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HEALTH CARE NEWS

THE MONTHLY NEWSPAPER FOR HEALTH CARE REFORM

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Vol. 16 No. 5 ~ June 2015

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California Seizes Estates

Some families of deceased Medicaid patients in California are receiving big bills from Medi-Cal, the state's Medicaid insurance program.

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Doctors in the Netherlands frequently withhold and withdraw treatment from the elderly, according to a study published in the *Journal of Medical Ethics*.

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S. Carolina Certificate of Need

South Carolina's House of Representatives voted 103–1 in April to end the state's certificate of need law in 2018.

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State Exchanges in Trouble

Almost half of the 17 health insurance exchanges set up by the states and the District of Columbia are in trouble financially and struggling to survive.

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Obama Threatens to Pull Funding from States over Medicaid Expansion



By Sean Parnell

“Expand Medicaid or else!”

That's the message the Obama administration sent to Florida, Kansas, Tennessee, and Texas. President Barack Obama has threatened to withdraw special funding to pay hospitals and doctors for care provided to impoverished citizens if the states do not comply.

The Centers for Medicare and Medicaid Services gave officials in those states the same message: Expand Medicaid or risk losing federal funding for “uncompensated care pools,” Medicaid money that helps pay for health care for the uninsured.

Florida could lose out on \$1.3 billion in uncompensated

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Chipotle Backs off GMO-Free Claim

By Kenneth Artz

Chipotle, the popular burrito restaurant chain, said in April it was going to stop offering its patrons genetically modified foods (GMO), pledging to no longer use modern biotechnology crops for any of its ingredients.

But the chain known for its “food with integrity” motto quickly had to back off from its promise to “remove the few GMOs in our food so that our cus-

tomers who choose to avoid them can enjoy eating at Chipotle.”

The company issued the following disclaimer: “[I]t is important to note that most animal feed in the U.S. is genetically modified, which means that the meat and dairy served at Chipotle are likely to come from animals given at least some GMO feed.”

CHIPOTLE, p. 6

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Coca-Cola Takes on Scaremongers

By Mathew Glans

At the April meeting of the Coca-Cola Company's shareholders, the National Center for Public Policy Research urged the soft drink manufacturer's CEO, Muhtar Kent, to do more to promote the safety and benefits of genetically modified organisms (GMOs).

The food industry has come under constant assault from anti-science activists demonizing GMOs in recent years.

Kent was asked to make himself and Coca-Cola's health scientists and nutrition specialists available to the media to combat unscientific activists and stand up for the promise of GMOs.

Kent replied, "Many of our regulatory affairs executives and scientific executives are involved in those discussions, and I'm very happy to even recommit them to a very productive dialogue with organizations like yours. And I'm very happy to be also a part of those where it can serve a purpose."

Debunking Unscientific Theories

Greg Conko, executive director of the Competitive Enterprise Institute, says Coca-Cola's strategy is the right approach to combating anti-GMO scaremongers, but U.S. companies have a long way to go.

"People love Coca-Cola and other major brands like Kellogg's, McDonald's, and Kraft Foods," Conko said. "These are brands people trust, so if consumers start hearing more from these people, and particularly from scientists within those sectors, then they are going to be exposed to more rational explanations, and maybe they are going to start asking questions."

Conko says radical green groups such as Greenpeace and the Center for Food Safety have been unchallenged when putting out misleading information stating people should avoid Coca-Cola because it contains high-fructose corn syrup, has genetically engineered ingredients, has too much sugar and too much caffeine, or other characteristics activists cast as worrisome.

If Coca-Cola isn't saying, "No, no, no, wait a minute, here's what we know about the ingredients we use," people are absolutely going to hear only one side of the argument, Conko says.

"But if Coca-Cola or some of those other companies start meeting these crazy theories with scientific evidence, then it will get consumers to start asking questions and it will get easier for them to get information from other trusted avenues like their family doctor, the health section of their newspa-

"People love Coca Cola and other major brands like Kellogg's, McDonald's, and Kraft Foods. These are brands people trust, so if consumers start hearing more from these people, and particularly from scientists within those sectors, then they are going to be exposed to more rational explanations, and maybe they are going to start asking questions."

**GREG KONKO
EXECUTIVE DIRECTOR
COMPETITIVE ENTERPRISE INSTITUTE**



pers, consumer reporters on television, etc.," Conko said.

"We need to start getting into those places where people are getting their news," Conko said. "That, along with the food companies standing up and defending themselves and their products, is what we really need to do to reach consumers."

Some Bend, Some Don't

CEOs who support sound science and refuse to bend to activist campaigns should be applauded, says Dr. Gilbert Ross, executive director of the American Council on Science and Health.

"It might be more productive to go to a company whose leadership is wavering on the subject and explain to them scientifically why it's repugnant to have companies flee from the science in order to please what they consider to be consumer concerns, which are exaggerated tremendously anyway," Ross said.

Need to Practice Self-Defense

Companies should refute the activists and stand up for their products if they are not doing anything wrong, says

H. Sterling Burnett, a research fellow of The Heartland Institute, which publishes *Health Care News*.

"Coke, just like all soft drinks, has been using corn syrup for its sweetener for a long time," Burnett said. "If soft-drink companies like Coke are not using cane sugar, they're probably using corn syrup, which means they're using GMO corn. As long as there's been corn syrup in soft drinks, there's been GMO corn in soft drinks. Not a single person has been shown to be harmed by this."

Burnett says these products are safe, and the people who are arguing against GMO ingredients, products, and medicines are fringe characters.

"They're just missing the boat," Burnett said. "These products are no less safe than anything else, regardless of the way they are created. In fact, they are better. You're not modifying perfect foods, because perfect foods don't need modification. They're making these foodstuffs better."

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

Obamacare Regulations Fell Assurant Health

By Matthew Glans

It's a tough time to be a small insurance company.

In 2010, the year President Barack Obama signed the Affordable Care Act (ACA), better known as Obamacare, Assurant Health (AH) had a net income of approximately \$54 million. Today, it may no longer have any value at all, because it is no longer a viable business. Some 1,700 employees company-wide might lose their jobs as a result.

In 2014, AH lost \$63.7 million and was on track to report operating losses of \$80 million to \$90 million for the first quarter in 2015. AH's parent company, Assurant Inc., says the company will be sold or shut down.

Underwriting Essentially Negated

AH must endure the disadvantage of being a fairly small company and one that once relied on prudent health underwriting before Obamacare. It primarily deals with individual and small-employer policies, says Dr. Roger Stark, a health care policy analyst at the Washington Policy Center and a retired physician.

"The guaranteed-issue aspect of the ACA essentially negates underwriting. Health insurance companies have struggled with plan pricing for the past few years because they now must sell to anyone, regardless of pre-existing conditions."

DR. ROGER STARK
POLICY ANALYST
WASHINGTON POLICY CENTER



"The guaranteed-issue aspect of the ACA essentially negates underwriting," Stark said, referring to Obamacare rules requiring health insurers to allow anyone to enroll, even if they're already sick. "Health insurance compa-

nies have struggled with plan pricing for the past few years because they now must sell to anyone, regardless of pre-existing conditions.

"Additionally, carriers must include all 10 benefit mandates required in the ACA, all of which potentially drive up plan prices," Stark said. "Unlike automobile or homeowners insurance, health insurance companies have no control over accepting risk and no control over their insurance product."

Company 'Embraced' Obamacare

Merrill Matthews, a resident scholar with the Institute for Policy Innovation, says AH's struggles are unfortunate but were predicted by nearly everyone—except the company's CEO.

"Because the company focused on individual and some small-group coverage, Assurant should have led the way in fighting Obamacare," said Matthews.

