

**52%**  
of legislators read  
*Health Care News*

**NEW PATIENT WAIT TIMES  
ARE LONGER SINCE  
OBAMACARE ROLLOUT – 5**

**OBAMACARE FLOUNDERING  
BECAUSE IT'S A BAD DEAL  
FOR MOST – 14**

**KING V. BURWELL COULD  
DEAL DEATH BLOW TO  
OBAMACARE – 17**

# HEALTH CARE NEWS

THE MONTHLY NEWSPAPER FOR HEALTH CARE REFORM

©2015 THE HEARTLAND INSTITUTE

[www.healthpolicy-news.org](http://www.healthpolicy-news.org)

Vol. 16 No. 4 ~ May 2015

## The Pulse

### Maryland Must Repay Feds

Maryland overbilled the federal government some \$28.4 million while building the state's health insurance exchange and will now have to repay the money. **Page 3**

### Whistleblower Faces Retaliation

A whistleblower who exposed a secret appointment waiting list at a Veterans Administration hospital in Shreveport, Louisiana is now being investigated. **Page 10**

### Global Payments Expand

Blue Cross Blue Shield in Massachusetts is greatly expanding its capitated, also referred to as "global payment," form of medical reimbursement. **Page 12**

### Kentucky Reforming CON

Kentucky is considering reforming its certificate of need law, which requires state government approval of new spending. **Page 16**

### Gov. Kasich Claims Challenged

Ohio's tax money will not be sent to other states if the state does not expand Medicaid, a federal agency says. **Page 18**

## Florida to Sue Feds Over Medicaid Expansion



Rick Scott  
Governor - Florida

By Sean Parnell

**F**lorida Gov. Rick Scott (R) will sue the federal government for trying to coerce his state to expand Medicaid.

"It is appalling that President [Barack] Obama would cut off federal health care dollars to Florida in an effort to force our state further into Obamacare," Scott said in a statement.

The agency Scott is suing, the U.S. Centers for Medicare and Medicaid Services (CMS), is currently withhold-

**FLORIDA, p. 8**

## National Doctor Shortage Looming

By Kenneth Artz

**T**he United States is facing what could be a deadly shortage of doctors, according to a report from the Association of American Medical Colleges (AAMC).

AAMC projects a shortfall of 90,000 U.S. physicians by 2025. The report finds there will be a critical need for doctors to treat an aging population increasingly subject to chronic diseases

in need of specialized care.

Darrell G. Kirch, AAMC's president and chief executive, told reporters during a telephone news briefing U.S. medical patients are growing older and sicker, living longer with chronic diseases such as cancer, and this is driving an increase in demand.

Unless creative, cost-effective solu-

**SHORTAGE, p. 6**

NON PROFIT  
ORGANIZATION  
US POSTAGE PAID  
BEAVER DAM, WI  
PERMIT NO. 412

The Heartland Institute  
One South Wacker #2740  
Chicago, IL 60606

PHOTO COURTESY BRUCE R. BENNETT/ZUMA PRESS/NEWS.COM

FOR THEM, THE INVISIBLE PRIMARY. GOT A FAVORITE?  
FOR YOU, THE INVALUABLE OPPORTUNITY. GOT TICKETS?



Ben Carson\* Scott Walker\* Carly Fiorina Ted Cruz\* Kelly Ayotte Rick Santorum\*



Marco Rubio Mike Huckabee\* Mike Pence Jeb Bush Rick Perry\* John Kasich



Bobby Jindal\* Chris Christie Allen West\* Rand Paul Susana Martinez Trey Gowdy

# WESTERN CONSERVATIVE SUMMIT 2015

THEY'RE ALL INVITED† • SO ARE YOU

JUNE 26-28, 2015 | DENVER, COLORADO

For Students Age 16-20  
Young Conservatives  
Leadership Conference  
with Hugh Hewitt  
"City on a Hill"  
June 21-26 at CCU  
[www.hewittccu.com](http://www.hewittccu.com)

**REGISTER NOW!**

[www.WesternConservativeSummit.com](http://www.WesternConservativeSummit.com)

Or call **844.685.4376**

*Presented by Centennial Institute at Colorado Christian University*

*\* Past Speaker, Confirmed 2015*



*† And More Confirming Daily*

# Health Care News



THE HEARTLAND INSTITUTE

## The Heartland Institute

One South Wacker Drive #2740  
Chicago, Illinois 60606  
312/377-4000 voice • 312/377-5000 fax

Health Care News is available on the Internet. Point your web browser to  
<http://www.heartland.org>  
<http://www.healthpolicy-news.org>

