public employees.

by Kim Crockett



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## ANALYSIS

# Steep Hikes in Obamacare Insurance Premiums Indicate the Cost ‘Death Spiral’ Is Under Way

By John R. Graham

*The Wall Street Journal* reports major insurers in some states are proposing hefty rate boosts for plans sold under Obamacare, setting the stage for an intense debate this summer over the law’s impact.

In New Mexico, market leader Health Care Service Corporation is asking for an average jump of 51.6 percent in premiums for 2016. The biggest insurer in Tennessee, BlueCross BlueShield of Tennessee, has requested a 36.3 percent

increase, on average, for its plans. In Maryland, market leader CareFirst BlueCross BlueShield wants to raise rates 30.4 percent across its products. Moda Health, the largest insurer on the Oregon health exchange, seeks an average boost of around 25 percent.

Health insurance companies cite high medical costs incurred by people newly enrolled under the Affordable Care Act.

The *Journal’s* article notes insurance commissioners in some states have the power to roll back rates if they judge them to be too high. The U.S. Secretary of Health and Human Services also claims to have a similar power, although there is no legal basis for it. It is unlikely insurance commissioners will be able to protect people from these rate hikes, because excessive rollbacks will merely cause health plan providers to exit the market, which would be catastrophic for Obamacare’s political future.

## Unexpectedly Early Arrival

Many health insurance experts predicted a coming death spiral, but it is remarkable the collapse of Obamacare is happening now. The situation must be worse than insurers are publicly disclosing to convince them to raise rates so rapidly in such a short period.

Obamacare is the best possible scenario for health insurers—a guaranteed market for their product. It is still very much at risk from the upcoming Supreme Court decision in *King v. Burwell*, however, and from Republican politicians who remain united in pledging to repeal and replace it with patient-centered health reform.

In light of those threats, health insurance plan providers should want to move public opinion in favor of Obamacare by keeping rate hikes low. They should even be willing to lose money in the insurance exchanges until Obamacare is secure. The

exchanges are still a small part of their book of business, so they can subsidize losses in exchanges for a while without risking solvency.

Much of the cost of the rate hikes will be borne by taxpayers instead of enrollees, because Obamacare’s tax credits to insurers operating in exchanges are based on the benchmark (the second-cheapest silver plan) and limited by beneficiaries’ household income. That too is hardly good news for Obamacare’s political future.

Announcing these rate hikes in summer 2015 indicates health plan providers’ experience in Obamacare exchanges must be painfully expensive.

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

## INTERNET INFO

John R. Graham, “Obamacare Premiums Explode,” National Center for Policy Analysis: <http://healthblog.ncpa.org/obamacare-premiums-explode/>

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## San Francisco to Require Warnings on Sodas

San Francisco is on its way to becoming the first in the nation to pass a law requiring health warnings on all ads for sugary drinks, putting soda in the same category as alcohol and tobacco.

Even if these warning labels work, they’re not likely to help anyone lose weight, says Michelle Minton, a senior fellow at the Competitive Enterprise Institute.

“If you weren’t already aware that consuming excess calories from any source may lead to weight gain, all this label tells you is that soda could make you fat,” Minton said. “But what happens when people switch to fruit juice—which is exempt from the label law? It’s just as easy to pack on weight by consuming an extra 300 calories from orange juice as it is from 300 calories from soda.”

Considering the amount of money our government throws at this issue, if their meddling did anything you would think we’d have seen an effect by now, Minton says.

“At best, we’ve seen a plateau in obesity, which is more likely due to people starting to ignore the government food guide pyramid they grew up with,” Minton said.

— Staff Reports

## LEGISLATIVE PULSE: MONTANA

*Editor's Note: The following is an interview with state Rep. Tom Burnett, a Republican member of the Montana House of Representatives from District 67. He previously represented District 63 in the Montana House from 2011 to 2013. Burnett serves on the Appropriations and Health and Human Services Committees.*



**"Misdirected resources vex taxpayers. Two examples of measures we take to minimize misspending are state audits of providers to correct miscoding and attention to applicants' records to thwart shielding of assets when an elderly person seeks Medicaid for nursing home placement."**

**TOM BURNETT**  
STATE REPRESENTATIVE  
GALLATIN COUNTY, MONTANA

**By Ken Artz**

**Artz:** How much does Medicaid cost your state annually, and how is it affecting your state's budget?

**Burnett:** Medicaid costs \$1.2 billion this fiscal year, 23 percent of our total state budget. It pays for the births of 43 percent of our babies, and enrollment has grown from 77,000 to 125,000 since 2002. This represents tacit [Medicaid] expansion, just without the official title.