"But the company embraced it, along with the health insurance industry, with Assurant's CEO explaining to me he thought the industry's lobbying efforts would ensure the final legislation would be good for the health insurance industry and his company," said Matthews. "It was clear to me at the time that while the CEO might have understood insurance, he knew nothing about politics."

ACA Winnows Out Smaller Businesses

The dynamics of ACA make it impossible to remain in business as a smaller insurance company, says Greg Scandlen, founder of Consumers for Health Care Choices and a senior fellow at The Heartland Institute, which publishes *Health Care News*.

Scandlen says Assurant supported Obamacare with the naïve belief having a law requiring everyone to buy what it sold would be good for its business, but two things about Obamacare made the hope illusory.

"The massive [ACA] regulations require the resources that only a giant company can provide," Scandlen said. "Why? Because all of the regulations must be met regardless of the size of the company. These costs must be spread across a very large base of business."

Insurers Must Micromanage Care

Obamacare no longer allows for the traditional "insurance" model to remain in business, says Scandlen. Collecting premiums and paying claims is not enough. The company must micromanage every aspect of the health care system in order to survive.

"There are no longer insurance companies in any meaningful sense of the term," Scandlen said. "They are health care management companies that actively control the behavior of patients, doctors, hospitals, and every other participant in health care delivery. Assurant never had the market clout or internal expertise to do any of that."

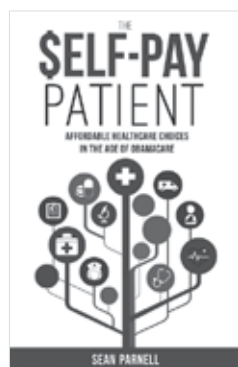
Scandlen says the United States is entering into an era of health care oligopoly where only four or five companies will control the entire system. These companies will have only one master: the federal government. No one else can determine a company's success or failure.

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

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Calif. Seizes Estates of Some Deceased Medicaid Patients

By Kenneth Artz

Some families of deceased Medicaid patients in California are receiving big bills from Medi-Cal, the state's Medicaid insurance program for the poor.

Medi-Cal's "estate recovery program" was established under a 1993 federal law granting states the option to seize assets of Medicaid beneficiaries after they die.

The law mandates states recover assets for nursing home care, and it also allows them to recover payment for medical services such as doctor visits, hospital stays, and other medical services for people 55 and over. Advocates say only 10 states engage in this optional recovery, and California is the most aggressive state taking advantage of the law.

SB33, a pending Senate bill introduced in 2014 by California state Sen. Ed Hernandez (D-West Covina), would abolish this practice of the California government.

Seen as Property Rights Violation

Gennady Stolyarov, editor-in-chief of *The Rational Argumentator*, says confiscation of the estates of deceased Medicaid recipients is an unconscionable violation of private property rights, especially with Medicaid becoming the sole recourse for paying for health care for a growing segment of the population.

"For such Medicaid recipients, a modest home may be one of their only major assets and a significant source of economic stability and hope for a more prosperous future," Stolyarov said. "If a deceased person's home is confiscated by Medi-Cal or another state's Medicaid program, then it cannot be passed to surviving family members, who might struggle to find an affordable shelter as a result."

Stolyarov says the estate recovery program is an example of an extremely hardhearted government program that forces people to suffer because of family members' prior debts or health care needs.

"A person should not lose the family home because one of his or her deceased parents had little or no income and took recourse to Medicaid to pay for treatments for terminal cancer or another

terrible disease," Stolyarov said. "This is especially true given the fact most Medicaid recipients have no easy way of knowing their estates are put in jeopardy when they sign up for the program."

This situation also sends a cautionary message about socialized health care arrangements purporting to provide "free" medical care, Stolyarov says.

"There is always a cost, and there are always strings attached when any aspect of health care is centrally planned," said Stolyarov.

Likened to Death Tax

Seton Motley, president of the public policy organization Less Government, says it's unfair for Medi-Cal to engage in estate recovery when citizens have been paying into the program for years in the expectation it will cover them at the end of their life.

"The U.S. House of Representatives just passed a repeal of the death tax," Motley said. "This is another death tax, and the Republicans' message should be, 'This is a death tax too, and we're getting rid of the states' option to come after you when you are already dead.'"

Sally Pipes, president of the Pacific Research Institute, agrees Medi-Cal's asset recovery system is just a second death tax.

"California needs more revenue because people with money are leaving the state and people who [rely on] entitlements are coming into the state," Pipes said.

The government and the people who are still in California can't afford all the entitlement programs the state has, and for the government to take funds from people who are on Medi-Cal or from their estate is just wrong, Pipes says.

"I like to say the Department of Motor Vehicles doesn't offer insurance to people, and it doesn't sell cars,"



"A person should not lose the family home because one of his or her deceased parents had little or no income and took recourse to Medicaid to pay for treatments for terminal cancer or another terrible disease."

GENNADY STOLYAROV, EDITOR-IN-CHIEF, *THE RATIONAL ARGUMENTATOR*

Pipes said. "So why should the California health care system and Medi-Cal make decisions about what kind of care people can get and whether they have coverage or not? It's completely wrong. "But the state needs the money,"

Pipes said. "And it's the liberal mentality to take it."

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

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 get it online at heartland.org.



INTERNET INFO

Sen. Ed Hernandez, Senate Bill 33, Proposed in the California State Senate, December 1, 2014: <https://www.heartland.org/policy-documents/sb-33-would-eliminate-medi-cals-option-estate-recovery>

Chipotle Backs off Claim of Being GMO-Free

Continued from page 1

The disclaimer also stated, “Many of the beverages sold in our restaurants contain genetically modified ingredients, including those containing corn syrup, which is almost always made from GMO corn.”

GMOs Are Here to Stay

H. Sterling Burnett, a research fellow at The Heartland Institute, which publishes *Health Care News*, says it would be extraordinarily difficult for any company with as many restaurants as Chipotle to eliminate all GMO ingredients.

“They say that their meats are free of hormones, and they tout being a restaurant chain that uses only organic foods, but there’s not enough organic corn in the world to accomplish this promise,” Burnett said.

Chipotle, like many other companies making similar announcements, has come to recognize GMOs are here to stay and are nearly everywhere in modern agriculture, Burnett says.

“They made this big, splashy announcement,” said Burnett. “The press shows up and they say, ‘Oh, they’re using non-GMO corn. They really care about us.’ But the fact is Chipotle had to add a little asterisk at the bottom of its ad telling us Chipotle is not really GMO-free because its beef, chicken, and pork come from animals that are raised on farms, and that means they are probably fed GMO corn. And the same goes for the tortillas, cooking oils, etc., because there is a chance they’re also made from GMO corn.”

Burnett says the important thing is neither the ad nor the disclaimer, because GMO ingredients are perfectly safe.

Clotting Agent Needed

Chipotle announced it was going to eliminate GMO ingredients in its corn and cooking oils, but the big one that no one seems to talk about is the cheeses, says Greg Conko, executive director of the Competitive Enterprise Institute.

“Most cheeses, unless they are the soft [types], that are made in the United States are produced with a clotting agent called Chymosin, a genetically engineered protein that is made from genetically engineered yeast and bacteria,” Conko said. “You need the clotting agent to curdle the milk into cheese.”

Conko says most cheeses produced in the United States are made with Chymosin, as is probably 90 percent of all the cheese produced globally. “It’s now used in essentially all cheeses, unless

“I’ve seen signs in its stores for years that talk about how their meals come from animals that weren’t fed any antibiotics, so in a sense, this was the next logical step for them to take and pretend to be greener than thou. But it turns out that it’s really all for show.”