### PUBLISHER

Joseph L. Bast

### ASSOCIATE PUBLISHER

Nikki Comerford

### EXECUTIVE EDITOR

Diane Carol Bast

### SENIOR EDITOR

S.T. Karnick

### MANAGING EDITOR

Ken Artz

[kartz@heartland.org](mailto:kartz@heartland.org)

### DESIGN AND PRODUCTION

Chris Whitehead

### ADVERTISING MANAGER

Nikki Comerford

### CIRCULATION MANAGER

Tonya Houston

### CONTRIBUTING EDITORS

Joseph Coletti, Benjamin Domenech  
James P. Gelfand, John C. Goodman  
Christie Herrera, Devon Herrick  
Robert Laszewski, Sean Parnell  
Greg Scandlen, Grace-Marie Turner

### BOARD OF DIRECTORS

William Armistead, Joseph Bast, Robert Buford  
Jeré Fabick, Dan Hales, James L. Johnston  
Jeff Judson, Chuck Lang  
Jeffrey Madden, Jeffrey V. McKinley  
Brian D. Singer, Herbert J. Walberg

**ADVERTISING:** Health Care News accepts display advertising and advertising inserts. For an advertising kit with rate card, contact Associate Publisher Nikki Comerford at 312/377-4000, e-mail [ncomerford@heartland.org](mailto:ncomerford@heartland.org).

Health Care News is published 10 times per year by The Heartland Institute. Heartland is a non-profit and nonpartisan public policy research organization serving the nation's federal and state elected officials, journalists, Heartland Members, and other opinion leaders. Its activities are tax-exempt under Section 501(c)(3) of the Internal Revenue Code.

© 2015 The Heartland Institute. Nothing in this issue of Health Care News should be construed as reflecting the views of The Heartland Institute, nor as an attempt to aid or hinder the passage of any legislation.

# Md. Exchange 'Colossal Failure,' State Owes Feds \$28.4 Million

By Kenneth Artz

Maryland overbilled the federal government some \$28.4 million while building the state's health insurance exchange and should now repay the money, says a report from the Office of the Inspector General (OIG) for the U.S. Department of Health and Human Services (HHS).

Federal auditors reported they found no fraud or criminal wrongdoing, but they say the state lacked oversight and internal controls. OIG recommends Maryland refund what the federal government paid to subsidize the cost of signing people up for health insurance coverage or Medicaid through the state's exchange.

The report concludes Maryland officials paid too many of the exchange's bills with a federal grant in 2013 and 2014, instead of using the state's Medicaid program, which is financed jointly by the state and federal government. As a result, the state received more federal money than it was entitled to and should now repay the excess funds.

Maryland was one of the first states to embrace Obamacare and eagerly went forward with building its own health insurance exchange, even as some three dozen states opted not to.

## Opening Day Disaster

The site crashed on the first day it was open for business in October 2013 and was later plagued with numerous software glitches and feuding contractors, ultimately performing worse than the similar but much larger HealthCare.gov site.

Maryland's exchange was finally scrapped and replaced with software borrowed from Connecticut's exchange, considered the nation's best-performing state exchange. This quick fix cost at least \$40 million, and Maryland relaunched its exchange in 2014.

Marc Kilmer (R), a member of the county council in Wicomico County, Maryland who worked on health care policy for the Maryland Public Policy Institute from 2006 until 2014, says it was obvious much taxpayer money had been wasted and the state should have conducted an investigation but failed to do so.

"The project was supposed to be a showcase for Democrat Lt. Gov. Anthony Brown to demonstrate his ability to get things done and set him up to become the next governor," Kilmer said. "He lost that race to a Republi-

**"Prior to its completion, everyone in state politics was talking up the Maryland exchange. And there was a lot of anticipation that the Maryland exchange would show that Obamacare was successful, so there was a lot of pressure on the state to deliver. But it turned into a colossal failure."**

MARC KILMER

MEMBER OF COUNTY COUNCIL

WICOMICO COUNTY, MARYLAND



can, which was pretty surprising since Maryland is heavily Democrat.

"Prior to its completion, everyone in state politics was talking up the Maryland exchange," Kilmer said. "And there was a lot of anticipation that the Maryland exchange would show that Obamacare was successful, so there was a lot of pressure on the state to deliver. But it turned into a colossal failure."

Public opinion and the fear of losing future elections are the reasons failure was never admitted, Kilmer says.

"A lot of critics said the state should have held back and seen what kinds of problems the other states experienced as they went forward," Kilmer said. "However, [liberals] wanted to show that Maryland could deliver, and Gov. Martin O'Malley was acting like it was a success, even before it was built. Afterwards, neither O'Malley nor Brown would mention it on the campaign trail because they didn't want to be tarred with it. But if it had been a success, you can bet they would have taken full credit for it and spoke about it every chance they got."