Montana reimburses providers like doctors, hospitals, psychiatrists, pharmacists, social workers, and group homes at a higher rate than all but four states. For example, Montana pays \$43.63 for a 10-minute office visit, whereas Utah pays only \$31.15 for the same visit. The Urban Institute reports that our reimbursement rates are 33 percent above the national average. Why a state where wages are 49th out of the 50 feels it can afford this baffles me.

**Artz:** What is the per-enrollee spending for Medicaid in your state, and by how much would burden go up if Montana expanded the program?

**Burnett:** Montana's per-enrollee spending is \$1,350. Montana's per-enrollee costs were above the national average in 2011, according to the Kaiser Family Foundation. Multiply that by 125,000 enrollees and you arrive at \$168 million a year, or \$506 for each state taxpayer.

In 2008, Montana's per-enrollee costs were the 10th highest of all the states, while our median household income languished near 46th place. Expansion will likely reduce per-enrollee costs, as the most needy populations are already in the program, but program growth, in absolute terms, is expensive.

**Artz:** Are fraud and waste in the program a problem in Montana?

**Burnett:** Misdirected resources vex taxpayers. Two examples of measures we take to minimize misspending are

state audits of providers to correct miscoding and attention to applicants' records to thwart shielding of assets when an elderly person seeks Medicaid for nursing home placement.

These program abuses likely pale in comparison with the phenomenon of applicants failing to report the income of all household residents as the program requires. A boyfriend in the household may have substantial income that the girlfriend fails to report, for instance. The number of children actually residing in the household is another opportunity for incorrect statements. The more children listed, the easier it is to meet federal poverty guidelines and qualify for benefits. Eligibility workers say household composition is lied about on a daily basis.

A federal rule change in October of 2013 allows a person to self-attest pregnancy, no doctor statement needed. This allows an applicant to obtain "full Medicaid," as opposed to basic Medicaid, receiving a better package of benefits.

Eligibility workers were aghast at hearing about the rule change. Medicaid's problems leave a great deal of

room for improvement so that benefits can go to the truly needy and taxpayers can have confidence their desire to help is being met appropriately.

**Artz:** Should Montana have fixed Medicaid before expanding the program?

**Burnett:** Medicaid should definitely be fixed, though the Montana Legislature instead recently enacted Obamacare Medicaid expansion, unwisely in my opinion. Up to 70,000 people—and there's no assurance that's actually an upper limit—will be added to the dependency rolls, weakening the self-reliance aspect of the pursuit of happiness.

At its core, Medicaid is a health care welfare program for our society's most needy. It is clear to eligibility workers that there is tremendous abuse of the system. We should put more effort into fixing the current system so that it provides benefits to the most needy instead of increasing spending to grow the program.

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

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## COMMENTARY

# Medicare Rules, State Regulations Prevent Cost-Saving Innovations

By John Goodman

**H**ave you ever wondered why doctors are reluctant to talk to you on the phone?

It's been almost a century since all the other professionals discovered the telephone is a handy way of communicating with clients, but not doctors. Why is that?

The short answer is that of the 7,500 tasks Medicare pays doctors to perform, somebody forgot to put "talking on the phone" on the list. Same for e-mail. Most private insurers and most employers pay the same way Medicare pays. That's why you can't communicate with your doctor the way you communicate with your lawyer or your accountant.

Help is on the way. A Dallas-based firm called Teladoc is providing telephone consultations to nearly 11 million patients nationwide. Say you are on a business trip and your allergy prescription runs out. You put in call to Teladoc and in 30 minutes or less you get a call back from a doctor who has access to your medical records. After a brief consultation, the doctor prescribes the medication you need.

**"The path forward is not as easy as it ought to be. The Texas Medical Board ... wants to put Teladoc out of business. If it gets its way, you won't be able to get a prescription from a doctor unless you have seen that doctor face to face, and communicating by Skype doesn't count."**

The service is a godsend. On average, the wait time to see a new doctor is five days in Dallas. Nationwide, the wait is about three weeks, significantly longer than the instantaneous consultation offered by Teladoc. *Dallas Morning News* writer Jim Landers reports the average primary care physician visit for a new patient in Dallas costs \$125. The national average is \$118. The cost for a Teladoc consultation is \$40 or less.