GREG KONKO
EXECUTIVE DIRECTOR
COMPETITIVE ENTERPRISE INSTITUTE

it’s a real high-end, artisanal, dairy-type operation,” Conko said.

Chipotle has not made any announcement about getting rid of cheese produced with Chymosin.

Soda Sweeteners, Feed Overlooked

Conko says another ingredient Chipotle uses is soda sweeteners.

“Nearly all soft drinks in America now use high-fructose corn syrup, which is derived from commodity corn that contains GMOs,” Conko said.

Commodity corn is also fed to cows, pigs, and chickens, so it’s likely GMOs

are in much of the meat Chipotle serves from animals fed commodity grain.

“Chipotle has been touting for a very long time its commitment to sustainability and its environmental practices,” Conko said. “I’ve seen signs in its stores for years that talk about how their meals come from animals that weren’t fed any antibiotics, so in a sense, this was the next logical step for them to take and pretend to be greener than thou. But it turns out that it’s really all for show.”

So why do it? Conko says the fast-food industry is responding to consumer shifts toward what are perceived to be healthier foods.

“This is kind of a way for companies in that industry to try and carve out a niche for themselves and make consumers feel better about eating a 1,000-calorie burrito,” Conko said.

Kowtowing to Fear-Mongers

The flight from GMOs by companies such as Chipotle, Panera Bread Company, and others is nothing more than kowtowing and pandering to overhyped fears, says Dr. Gilbert Ross, executive director of the American

Council on Science and Health.

“They believe the public is afraid of biotechnology and GMO foods,” said Ross. “Instead of standing up for the science, since every scientific body in the world says GMO ingredients are perfectly safe and that their potential for helping agriculture is real, and saving a lot of people from malnutrition and starvation ... we now have these people saying [genetically engineered] food is ‘Frankenfood,’ and they’re scaring the public.”

This fear is being promoted by big organic companies that have a vast amount of money and very powerful friends, Ross says.

“They’re trying to scare the public away from GMOs and get GMOs labeled because they think the public will have to buy more organic, which is more expensive but confers no health benefit whatsoever,” Ross said.

“It makes no sense scientifically, medically, or by any other standard,” Ross said.

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



Millennials' Insurance Premiums Skyrocketing

By Sean Parnell

Health insurance premiums for young, healthy Americans have increased significantly under the Affordable Care Act (ACA), also known as Obamacare, at the close of the law's second open-enrollment period, according to a recent analysis from The Heritage Foundation.

Researchers at Heritage found non-group health insurance premiums paid by millennials increased on average 5.3 percent from 2014 to 2015, which is in line with what analysts expected. For the nation's 27-year-olds, premiums increased by 8.46 percent.

Millennials in some states were hit with double-digit increases. In Alaska, young enrollees in Obamacare saw their premiums increase 28 percent, from \$216.12 per month in 2014 to \$235.57 in 2015. This is comparable to the 28 percent increase among 50-year-old Alaskans and the 24 percent increase for family rates.

Other states with insurance spikes for millennials are Kansas (17.8 percent), Louisiana (17.22 percent), Minnesota (19.2 percent), North Carolina (15.6 percent), Ohio (19 percent), Pennsylvania (18 percent), Tennessee (18 percent), and Virginia (15 percent).

Community Rating Cited As Cause

Dr. Roger Stark, a health care policy analyst at the Washington Policy Center and a retired physician, says ACA has a mandate of community rating, which means the young and healthy pay more for insurance than they would in a free market.

"Premium prices for those aged 18 to 34 went up compared to pre-ACA pricing," Stark said.

"The individual mandate theoretically forces young adults into the insurance pool [at higher prices], yet many young people are going without insurance and paying the fine or tax," Stark said.

'Fair' and Expensive Premiums

Merrill Matthews, a resident scholar with the Institute for Policy Innovation, says every pro-liberty health policy expert had tried to explain to the Democrats writing Obamacare that "modified community rating"—in which the government prohibits insurers from pricing health insurance based on an applicant's risk factors, allowing only some variation based on age and geography—would drive up the cost of health insurance for younger and healthier people.

"Democrats refused to listen—well, almost [completely]," Matthews said.

The Senate version of Obamacare,



the version that actually became the law, permitted only a three-to-one spread in premiums, meaning the most expensive premium could be only three times higher than the least expensive, Matthews says. Actuaries say the spread should be more like five-to-one or seven-to-one.

Matthews says the House version allowed only a two-to-one spread, which would have made health insurance even more expensive for young people.

"And so premiums are going up for younger people, even though much of the cost is hidden by federal subsidies," said Matthews. "And it will likely only get worse as the [nation's] population ages."

In an attempt to make premiums "fair," reducing the normally wide variation in premiums, young people, who would normally have very low premiums, have to pay significantly more.

Required to Overcharge Young

The price of premiums under Obamacare has always been a guessing game, says Greg Scandlen, founder of Consumers for Health Care Choices and a senior fellow at The Heartland Institute, which publishes *Health Care News*.

Insurers have no idea what kind of risks are enrolling each year because they are not allowed to ask basic health

questions, Scandlen says. Without knowing the risks they are attracting, insurers cannot know how much to charge.

This problem was eased somewhat under Obamacare's reinsurance risk corridors and risk adjustment programs that subsidized companies that lost money over the first three years. But those programs simply allowed companies to underprice their policies, Scandlen says. Those subsidies will soon no longer be available, so insurers will have to get more serious about pricing.

There is an even more important issue at work as well, Scandlen says: Obamacare required insurers to overcharge young people to subsidize older people.

'Fundamental Contradiction' in ACA

Proponents of ACA claimed insuring younger people was one of the most important reasons to support the law, says Scandlen.

"Most of the uninsured have always been under age 30," Scandlen said. "So there is a fundamental contradiction: Health plans are required to overcharge the very people they most want to attract."

The policy wonks in Washington, DC tried to square this circle by punishing people who failed to enroll and provid-

ing subsidies to many who do enroll, but these carrots and sticks are extremely hard to administer, Scandlen says.

"Most of the people who received subsidies are now having to pay back some of the money they got, and the penalties apply only to those who get tax refunds," Scandlen said.

"The more complicated this all gets, the more likely young people are to just ignore the whole thing," Scandlen said. "Most of them don't think they need health insurance in the first place, so they are not motivated to work through all the complications."

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

INTERNET INFO

Drew Gonshorowski, "2015 ACA-Exchange-Premiums Update: Premiums Still Rising," *Issue Brief #4366*, The Heritage Foundation, March 20, 2015: <https://www.heartland.org/policy-documents/2015-aca-exchange-premiums-update-premiums-still-rising>

Obama Threatens States over Medicaid Funds

Continued from page 1

care funding if the state decides not to expand Medicaid. Gov. Rick Scott (R) is threatening to sue the Obama administration if it cuts funding, which is set to expire June 30.

Forcing States to Reconsider

The U.S. Supreme Court ruled the federal government could not force states to expand Medicaid under the Affordable Care Act (ACA), but the Obama administration has taken a different track to accomplish the same goal.

Dr. Roger Stark, a health care policy analyst at the Washington Policy Center and a retired physician, says the Obama administration is targeting hospitals that deal with a high percentage of low-income people who receive funds through the Medicaid and Medicare Disproportionate Share Hospital (DSH) programs in an effort to force Medicaid expansion.

Stark says the architects of ACA assumed the number of uninsured and underinsured people would drop precipitously beginning in 2014, when states expanded Medicaid. Hospitals in

states that did not expand Medicaid are now facing a decrease in DSH funding with no offset in reimbursement from Medicaid.

"Basically, the federal government is now forcing non-expansion states to reconsider," Stark said. "Each of these states must do a cost analysis. State taxpayers may still be better off without expansion, and there is no question federal taxpayers would be better off without expansion."