## Government Blamed Contractors

Christopher B. Summers, president of the Maryland Public Policy Institute, says the state government oversold the project and its projections turned out to be way off.

"They did what politicians always do when things go south—they blamed it on somebody else," Summers said. "In this case, they blamed it all on the contractors."

"Maryland Republican Rep. Andy Harris said that if the state had only done its job, it could have avoided this disaster," Summers said. "But they didn't, and when it failed and there was no investigation from the state, he requested one from federal auditors."

Maryland has not detailed all the public funding used to develop its health insurance exchange, but estimates have put the tab at around \$261 million by the end of 2015. More than 80 percent of the costs are expected to be paid using federal dollars.

Ken Artz ([kartz@heartland.org](mailto:kartz@heartland.org)) is managing editor of Health Care News.

## INTERNET INFO

Daniel R. Levinson, Inspector General, U.S. Department of Health and Human Services (HHS), "Maryland Misallocated Millions to Establishment Grants for a Health Insurance Marketplace," March 2015: <https://oig.hhs.gov/oas/reports/region1/11402503.pdf>

# Health Info Exchanges Have Pros, Cons

By Loren Heal

**H**ealth information exchange (HIE) is the transfer of electronic information such as lab results, clinical summaries, and medication lists, and its proponents claim it can be used to boost efficiency, reduce health care costs, and improve outcomes for patients.

Because of its potential benefits, the federal government has boosted financial incentives for hospitals and physician practices to engage in some type of HIE with outside organizations. But HIE has yet to show strong evidence that it will live up to the hype, accord-

ing to a survey of research data analyzed in a study for *Health Affairs*.

Hospitals may eventually benefit from HIE, but for now, tradeoffs exist in data security and the doctor-patient bond, says study coauthor Saurabh Rahurkar of the University of Alabama-Birmingham.

The major benefits of HIE the study identified were a reduction in the use of imaging tests, labs, and diagnostic tests, and the associated costs of these tests.

## Perverse Incentives

Health information technology (HIT) may seem like a good idea because it makes sense for a doctor to have access to a patient's medical history at his or her fingertips. Devon Herrick, a senior fellow in health care policy at the National Center for Policy Analysis, says what looks good on paper doesn't always work well in practice.

"It's not that health IT isn't a great idea, but in our current system the incentives are convoluted and perverse," said Herrick. "Health care systems cannot be expected to imple-



ment a HIT system that is not in their self-interest to implement. Redundant medical testing that health economists call waste, hospitals count as revenue."

Herrick says doctors don't have an incentive to see if patients already had an MRI since the hospitals want to sell services to their patients. Doctors are not competing on price, so the fact that patients may be able to save a bundle on an MRI isn't a concern for the physician. When doctors know an expensive test has been completed, however, they are less likely to put the patient through another one, the data suggest.

"I would expect to see HIEs result in improved clinical decision-making by providing access to comprehensive patient information," said Herrick. "Emergency departments are a setting that is most likely to benefit from this, and as such, I would expect to see benefits in health outcomes in ED settings, such as reduction in inpatient ED admissions, repeat ED visits, and costs associated with ED visits."

Data aggregated by HIEs could also benefit research endeavors by making available rich datasets to individuals interested in improving care, says Herrick.

"Besides ED settings, we need to also focus on areas that have thus far not been studied," said Herrick. "For example, populations with any chronic diseases, such as diabetes, asthma, cancer, etc. Lastly, to fully study the impact of HIEs, planned studies are needed to assess actual use of the system and not simply whether a system exists. This has, thus far, been absent for previous studies."

## INTERNET INFO

Saurabh Rahurkar, Joshua R. Vest, and Nir Menachemi, "Despite the Spread of Health Information Exchange, There is Little Evidence of Its Impact on Cost, Use and Quality of Care," *Health Affairs*, March 2015: <http://content.healthaffairs.org/content/34/3/477>

## SAVE MEDICARE PART D DON'T LET BIG GOVERNMENT RUIN PRESCRIPTION DRUGS

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!



**"It's not that health IT isn't a great idea, but in our current system the incentives are convoluted and perverse."**

DEVON HERRICK, SENIOR FELLOW  
NATIONAL CENTER FOR  
POLICY ANALYSIS

## Risk of Leaks

Information security concerns have been consistently reported as barriers to HIE adoption, but Rahurkar says there is risk involved in any means of storing records.