## Medical Board Interference

Telemedicine is the wave of the future. It's convenient and cost efficient. That's why a lot of employers are ignoring Medicare payment practices and sign-

ing their employees up.

The path forward is not as easy as it ought to be. The Texas Medical Board (TMB), acting as if it's a wholly owned subsidiary of the Texas Medical Association, wants to put Teladoc out of business. If it gets its way, you won't be able to get a prescription from a doctor unless you have seen that doctor face to face, and communicating by Skype doesn't count.

TMB claims it is only interested in protecting patients, but the same board that thinks you shouldn't be able to get a prescription from a Teladoc doctor you have never met says it's permissible for you to get a prescription from an "on-call" doctor you have also never met who is substituting for your regular doctor and probably isn't looking at your medical records when he orders the prescription.

## Protecting Doctors from Competition

Why is one okay and not the other? The only difference I can see is economic. On-call doctors add to total health care spending. They increase revenue for doctors as a whole. Teladoc is challenging orthodoxy and threatens to lower the cost of care and reduce overall physician incomes.

Let's not ignore patient safety. There are problems that cannot be handled over the phone and require face-to-face encounters. But who are the best people to make those decisions? You and a doctor who has your medical records or an impersonal group of bureaucrats who have never met either of you and who seem to be motivated primarily by protecting doctor incomes from unwelcome competition?

The current conflict is nothing new. The American Medical Association was formed more than a century and a half ago, and its goals were political from



day one. Scholarly studies—including my own book *Regulation of Medical Care*—court documents, and other records have produced overwhelming evidence the long-term goal of organized medicine has been to create the equivalent of a medieval guild.

Texas has surrendered to this raw pursuit of special-interest favoritism. It has some of the most stringent regulations limiting the ability of nurses to deliver the care they are qualified to give and some of the most harmful restrictions on walk-in clinics in the nation.

The United States should embrace these innovations, not outlaw them. The quickest way to lower taxpayer costs, raise quality, and improve access to care for the more than 100 million Medicare and Medicaid patients would be to give them immediate access to phone and e-mail services, walk-in clinics, and the services of nurse practitioners.

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

## Drug Transparency Bill Shelved in California

A drug transparency bill in the California State Legislature, thought to be the first of its type in the nation, has stalled. AB 463, proposed by Assembly Member David Chiu (D-San Francisco), would have required pharmaceutical manufacturers to explain their prices.

The actual point of the bill was to mislead the public, says John C. Goodman, a senior fellow at the Independent Institute and president of the Goodman Institute for Public Policy Research.

"They want to know how much you spent on the drug you are selling, not how much you spent on the other 999 drugs you tried and failed to develop," Goodman said. "They don't need to force Pfizer to disclose what it spends on R&D, because I suspect we already know what it is from their annual report."

— Staff Reports

## INTERNET INFO

Jim Landers, "Is Texas quashing competition among doctors or upholding safety?" *Dallas Morning News*: <http://www.dallasnews.com/business/columnists/jim-landers/20150413-is-texas-quashing-competition-among-doctors-or-upholding-safety.ece>

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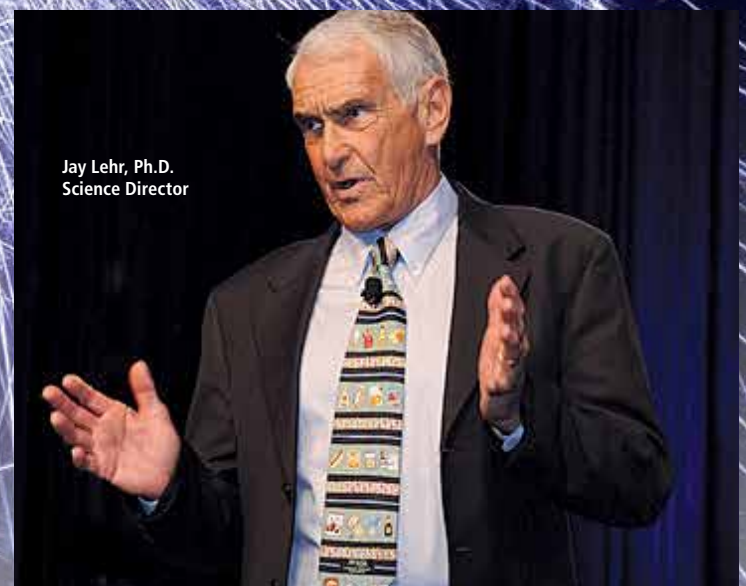
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