Federal Pay to Play

The federal government has historically provided additional money to hospitals with a disproportionate share of uninsured patients to cover some of those costs, says Merrill Matthews, a resident scholar with the Institute for Policy Innovation.

"Obamacare's creators envisioned near-universal coverage ... so [they] planned to sunset those additional funds," Matthews said. "They never anticipated that about half of the states, thanks to a Supreme Court ruling, would refuse to expand Medicaid."

Matthews says in an attempt to work around the Supreme Court ruling, fed-

eral officials have reverted to an old-but-effective tactic: Tell the states that if they want federal "pay," they have to "play."

"The real scandal here is the citizens of states send their tax dollars to Washington, DC and the feds will only let them have their money back if they do what Washington wants them to do," Matthews said. "It would be a great campaign theme for the various presidential candidates: The only tax money going to Washington should be for what the federal government needs to fulfill its limited, constitutional obligations."

Federal Coercion

Greg Scandlen, founder of Consumers for Health Care Choices and a senior fellow at The Heartland Institute, which publishes *Health Care News*, says although the Supreme Court has already ruled the states cannot be coerced into expanding Medicaid, the Obama administration seems to be focused on its own whims and preferences.

"The federal government has long made funds available to hospitals that

serve large numbers of poor and uninsured," Scandlen said.

That money has continued to be sent to hospitals because coverage expansions do not fully solve the problem of uncompensated care. Now, the Obama administration is threatening to cut off those funds to any state that has not expanded Medicaid, even though the Supreme Court has ruled such expansions must be left to the states.

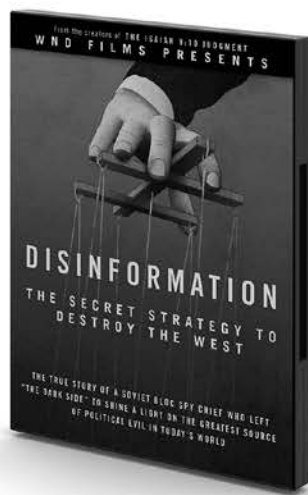
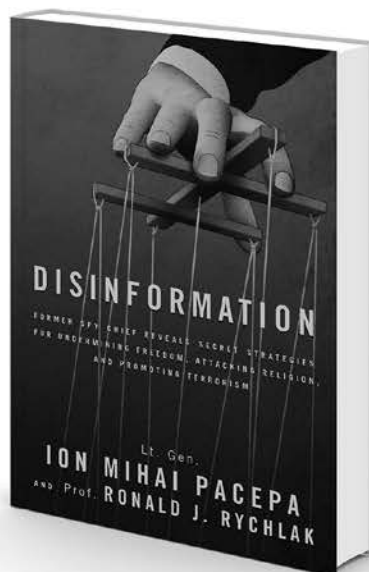
"The administration argues states which expand Medicaid will not need as much uncompensated care money," said Scandlen. "That may or may not be true, but it shouldn't matter to the federal government because it is providing the funds in either case—in the form of Medicaid payments or in the form of uncompensated care payments. Which method of providing care is better for its own people should be a state decision."

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

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Obamacare Strains Emergency Rooms

By Jim Waters

Three-quarters of the 2,099 doctors responding to the nationwide survey conducted by the American College of Emergency Physicians indicate they have seen an increase in emergency room (ER) visits since the Affordable Care Act (ACA), better known as Obamacare, went into effect on January 1, 2014.

In the same survey, 28 percent of the respondents say ER use has “increased greatly.”

What providers are witnessing daily in the ER is not what the Obama administration promised would happen, says Dr. Richard Armstrong, a surgeon who practices in Michigan and serves as a board member of the Docs4PatientCare Foundation.

“Obamacare obviously did nothing to reduce the incentive for patients to use the ER as their primary care doctor,” Armstrong said.

High ER Primary Care Costs

All people make their choices based on incentives, and yet Obamacare did nothing to require co-pays from Medicaid patients, Armstrong says.

“It’s not unusual to see a Medicaid patient who simply has a headache to come to the emergency room instead, because it won’t cost them anything to get some Advil [there], which they could buy themselves at the drugstore across the street,” Armstrong said.

This drives up the cost of care for hospitals who believe they are bound by law to treat these patients and don’t want to turn patients away. A 2013 study by the Robert Wood Johnson

Foundation reported a visit to the ER costs about \$580 more on average than the same treatment administered in a primary care doctor’s office.

Picking Plans Does Not Work

One of the stated primary goals of Obamacare is to expand Medicaid, even though it’s long been known Medicaid patients use the ER more than patients with other means of paying, says Dr. John O’Shea, a Pennsylvania surgeon who also serves as senior fellow in The Heritage Foundation’s Center for Health Policy Studies.

The problems are worse in states with the greatest shortage of primary care physicians, which are the same states experiencing the largest expansion of Medicaid, O’Shea says. This situation will be exacerbated if government projections of primary care physician shortages come true. Some experts predict the United States could have a shortage of primary care physicians exceeding 20,000 doctors by 2020.

O’Shea says the cost of health care is also being driven up by government officials picking plans for low-income patients rather than allowing market forces to control the process, including allowing these patients to choose care that works best for them.

“This is another serious reminder the government picking plans, even for Medicaid patients, just doesn’t work,” O’Shea said. “It would be better for the government to heavily subsidize patients and let them choose the care that works best for them, rather than what is happening now.”



“Obamacare obviously did nothing to reduce the incentive for patients to use the ER as their primary care doctor.”

DR. RICHARD ARMSTRONG, BOARD MEMBER, DOCS4PATIENTCARE FOUNDATION

Instead of doing the hard work of addressing specific problems in the health care system, such as the lack of access to primary care doctors by Medicaid patients, O’Shea says it was politically easier just to declare millions of previously uninsured people were now covered.

“It looks really good politically, and that’s what they went for,” O’Shea said.

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

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Dr. Oz Criticized for Unscientific Issue Advocacy, Endorsements

By Kenneth Artz

Citing controversial positions and unscientific public statements, 10 doctors have signed a letter stating Dr. Mehmet Oz should be fired from the faculty of Columbia University.

Oz, a faculty member and cardiothoracic surgeon at Columbia University Medical Center, moonlights on TV and radio as “Dr. Oz” and “America’s doctor,” often dispensing advice on miracle cures and fat-burning pills. His critics say he’s nothing more than a modern-day charlatan and snake-oil salesman.

“Dr. Oz has repeatedly shown disdain for science and for evidence-based medicine, as well as baseless and relentless opposition to the genetic engineering of food crops,” wrote Dr. Henry I. Miller of the Hoover Institution at Stanford University, along with nine other doctors. “Worst of all, he has manifested an egregious lack of integrity by promoting quack treatments and cures in the interest of personal financial gain.”

“[Oz is guilty of] outrageous conflicts of interest or flawed judgments about what constitutes appropriate medical treatments,” wrote Miller.

Miller and the other nine doctors who signed the letter say Oz should no longer remain on the faculty of a “prestigious medical institution.”

Numerous Irresponsible Claims Cited

Dr. Gilbert Ross, medical and executive director of the American Council on Science and Health and a signer of the letter, says although Oz may be a very good cardiothoracic surgeon, he is out of his depth when it comes to talking about nutritional supplements, magical cures, energy-harnessing, talking to the dead, and special supplements that will burn fat without exercise or diet.

“It’s all nonsense and snake oil,” Ross said. “He’s a TV pitchman, and for being an entertainer on TV, he’s doing quite well.”

Ross says the problem is Oz is known as “America’s doctor.”