"I personally believe the tradeoff is worth it, but we have not seen this issue sufficiently publicly debated," said Rahurkar.

Another barrier to adoption is the intrusion of computers and mobile devices into the doctor-patient relationship, Herrick says.

"One problem I've heard of from health care providers is how much productivity is lost when they continually have to use a pull-down menu and find the correct checkboxes while seeing a patient," said Herrick. "Rather than looking the patient in the eye or looking for subtle signs of disease, the doctor struggles with software on an iPad or computer screen."

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



By Matthew Glans

If you are a new patient needing to see a doctor for the first time, you may have to wait, according to a survey by Merritt Hawkins, a physician search and consulting firm that questioned some 1,399 medical offices in 2014 to determine wait times for new patient appointments in various specialties.

In 15 metropolitan areas across the United States before Obamacare expanded coverage, the average wait time for a new patient to see a physician in five medical specialties was only 18.5 days.

After implementation of Obamacare, wait times increased. The longest increase by far was in Boston, where patients waited an average of 72 days to see a dermatologist and 66 days to see a family doctor. The shortest wait times were in Dallas, where the average wait time was 10.2 days for all specialties, and just five days to see a family doctor.

#### Striking Differences Exist

Sean Parnell, president of Impact Policy Management and a policy advisor to The Heartland Institute, which publishes *Health Care News*, says the differences between Massachusetts and Texas are striking since the states pursued different paths and achieved far different results.

"Massachusetts has gone towards more central planning by expanding its Medicaid program with reimbursements so low many doctors limit the number of patients on the program they will see," said Parnell. "Mean-

while, over in Texas, the Lone Star State has remained more market-oriented with self-pay patients, many of them uninsured, who are still able to access care simply by paying directly for their treatment."

#### Why Wait Increased in Massachusetts

When Massachusetts passed Romneycare in 2006, wait times started growing until something as routine as a normal physical would have to be scheduled 18 months out, says Merrill Matthews, a resident scholar with the Institute for Policy Innovation.

"There was suddenly a big influx of people into the [Massachusetts] system, creating a backlog, and emergency room use went up because people with insurance got tired of waiting," Matthews said.

There are several other reasons why wait times increased in Boston, says Matthews.

"More people who were previously uninsured were now getting care," said Matthews. "This is not necessarily a bad thing, but it did cause their utilization of health care services to spike. Also, expansion of Medicaid also put some scheduling pressure on health care providers."

Dallas avoided many of these problems because Texas has always had a lot of physicians due to the high number of medical schools in the state, says Matthews.

"Also, [Texas] passed malpractice reforms about nine years ago and the joke was that when Texas did this, all the Texas trial lawyers moved to Oklahoma and all the Oklahoma doctors moved to Texas," said Matthews.

#### Restrictive Regulations Blamed

In contrast to business-friendly Texas, a right-to-work state with no state income tax, Massachusetts has a restrictive set of regulations about who doctors can see for medical treatment, says Josh Archambault, a senior fellow at the Foundation for Government Accountability and formerly a

senior fellow in health care policy at The Pioneer Institute in Boston.

"If you live in Boston and you want medical care, you pretty much have to go to a hospital there because there are no Minute Clinics or doc-in-a-boxes, etc.," said Archambault. "You have to go to a hospital for everything, and even if you see a physician's assistant or a nurse practitioner, they bill everything at [medical doctor] rates, so this makes things necessarily more expensive."

Massachusetts is very insurance rich—high rates of private insurance,

employer-provided insurance, and state-provided insurance—and about 95 percent of the state is insured, says Archambault.

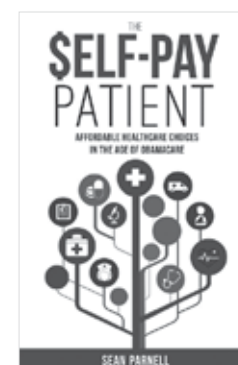
"The tradeoff is there is rationing through time, thus the long waits," Archambault said. "If you are a new patient on Medicaid, there are certain pockets in the state where it is hard to even find a doctor who will see you."

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

# Defend Yourself Against Bureaucratic Medicine

*The Self-Pay Patient: Affordable Healthcare Choices in the Age of Obamacare* reveals the secret to taking control of your health costs, how to find affordable care outside of conventional insurance, how to escape bureaucratic medicine, and how to opt-out of Obamacare.

*The Self-Pay Patient*, \$9.95 paperback (available only on Amazon.com). \$7.95 e-book (Amazon, iTunes and Barnes & Noble).