“I think [Oz] calls himself that, and



Dr. Mehmet Oz

PHOTO COURTESY MICHAEL VUERTENBERG / WORLD ECONOMIC FORUM. SWISS-IMAGE.CH

he has an audience of several million people, many of whom trust everything he says, and some of them actually look upon him as their own doctor,” Ross said. “They don’t have another doctor, and when you ask them who their doctor is, they say ‘Dr. Oz.’

“Unfortunately, he has a lot of followers who will do anything he says, so when he talks about nutrition, supplements, snake oil, magic fat burners, miracle cures, and various antioxidant potions, that’s very irresponsible of him,” Ross said.

School’s Prestige at Issue

Ross says the TV doctor’s pitching of irresponsible cure-alls is why he cosigned the letter to the Columbia Medical School faculty suggesting they review Oz’s qualifications to remain a spokesman under the auspices of the highly respected medical school.

“Now, since all this happened and it became a big public eruption and a maelstrom, [Oz] did his own show and the national news shows where he attacked the people who wrote the letter, myself included, to distract attention from his own malfeasance,” Ross said.

Oz promised to clean up his act a little and his logo for the show, making the “Dr.” a little smaller, and he now says the program is not really a doctor show but instead is just TV entertainment, Ross says. Oz also agreed to resist the urge to aggressively sell miracle cures.

Neglect of Surgical Career

Dr. John Dale Dunn, an emergency physician and policy advisor to The Heartland Institute, which publishes *Health Care News*, says the worst thing about the situation is Oz’s apparent neglect of his career as a cardiothoracic surgeon.

“I’m guessing he makes a good living at it and is relatively successful, but now he’s in an area he knows nothing about—biochemistry, pharmacology, molecular biology, etc.—and he’s reaching out to expand his fame and fortune,” Dunn said.

“Oz is a surgeon,” Dunn said. “He got into this because surgeons fix things. They don’t want to be TV stars or salesmen. But here he is. I would bet he got into [the discussion of] GMO foods because he knew he would get a lot of support from a lot of neurotic people

“Dr. Oz has repeatedly shown disdain for science and for evidence-based medicine, as well as baseless and relentless opposition to the genetic engineering of food crops. Worst of all, he has manifested an egregious lack of integrity by promoting quack treatments and cures in the interest of personal financial gain.”

DR. HENRY I. MILLER
HOOVER INSTITUTION

who are afraid we’re creating Frankenfoods.”

Oz Backs Away from Miracle Cures

Concern about the lack of science behind many of Oz’s unscientific claims and questionable medical advice has been growing over the years and reached a new level in the spring of 2014, when members of Congress grilled him about having helped advance fraudulent claims about dietary supplements, says Angela Logomasini, a senior fellow in environmental risk, regulation, and consumer freedom at the Competitive Enterprise Institute.

Rather than owning up to or defending the positions he has taken, Oz personally attacked the 10 doctors, which didn’t work, Logomasini says.

“Oz is finally being held accountable for a lot of the junk science he has peddled on his show,” Logomasini said. “And it’s having an impact. At least Oz has backed away from claims about dietary supplement ‘miracles’ that cure obesity. Whether he will change his tune on other things remains unclear.”

Logomasini says criticism of Oz appears to be part of a larger trend countering junk science in the media and on the Internet, and it appears to be a nonpartisan and apolitical movement.

“New science-minded voices have emerged within the medical community—see Sciencebasedmedicine.org—and among science bloggers—see Scibabe.com,” Logomasini said. “Dr. Oz and others who benefit from sensationalist unscientific claims are finally being called to the mat, and it’s about time.”

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

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FDA Policies Driving Up Costs of Generic Drugs

By Devon Herrick

Consumers increasingly report sticker shock as generic drugs sold for decades have suddenly become scarce and expensive.

Sometimes generic drug prices skyrocket due to aging equipment. Old drugs are often made on aging production lines, which are sometimes shut down for maintenance or stopped after the manufacturer is warned by the U.S. Food and Drug Administration (FDA) that the facility is out of compliance with current good manufacturing practices.

Another reason drug prices rise is when one of the few remaining suppliers ceases production and retools to make newer, more profitable drugs. After a manufacturer leaves the market, it can take many months for FDA to approve a new firm applying to enter.

"The FDA is partially responsible for ongoing generic [price] inflation," said Adam Fein, president of Pembroke Consulting, a drug channel consultancy.

Fein says FDA has a backlog of about 4,000 applications to clear and the agency's regulatory hurdles are blocking Indian generic drugmakers from entering the market.

"Buying pharmaceuticals from the perspective of the patient or the hospital is not like buying a car or a dishwasher," said Dr. Jeremy Greene, a physician and assistant professor of medicine at Johns Hopkins University. "You can't just wait for them to go on sale."

"We don't control the timing of when we are sick and need to buy essential medicines," said Greene. "Price spikes are neither rare nor trivial."

Removing Generics from Market

In 2006, FDA implemented an initiative to get some cheap generic drugs off the market. More than 1,000 medications predate FDA's approval process under the 1938 Food, Drug & Cosmetics Act and were grandfathered in but never officially approved. Although many of these remedies have been used safely for decades, FDA wants them off the market and replaced with expensive "approved" versions from any drugmaker willing to conduct clinical studies on them.

One example is Colchicine, an inexpensive drug used to treat gout and other inflammatory conditions. A pharmaceutical company agreed to conduct clinical studies on the 3,000-year-old remedy and sought FDA approval for it as a new drug. Once approved by FDA, the generic, grandfathered versions of



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DR. JEREMY GREENE, JOHNS HOPKINS UNIVERSITY

the drug were pulled from the pharmacy shelves. As a result, the therapy's price rose from pennies per pill to as much as \$7 per tablet.

Another example is neostigmine, which is routinely used at the end of surgery to reverse the effects of anesthesia. It had been used for decades and predated FDA's approval process. After a drugmaker began clinically testing the product, the generic versions of the old drug became scarce, as other manufacturers knew the older, generic versions would be forced off the market. Once Bloxiverz, the newer version of neostigmine, was approved in June 2013, the exclusive manufacturer was able to raise the price. Between October 2013 and April 2014, the price rose by 522 percent, according to a congressional investigation.

One of the most egregious examples of price hikes for testing an old drug is Delalutin, a progesterone injection originally approved in 1956 to prevent

miscarriages. Although Delalutin was dropped by its manufacturer in 2000, it was still available at compounding pharmacies for about \$10 per injection. In return for performing some small clinical trials for its use in preventing preterm births, a drugmaker was granted an exclusive seven-year permit to market it as an "orphan drug" under the brand name Makena. Armed with an exclusive right to sell the drug, the price shot up from just \$10 per injection at compounding pharmacies to \$1,500 for the name-brand injections. Makena's price was later reduced to \$690.

No Problems, Still a Problem

Shortly after FDA's 2006 initiative began, Deborah Autor, director of the Office of Compliance at the FDA Center for Drug Evaluation and Research, told *FDA Consumer* magazine, "Even if the drug has been marketed for many years with no known safety problems,

companies will still need to comply. The absence of evidence of a safety problem does not mean a product is truly safe."

Joseph Biskupiak, a research professor in the Department of Pharmacotherapy at the University of Utah, says it is hard to fault companies for trying to recoup the cost of expensive clinical trials.

"FDA cannot approve a drug without the clinical trials, so it is up to Congress to decide if it is really necessary to conduct a clinical trial on a drug that has been used for many years just to get it approved," said Biskupiak.

"[Congress could legislate] an alternative pathway to approval for these grandfathered drugs that does not require a costly clinical trial," Biskupiak said.

Some of the generic drug price spikes are unavoidable as firms update facilities or decide to exit the market, and some generic drug inflation is due to slow action by FDA. In other cases, FDA is needlessly forcing consumers to pay higher prices to prove a drug that's been used safely for decades is actually safe.

Devon M. Herrick, Ph.D. (devon.herrick@ncpa.org) is a health economist and senior fellow at the National Center for Policy Analysis.

States Can't Be Sued Over Low Medicaid Rates, Court Rules

By Sean Parnell

In a victory for states trying to hold down Medicaid costs, the U.S. Supreme Court ruled providers cannot sue over low reimbursement rates.

The case, *Armstrong v. Exceptional Child Center*, was brought by a group of Idaho providers of Medicaid services who sued Idaho state officials, arguing their payments from the state were too low under the governing statute.

Federal law requires states to set Medicaid reimbursement rates at levels ensuring payments are consistent with efficiency, economy, and quality of care, but it generally leaves states free to determine the specific rates.

The court's ruling prevented state budgets from undergoing even greater stress from Medicaid funding, says Josh Archambault, a senior fellow

at the Foundation for Government Accountability.

"If providers had prevailed in this case, a Pandora's box of litigation would have been opened, with providers in all 49 other states suing for higher reimbursement rates," Archambault said. "As a result, the cost of paying for the current Medicaid population would have exploded for taxpayers."

The win for taxpayers and state budgets will likely lead to continued problems for the poor in accessing health care, Archambault says.

"The flip side of the decision is that many Medicaid patients will come to realize that having access to a Medicaid card is not the same as having access to health care," Archambault said. "Many providers decide to not participate in



"The flip side of the decision is that many Medicaid patients will come to realize that having access to a Medicaid card is not the same as having access to health care."

JOSH ARCHAMBAULT
SENIOR FELLOW
FOUNDATION FOR GOVERNMENT
ACCOUNTABILITY

the program due to poor reimbursement rates."

No 'Cause of Action'

The court's ruling focused on whether the federal law requiring states to set Medicaid reimbursement rates created a "cause of action" for providers allowing them to sue in court if the state failed to adhere to the law's requirements.

The Ninth Circuit Court of Appeals ruled there was such a cause of action, but the Supreme Court reversed the decision and ruled Congress had not included a private cause of action, so the courts could not step in to determine whether the state was compliant with the law.

Writing for the majority, Justice Antonin Scalia said, "[T]he sole remedy Congress provided for a State's failure to comply with Medicaid's requirements—for the State's 'breach' of the Spending Clause contract—is the withholding of Medicaid funds by the Secretary of Health and Human Services."

In previous cases the Supreme Court had ruled the "express provision of one method of enforcing a substantive rule suggests that Congress intended to preclude others," Scalia wrote.

'Unsustainable, Deteriorating Program'

Archambault says the case shows it's time to consider fundamental reforms to restructure Medicaid.

"Instead of focusing on the debate over reimbursement levels, the case should push policymakers to ask tough questions about the value we are getting for the tax dollars being currently spent, and if we should have so many individuals on an unsustainable, deteriorating program," Archambault said.

"In other words, is there a better way to lower health care prices and costs for all individuals, or a better way to administer Medicaid coverage than the current, broken, safety net program?" said Archambault. "Those policy discussions are much more important in the long run [than it is for] providers ... to get their hands on more taxpayer money or patients falling through the cracks of a poorly designed, government-administered [health care] program."

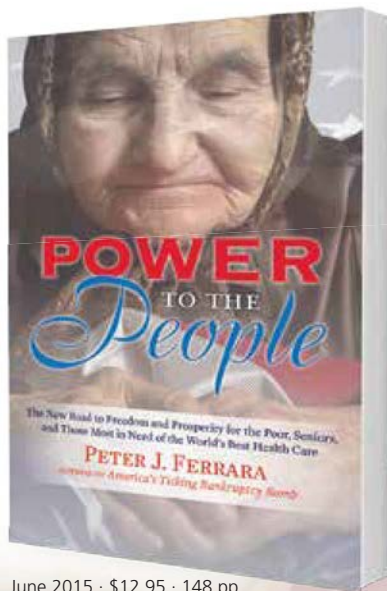
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Nevada Seeks to Abolish Health Insurance Exchange

Nevada has joined the growing ranks of states with failing state-run health insurance exchanges. NevadaHealthLink.com, also known as the Silver State Health Insurance Exchange, was launched in October 2013 as part of President Barack Obama's health care overhaul. It got off to a rocky start, firing Xerox one year after hiring the company to run its exchange, a move that prompted several Nevada Republicans to call for scrapping the project.

Few Nevadans even used it, says Devon Herrick, a health economist and senior fellow at the National Center for Policy Analysis.

"After it failed to live up to its hype, state officials pulled the plug and decided to let the feds run it," Herrick said. "As the federal funds run low, I expect more states will decide to abandon the exchange and let state residents just buy off the federal exchange."

—Staff Reports

Dutch Elderly Are Often Denied Treatment

By Kenneth Artz

Doctors in the Netherlands frequently withhold and withdraw treatment from the elderly, a study published in the *Journal of Medical Ethics* has found.

The researchers say this is not the result of prejudice against the elderly but instead for considerations of comfort and respect and an intention to avoid pointless treatment. Critics say the true purpose of the Netherlands officials' actions is to save the government money by denying care to the elderly.

The study, titled "Old age and forgoing treatment: A nationwide mortality follow-back study in the Netherlands," found that forgoing treatment decisions were made for a substantial percentage of patients in the Dutch population and that rates increased steadily with age. The three types of treatment most frequently withheld or withdrawn were artificial hydration/nutrition, medication, and antibiotics, with significant differences among the age groups studied.

Hospitals as Houses of Horrors

"The Netherlands is known for euthanasia," Twila Brase, president and cofounder of Citizens' Council for Health Freedom, said. "If euthanasia is an option, then you can become [vulnerable to] those who think you've become a burden because you haven't already availed yourself of euthanasia."

Any time euthanasia is available, the hospital becomes a place of terror, says Brase.

"It is no longer a sanctuary, but a house of horrors, where if you go in you might not come out because someone may decide you can't come out," Brase said. "Hospitals are becoming a scary place, and not for the usual reasons."

Coming to the USA?

With the implementation of the Affordable Care Act and the growing unsustainability of Medicare, which are part of a \$43 trillion unfunded liability, payroll taxes will no longer be able to cover the costs of Medicare, Brase says.

"Payroll taxes are not even paying for today's retirees," Brase said. "2008 was the first year where the amount brought in by payroll taxes was insufficient, so now we are in our seventh year of deficit spending. [We're] squeezing doctors, paying higher costs, and limiting treatment; the docfix bill will push [doctors] to ration care if things continue down this road and no one intervenes to institute radical change."

The push is on for providers to



"It is no longer a sanctuary, but a house of horrors, where if you go in you might not come out because someone may decide you can't come out. Hospitals are becoming a scary place, and not for the usual reasons."

TWILA BRASE
PRESIDENT AND COFOUNDER
CITIZENS' COUNCIL FOR HEALTH FREEDOM

ration care because the money is being rationed, Brase says.

"If we don't want to go down the road the Netherlands is on, we must repeal Obamacare and create an escape hatch for Medicare," Brase said.

Denying Care to the Elderly

Sally Pipes, president of the Pacific Research Institute, says the American public does not want a similar problem to take hold in the U.S. health care system. The way government-centered health care systems, such as the National Health Service (NHS) in the United Kingdom and Canada's universal health care system, reduce costs is by denying care to the elderly, Pipes says.

The Dutch, British, and Canadian governments make decisions about how long people should live and how much care they should get, Pipes says. Government bureaucrats end up making decisions for families.