## INTERNET INFO

"Physician Appointment Wait Times and Medicaid and Medicare Acceptance Rates: 2014 Survey," Merritt Hawkins: <https://kaiserhealthnews.files.wordpress.com/2014/01/mha2014waitsurvpdf.pdf>



**"Caps on federally funded graduate medical education slots haven't changed since 1997, even while [numbers of] medical school graduates have grown substantially."**

**DR. CHARLES LOCKWOOD**  
SENIOR VICE PRESIDENT  
UNIVERSITY OF SOUTH FLORIDA HEALTH

# National Shortage of Doctors Looming

Continued from page 1

tions can be found, the looming shortage of doctors could undermine patient care across the country. The problem is particularly severe in the Midwest and Florida, says Dr. Charles Lockwood, dean of the Morsani College of Medicine and senior vice president of the University of South Florida Health in Tampa.

"Caps on federally funded graduate medical education slots haven't changed since 1997, even while [numbers of] medical school graduates have grown substantially," Lockwood

said. "That means there are simply not enough [graduate medical education] spots in Florida for all or most of Florida's medical students to stay here for their residency training, so we are essentially exporting a critical resource already in serious short supply."

## Barriers to Entry a Concern

Devon Herrick, a senior fellow and health care researcher at the National Center for Policy Analysis, says the free market can ease the doctor shortage.

"The medical establishment has long sought to restrict the supply of physicians to keep salaries high. It needs to get out of the way," Herrick said.

"Scope of practice laws need to be changed in many states," Herrick said. "Nurse practitioners and physician assistants need a path to independent practice or semi-autonomy, rather than servitude to doctors. Dental hygienists need to be allowed some independent practice. Alaska even allows dental technicians a level of independent practice; mostly they are allowed to treat Inuit, because of a shortage of dentists." (See "Nebraska Grants Nurse Practitioners Full Practice Authority, page 11.)

Herrick also recommends increasing residencies, especially in primary care and other vital specialties.

"There are foreign medical graduates who want a residency in the United

States but cannot find one," Herrick said.

Herrick also says lawmakers should remove state and local regulations that inhibit doctors and nurse practitioners from offering services.

"Boston actively fought MinuteClinic when CVS wanted to open 11 clinics in the Boston area," said Herrick. "The Boston health department didn't think a nurse in a 10x10 box was the type of care Bostonians needed. Why not allow CVS and patients to decide that?"

## Market Distortions Cited

Government-planned, third-party payment systems have created ingrained market distortions and caused an excessive demand in health care, says Dr. Roger Stark, a health care policy analyst at the Washington Policy Center and a retired physician. When someone else pays, there is no incentive for patients to question the price or quantity of services consumed in their care, he says.

"To correct these distortions, we must allow the health care market, not central planners, to determine the number of doctors needed," Stark said. "We can do this by removing employers and government—except for safety-net programs for the most needy—from health care financing and allowing patients to control their own health care dollars.

"We can accomplish this by changing the tax code, encouraging the use of high-deductible health insurance, encouraging the use of health savings accounts, allowing the interstate purchase of health insurance to increase competition, and means-testing Medicare," Stark said.

*Ken Artz (kartz@heartland.org) 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 new *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).



## INTERNET INFO

"Final Report: The Complexities of Physician Supply and Demand: Projections from 2013 to 2025," produced by IHS Inc. for the Association of American Medical Colleges, March 2015: <https://www.aamc.org/download/426242/data/ihsreportdownload.pdf>

# Govt. Overpaid for Swing Beds, Report Says

By Kenneth Artz

The federal government overpaid critical access hospitals (CAH) by about \$4.1 billion over six years to provide skilled nursing services using hospital swing beds, says a report from the U.S. Department of Health and Human Services' Office of the Inspector General (OIG).

OIG's report calls for the Centers for Medicare and Medicaid Services (CMS) to push for legislation adjusting CAH swing-bed reimbursement rates to match the lower rates paid to skilled nursing facilities.

CAHs were created when Congress established the Rural Flexibility Program in 1997. They were designed to ensure patients in rural areas would have access to a range of hospital services without having to travel far from their homes.

## Shortcoming of Government Planning

Devon Herrick, a senior fellow and health care researcher for the National Center for Policy Analysis, says the loophole in the law is the result of ill-conceived central planning and price controls.

"Without price signals, it's impossible for the government to know the market price to reimburse providers for services," said Herrick.

"But at the very least, the government should not reimburse facilities at different rates for the same service," Herrick said. "Hospitals are currently buying physician practices because the hospital-owned practices can bill at outpatient rates that are much higher than what a physician can bill from his own office."

"Medicare pays far more for lab tests and x-rays performed in hospitals than the same service performed in a radiology clinic or an independent lab," said Herrick. "Because of the differences in reimbursements, hospitals game the system. These types of games should stop."

## Oversight Questioned

Dr. Roger Stark, a health care policy analyst at the Washington Policy Center and a retired physician, says Medicare has reimbursed CAHs at a higher rate than urban facilities for various services for at least the past 25 years. Proponents of the system argue rural hospitals are at greater risk of financial problems.

"Closure would force seniors to travel out of their communities for health care," Stark said. "Of course, this is another example of the government picking winners and losers."



"The CMS oversees Medicare payments, with questionable levels of congressional oversight," Stark said. "CMS is a huge agency, yet our elected officials have the ultimate responsibility of guarding against waste, fraud, and abuse."

## Manipulating Funding

Dr. John Dale Dunn, an emergency physician and policy advisor to The Heartland Institute, which publishes *Health Care News*, says the federal government is constantly trying to trim Medicare expenditures for the elderly so it can transfer the saved money to Medicaid programs for impoverished Americans.

"These bureaucrats are all about some kind of manipulation of the expenditures for [groups] whom they deem valuable," Dunn said. "But if you cut funding for Medicaid, you're cutting off that group's health care. Medical ethics don't allow us to play games with peoples' lives or the obligations of physicians to provide the best comfort and care they can for sick and ailing people."

"At the time this law was passed, it was designed to keep CAHs alive," said Dunn. "One of the things CAHs do is

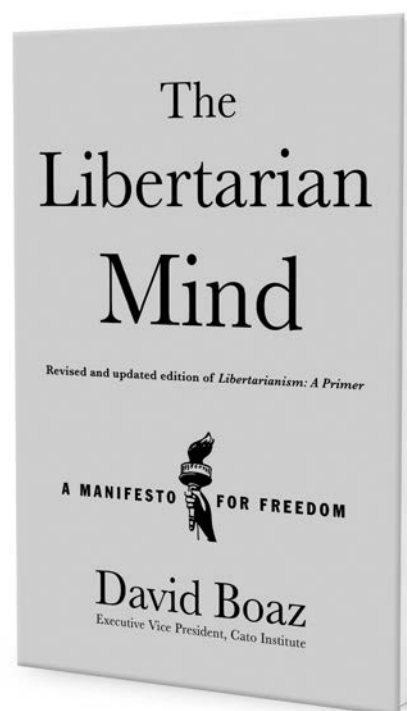
that they provide swing-bed care, which is basically higher-level care than you'd receive in a nursing home. But if you live in the big city, you probably think that the money is wasted and that the rural person should just come to a hospital in the big city for treatment, where everything is centralized and

supposedly cheaper. But it can be very disruptive to move sick people around like that. I happen to think that distribution of health care in rural areas is beneficial."

Ken Artz ([kartz@heartland.org](mailto:kartz@heartland.org)) is managing editor of *Health Care News*.

*"The Libertarian Mind belongs on every freedom-lover's bookshelf."*

— SENATOR RAND PAUL



*"The Libertarian Mind is so convincing critics will want to condemn it, regulate it, tax it, fleece it, and forbid it. Fortunately, good ideas haven't been outlawed—yet."*

— PETER THIEL, technology entrepreneur and investor, author of *Zero to One*

*"Boaz's message is both timeless and extraordinarily relevant to the challenges that we are facing today. It deserves to be read carefully and thoughtfully by everyone who truly cares about creating a more ethical and prosperous world."*

— JOHN P. MACKEY, Co-founder and Co-CEO, Whole Foods Market

PUBLISHED BY SIMON & SCHUSTER

CATO  
INSTITUTE

AVAILABLE NATIONWIDE AND AT [CATO.ORG/STORE](http://CATO.ORG/STORE).

## INTERNET INFO

Department of Health and Human Services, Office of Inspector General, "Medicare Could Have Saved Billions At Critical Access Hospitals If Swing-Bed Services Were Reimbursed Using The Skilled Nursing Facility Prospective Payment System Rates," March 2015: <http://oig.hhs.gov/oas/reports/region5/51200046.pdf>

# Florida to Sue Feds Over Attempt to Force Medicaid Expansion

Continued from page 1

ing funding from the state's \$2.2 billion Low Income Pool (LIP), a program that helps Florida hospitals treat low-income patients. If the funding is not renewed, Florida could be looking at a \$1.3 billion budget gap.

This latest exchange between Scott and the federal government goes back before the 2012 Supreme Court ruling that determined the federal government could not withhold all Medicaid funding from states that refused to expand the program. The ruling dealt a critical blow to Obamacare, which always had mandatory Medicaid expansion as one of its primary goals.