"I'm really worried that unless we

repeal and replace Obamacare, we're going to be in a situation of ultimately getting a single-payer, universal health care system where the long-term survival of our elderly will be at the discretion of government, not doctors, patients, and families," Pipes said.

Patient's Consent Deemed Essential

Seton Motley, president of the public policy organization Less Government, says the first question he would ask is: Did the patient want that to happen?

"If not, then they're murdering these people," Motley said. "This is why I don't want state officials working on behalf of the government to make life-ending decisions for me or anyone else without the benefit of the consent of the people whose lives they are ending."

Motley says these policies are similar to state-mandated and state-encouraged abortion, but on the other end of life.

"And that's why governments shouldn't be in the health care busi-

ness," Motley said. "I think Sarah Palin was correct—the Netherlands is the future of Obamacare."

Doctors' Default Position Changing

It is extremely important to respect the liberty of patients to make choices regarding their medical care and the aggressiveness with which they want to fight for their lives, says Gennady Stolyarov, editor-in-chief of *The Rational Argumentator*.

"What is disturbing about the findings of this study is that withholding treatment from certain patients—particularly the elderly—appears to be becoming a default decision by doctors in many cases, rather than a decision deliberately opted into by patients," Stolyarov said. "The culture of medicine should always be guided by the premise that taking action to save life is the default, and only the patient should be able to make a different decision."

This is the new bioethics, says Dr. John Dale Dunn, an emergency physician and policy advisor to The Heartland Institute.

"When you adopt a socialist value system, you stop thinking about the value of the individual and start thinking about the abstract value of what's best for the collective."

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

S.C. House Votes to End Certificate of Need Law

By S.T. Karnick

South Carolina's House of Representatives voted 103-to-1 in April to end the state's certificate of need (CON) law in 2018.

CON laws are a complex set of regulations that limit health care choices by preventing providers from entering new markets or increasing existing capacity without first gaining approval from state regulators to buy equipment, expand facilities, or open new ones.

When a company applies to enter a new market, existing providers can use the CON process to block them, allowing a few wealthy and large hospital chains to control the market and keep prices high. Opponents argue those decisions should be made by consumers in a free market, not by the government.

'Ultimate Bulwark' of Incumbents

Katherine Restrepo, health and human services policy analyst at the North Carolina-based John Locke Foundation, says CON laws, rather than consumers, ultimately pick who is able to compete in the health care industry.

"In North Carolina, having a certifi-

"Basic economics tells us that restricting supply increases costs for consumers, which is exactly what this current law does."

KATHERINE RESTREPO, POLICY ANALYST, JOHN LOCKE FOUNDATION

cate of need is the ultimate bulwark," Restrepo said. "For health care entities to receive a facility fee reimbursement from Medicare and Medicaid, they must be licensed."

Restrepo says incumbent CON holders can block potential competitors from entering the market.

"In many ways, the concept of managed competition limits patient access and allows CON holders to artificially raise the cost of certain health care services to subsidize money-losing services," Restrepo said.

"Basic economics tells us that restricting supply increases costs for consumers, which is exactly what this current law does," Restrepo said. "Hospitals, however, argue that health care is an exception to economics 101 because the price-controlling government has had such a strong presence

since Medicaid and Medicare passed in 1965, and because of this, health care is not a free market.

"To that point, the Hospital Association is correct, but does that mean an already overwhelming and unpredictable regulatory environment needs additional oversight in the form of CON?" Restrepo asked. "Or that attempts to free the market should be resisted?"

'Failed to Achieve Goals'

With a near-unanimous vote in its House of Representatives, South Carolina is well on its way to repealing its obstructive certificate of need law, says John Nothdurft, government relations director at The Heartland Institute, which publishes *Health Care News*.

"The legislators in the House should be commended for their effort, especial-

ly since South Carolina CON laws have failed to achieve the goals their sponsors tout," Nothdurft said.

Nothdurft says the stated goal of CON programs is to manage health care costs, but research has shown they actually increase costs for consumers by hindering competition and forcing providers to use older facilities and equipment, resulting in health care costs 11 percent higher in CON states than in non-CON states.

CON laws benefit existing providers, providing inappropriate influence to competitors during the vetting processes, says Nothdurft. When a company applies to enter a new market, competitors often use the CON process to block potential competition. As a result, CON laws raise the price of medical care by preventing new medical providers from competing with existing hospitals.

"Hopefully the Senate follows soon and South Carolinians will receive the health care options they deserve," Nothdurft said.

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

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FDA Moves to Regulate E-Cigarettes



By Matthew Glans

The U.S. Food and Drug Administration (FDA) has issued a proposed rule that would extend the agency's tobacco authority to cover additional products that meet the legal definition of a tobacco product, such as e-cigarettes.

At present, only e-cigarettes that are marketed for therapeutic purposes are regulated by the FDA Center for Drug Evaluation and Research. The FDA Center for Tobacco Products currently regulates cigarettes, cigarette tobacco, roll-your-own tobacco, and smokeless tobacco.

Dr. Stephen Ostroff, appointed in April as acting head of FDA, says strengthening e-cigarette regulations is one of his top priorities because new federal data show the use of e-cigarettes among middle and high school students has tripled over the past year.

Before FDA can regulate e-cigarettes as it does other tobacco products, it must first send a "deeming regulation" to the Office of Management and Budget (OMB) for review. It usually takes two months for OMB to hold meetings and assess the consequences of proposed final regulations.

E-cigarettes are devices that heat liquid nicotine in a disposable cartridge, creating a vapor the user inhales. There is no burning of tobacco and no secondhand smoke. The devices have been widely touted as successful smoking cessation products by many scientists and doctors.

'Safer Alternative to Smoking'

Devon Herrick, a senior fellow with the National Center for Policy Analysis, says the concept of a nicotine substitute for smoking dates back to the 1960s, when a Swedish scientist heard about flight crews and submariners switching to smokeless tobacco when they could not smoke.

"Since that time, nicotine replacement therapy has been shown to benefit smokers wanting to quit," said Herrick. "It seems odd the FDA is rushing to put the kibosh on a safer alternative to smoking."

FDA's push to regulate e-cigarettes may invite unintended health consequences, says Gennady Stolyarov, editor-in-chief of *The Rational Argumentator*. Although many nonsmokers have absolutely no attraction to e-cigs or tobacco products of any sort, for some individuals, e-cigs may work as a substitute for traditional tobacco products or as a part of a transitional approach toward the cessation of smoking.

E-cigs lack the carcinogenic byproducts found in traditional tobacco smoke, and they also minimize the harm caused by secondhand smoke, says Stolyarov. If somebody wishes to smoke, it is better for that person's health and the health of others if the person uses an e-cigarette.

Concerns About Young People

Many advocates of greater regulation and higher taxes on e-cigarettes say they are concerned young people are using the products and may eventually transition to using more harmful tobacco products. Stolyarov says these claims are largely unfounded and additional regulations will not solve that problem.

"It is well-known many teenagers under the age of 18 will find ways to access tobacco products in spite of existing prohibitions," said Stolyarov.

"Furthermore, if [an e-cigarette] black market ... for young people emerges, that market would be characterized by much less transparency in the composition of e-cigarette products, thereby putting the safety of young people at risk, as well as all of the perils of physical violence and cultural degeneration that black markets

... have produced throughout history," Stolyarov said.

Cleaner than a Prius

Since e-cigarettes emit water vapor, it's not clear what the federal agency will be regulating, says Seton Motley, president of the public policy organization Less Government.

"This is absurd," Motley said. "Either they're ignorant and don't know it's not tobacco, which means they're colossal

fools, or they know and don't care and are using this as an excuse to gather more power.