The Obama administration is now pressing the same agenda by denying previously established funding for an unrelated program.

LIP expires in June, and federal health officials say they are open to negotiating a successor program, but no deal has yet been reached.

## Feds Are Not Trustworthy

Christie Herrera, a senior fellow at the Foundation for Government Accountability, says Scott is right to sue CMS.

"This is the central argument against Medicaid expansion, that the feds are untrustworthy and will go back on the funding promises they make to states," Herrera said. "That is true with LIP, and it is true with Medicaid expansion."

"We're also seeing similar federal intimidation in Texas, where CMS is threatening to withhold uncompensated care payments to hospitals unless the state expands Medicaid," Herrera said.

Federal officials claim they're doing



**"This is the central argument against Medicaid expansion, that the feds are untrustworthy and will go back on the funding promises they make to states. That is true with LIP, and it is true with Medicaid expansion."**

**CHRISTIE HERRERA, SENIOR FELLOW  
FOUNDATION FOR GOVERNMENT ACCOUNTABILITY**

Texas a favor because Medicaid expansion would virtually wipe out uncompensated care, Herrera says. But that has not been the case in states such as Maine, where charity care actually increased nearly fourfold after Medicaid expansion.

"Even the Supreme Court says the feds can't commandeer the states with bribes and penalties."

Dunn says all the talk about ACA making health care cheaper and better is really a form of Kabuki theater. The intent of driving private insurance out of the health care system and replacing it with Medicaid on steroids is the real aim of the program.

"And remember this, Medicaid is the worst of all the government systems," Dunn said. "It pays the worst and delivers mediocre results. Nobody likes Medicaid except bureaucrats."

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

## Kabuki Theater

Dr. John Dale Dunn, an emergency physician and policy advisor to The Heartland Institute, which publishes *Health Care News*, says expanding Medicaid was always an integral part of the implementation of the Affordable Care Act (ACA).

"One of the reasons why ... ACA is on the rocks is because [federal officials] have continually tried to coerce the states to become their agents through expansion of Medicaid," said Dunn.

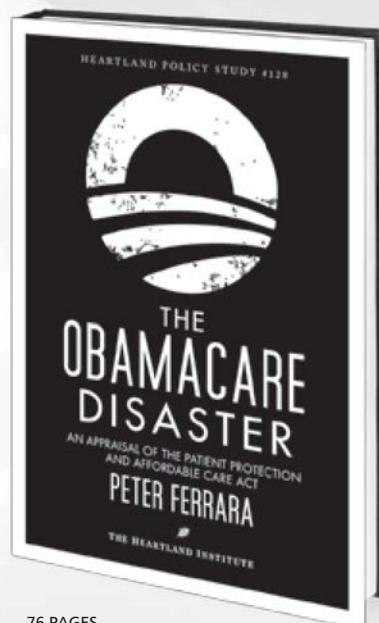
## Health care deformed

Rather than liberate the American health care system from bureaucracy and waste, Obamacare blankets it with more of both, suffocating innovation and destroying freedom. **PETER FERRARA**, senior fellow for entitlement and budget policy for The Heartland Institute, offers a devastating appraisal of how Obamacare expands the reach of government, raises costs, and reduces benefits.

[healthpolicy-news.org](http://healthpolicy-news.org)

1-10 copies	\$5.95 each
11-50	\$4.95
51-100	\$3.95
101 or more	\$2.95

Shipping and handling are included in the price.  
To order, call Cheryl Parker at 312.377.4000



76 PAGES  
PUBLISHED 2010

**THE HEARTLAND INSTITUTE**  
HEARTLAND.ORG

## Nearly 28% of All Federal Taxes Go for Health Care

The share of each U.S. taxpayer dollar spent on health care has risen by 22 percent since 2012, and now some 27.49 percent of all federal taxes are spent on health care, *The Weekly Standard's* Jeryl Bier reports.

John R. Graham, a senior fellow at the National Center for Policy Analysis, says the trend is not a healthy one.

"We are only three years into the Baby Boomers entering into Medicare, and we already have more health care entitlement spending than defense spending," Graham said. "Thus the so-called Medicare doc fix, which adds another \$141 billion to the federal deficit, shows Congress has no clue how to get this under control."