"The tailpipe of your average [Toyota] Prius emits more water vapor than an e-cigarette," Motley said. "Maybe the FDA needs to regulate them as well?"

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

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Almost Half of State Exchanges Are Struggling

By S.T. Karnick

Almost half of the 17 health insurance exchanges set up by the states and the District of Columbia under the Affordable Care Act (ACA), also known as Obamacare, are in trouble financially, *The Washington Post* reports.

The setbacks are creating fiscal headaches for state officials just five years after the passage of President Barack Obama's massive health care reform bill.

Many of the exchanges are dealing with rising costs, especially those related to inefficient technology, expensive customer support centers, and unexpectedly low enrollments.

To stave off financial crisis, state officials are considering a number of solutions, such as raising fees on insurers, cost-sharing with other states, and begging state lawmakers for a quick shot of cash. Others are looking at turning over the whole enterprise to the federal exchange HealthCare.gov.

Enrollment Short of Predictions

Dr. Roger Stark, a health care policy analyst at the Washington Policy Center and a retired physician, says many state exchanges were set up as public-private partnerships and were required to be financially self-sufficient, but enrollment for most exchanges has fallen short of predicted levels.

"Premium fees to support the exchanges have consequently not met goals," Stark said. "Washington State, where individual-market enrollment is at

"Those universal-coverage dreams turned into financial nightmares, and every one of those states eventually dramatically modified, scaled down, or eliminated their plans."

MERRILL MATTHEWS, RESIDENT SCHOLAR
INSTITUTE FOR POLICY INNOVATION

60 percent of [the] predicted [level] and 80 percent of overall enrollees are in Medicaid, is an excellent example."

Universal Aspirations, Financial Nightmares

Several mostly blue states jumped on the health insurance exchange bandwagon as a way of showing support for Obamacare, says Merrill Matthews, a resident scholar with the Institute for Policy Innovation.

Something similar happened in 1993 and 1994 with Clintoncare, Matthews says. Several states passed their own versions of the Clinton health care proposal—which never passed in Washington, DC—explaining they were going to reduce the number of uninsured and thereby save so much money they eventually would be able to provide universal cover-

age for all their residents.

"Those universal-coverage dreams turned into financial nightmares, and every one of those states eventually dramatically modified, scaled down, or eliminated their plans," Matthews said.

"It's entirely possible we will see something similar with health insurance exchanges, though what direction those changes take would depend on the Supreme Court's June ruling," Matthews said, referring to the decision in *King v. Burwell*.

'Doomed from the Start'

Greg Scandlen, founder of Consumers for Health Care Choices and a senior fellow at The Heartland Institute, which publishes *Health Care News*, says the situation is another example of the federal government's interference in the U.S. economy.

"Policy wonks sit around a table in Washington, DC and make ambitious plans for ruling the world without any understanding of what it takes to run a business, in this case, a health insurance exchange," Scandlen said.

The state exchanges could be successful only as long as they were receiving billions of dollars in federal subsidies, Scandlen says. The business model cannot work on its own. It adds enormous costs to the simple transaction of choosing an insurance plan.

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

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COMMENTARY

People Aren't Getting More Care or Better Care Under Obamacare

By John Goodman

Some 14 million people are newly insured because of the Affordable Care Act (ACA), and millions of others have more generous insurance with promising new benefits.

INTERNET INFO

Brian W. Ward, Tainya C. Clarke, Gulnur Freeman, and Jeannine S. Schiller, "Early Release of Selected Estimates Based on Data From the January–September 2014 National Health Interview Survey," Centers for Disease Control and Prevention, March 24, 2015: <https://www.heartland.org/policy-documents/early-release-selected-estimates-based-data-january-september-2014-national-health->

So you might think doctors' offices would be flooded with new patients seeking more care than they had before. It's not happening.

To exclude the effects of the 2008 financial crisis, the recession, and the slow recovery, John R. Graham, a senior fellow with the National Center for Policy Analysis, compares the latest estimates from the Centers for Disease Control and Prevention with the results of the organization's survey conducted one decade ago. The result:

"The proportion of people of all ages with a 'usual place to go for medical care' was 87.8 percent [in 2014], the same as it was in 2002–2003," Graham said. "Further, 5.7 percent reported that they failed to obtain needed medical care due to cost last year, the same as it was in 2003–2004."

A possible explanation, says Graham, is the proportion of the uninsured population is not much different from

"My own view is the importance of health insurance has been enormously exaggerated by the health policy community."

what it was a decade ago.

Another study focuses on what happened in 2014, the first year of access to expanded Medicaid programs and the health insurance exchanges. New data from 16,000 providers across the country, collected by AthenaHealth, show requests for new appointments just barely edged upward in 2014. The proportion of new patient visits to primary care doctors increased from 22.6 percent in 2013 to 22.9 percent in 2014.

My own view is the importance of health insurance has been enormously exaggerated by the health policy community. People without health insurance often find a way to get insurance when a family member develops a serious health problem. Even when they don't, they tend to find ways of getting health care.

The kind of insurance people are acquiring is not conducive to an increase in doctor visits. Because of the high deductibles in the plans sold in Obamacare exchanges, most people with newly acquired private insurance are paying the full bill out of pocket. It's as though they were uninsured!

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.

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GMOs Are Good, Scientist Says

By Matthew Glans

Amanda Maxham, Ph.D., Ayn Rand Institute's resident expert on science and the environment, says genetically modified foods are beneficial, strongly contradicting a growing contingent of activists pressing for governments and businesses to limit or ban their use.

In May, Maxham praised genetically modified organisms (GMOs) in a lecture she delivered in Chicago titled "Why GMOs Are Good." The event was sponsored by the Institute for Humane Studies.

Although many people believe organic and non-GMO foods are healthy and genetically engineered foods are not, the truth is GMO technology has been improving the food we eat for the past 20 years, making it safer, more nutritious, and plentiful, Maxham says. As the public continues to be misinformed by activists such as Dr. Oz, Foodbabe, and some environmental groups, the world continues to miss out on the life-changing food improvements GMOs provide.

Regulatory Environment Stifling Biotech

GMO foods are designed to expand yields, resist weeds and insects, and survive drought, Maxham says. Farmers and consumers alike are reaping the benefits, but there is an army of anti-GMO activists arguing biotechnology is bad and poisonous.

"As a result, the regulatory environment makes it very difficult to bring a new product to market, even though it might be perfectly safe to eat," said Max-

ham. "This is a real suppression of technology that could be feeding people and preventing and curing diseases.

"GMOs are just another form of technology," Maxham said. "I find it strange that we embrace every other form of technology in our lives but not when it comes to food."

GMOs Prevent Habitat Loss

Environmentalists are masters at preying on many people's fear of things they do not understand. Many Americans don't realize that although the technology is different between GMOs and traditional agricultural cross-breeding, the end result is substantially the same, says H. Sterling Burnett, a research fellow at The Heartland Institute, which publishes *Health Care News*.

"The GMO debate is arguably the best test case today for whether those who claim to be environmentalists really care about the environment, because without the widespread adoption of biotechnology to increase yields and decrease inputs, producing the food needed to feed another two billion people nutritious diets will require the wholesale conversion of innumerable lands and wildlife habitats to farm fields," Burnett said.

It will also require the increased use of more powerful pesticides, says Burnett. Habitat loss is already the single biggest factor in wildlife population declines and extinction.



"GMOs are just another form of technology. I find it strange that we embrace every other form of technology in our lives but not when it comes to food."

AMANDA MAXHAM, AYN RAND INSTITUTE

"So if you care about wildlife and open, wild spaces, you should embrace biotechnology," said Burnett.

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

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