## INTERNET INFO

Jeryl Bier, "27.49% of Everyone's Tax Bill Is Spent on Health Care," *The Weekly Standard*, April 16, 2015:  
[http://www.weeklystandard.com/blogs/2749-everyones-tax-bill-spent-health-care\\_920978.html](http://www.weeklystandard.com/blogs/2749-everyones-tax-bill-spent-health-care_920978.html)

# Obama Seeks Medicare D Drug Price Negotiation

By Loren Heal

President Barack Obama's latest budget proposal calls for the federal government to negotiate Medicare Part D drug prices directly with pharmaceutical companies.

Under Medicare Part D, seniors with Medicare can sign up for prescription drug plans offered by competing companies. The insurers negotiate prices with drug companies and offer a wide variety of benefit and pricing levels to Medicare beneficiaries. The plans are subsidized, with the government often picking up the entire premium.

The program has been wildly successful since the Medicare Modernization Act (MMA) of 2003 was passed, resulting in dramatically lower costs than expected when the program was launched.

John R. Graham, a senior fellow in health care policy at the National Center for Policy Analysis, says directly negotiating prices would work against the design of the program.

"There is no benefit to such a move," Graham said. "The Medicare Part D drug benefit has come in at a cost billions of dollars less than originally

**"PhRMA does not support proposals that fundamentally alter the structure of the successful Medicare Part D program. The program keeps costs low for both beneficiaries and taxpayers through competition and negotiation, while improving access to medicines and holding down other health care costs."**

ALLYSON FUNK, PHARMACEUTICAL RESEARCH AND MANUFACTURERS OF AMERICA

estimated. This success accounts for 60 percent of the slowdown in the rate of growth in Medicare spending that is improving government finances."

## Diverse Group Opposes Bill

A letter endorsed by a diverse group of more than 200 health and consumer organizations urged the Centers for Medicare and Medicaid Services (CMS) to withdraw the proposal. The group includes patient advocates such as the AIDS Alliance, retailers including CVS Caremark and Walmart, insurers, and drug manufacturers.

"The rule would dramatically expand the federal government's role in Medicare Part D despite the fact that there

is no compelling reason for doing so," the organizations wrote to CMS. "Reshaping Part D in this way will neither improve quality and affordability, nor incentivize plan innovation."

Also signing the letter was the Pharmaceutical Research and Manufacturers of America (PhRMA).

"PhRMA does not support proposals that fundamentally alter the structure of the successful Medicare Part D program," said spokesperson Allyson Funk. "The program keeps costs low for both beneficiaries and taxpayers through competition and negotiation, while improving access to medicines and holding down other health care costs."

"Since Medicare Part D's enacting

legislation was signed into law in 2003, the nonpartisan Congressional Budget Office has been consistent and clear in its views that ... private plans can effectively negotiate savings on Medicare drug costs, and [that] striking the non-interference clause of the MMA, which prevents the Secretary of HHS from interfering in the negotiations between Medicare Part D plans and drug manufacturers, is unlikely to achieve any significant savings unless the government restricts beneficiary access to prescription drugs or fixes prices," said Funk.

CBO says much of the Medicare Part D savings comes from insurers advocating the use of generic drugs in place of brand names as generics become available.

## Price Hikes Predicted

The proposal would raise prices to consumers, Graham says.

"One consequence is that drug prices charged to private payers in the commercial market would increase, as drug makers tried to counter the effect of the federal price controls," Graham said.

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

## Make our new home...



## ... your legacy.

Make a tax-deductible contribution to The Heartland Institute and we will name a room in our new building after you or someone you love or respect, or place your name on the permanent Donor Appreciation Wall. Other donor recognition opportunities are also available. For more information, contact Gwendalyn Carver at 312/377-4000 or [gcarver@heartland.org](mailto:gcarver@heartland.org).

# VA Whistleblower Facing Govt. Retaliation

By **Tori Richards**

The U.S. Office of Special Counsel (OSC) is investigating claims of a whistleblower who revealed the use of a secret appointment waiting list at a Veterans Administration (VA) hospital in Shreveport, Louisiana.

The list included 37 veterans who died awaiting care.

Mental health social worker Shea Wilkes, an employee at Overton Brooks VA Medical Center in Shreveport, Louisiana, contacted the media in June 2013 to reveal his bosses and the VA inspector general (OIG) had done nothing to address his year-old complaints about excessive wait times. Wilkes' attorney Richard John says OIG turned the tables on his client, opening a criminal investigation into how Wilkes obtained the list he used as evidence to show patients were not receiving adequate care at Overton Brooks VA Medical Center.

The Office of Special Counsel, an independent office established to protect whistleblowers and reporting to the president, says it wants to get to the bottom of the secret appointment list and find out why Wilkes has not been granted whistleblower protection.

"The Special Counsel is really interested in helping," Wilkes said.

## Focused on Whistleblower

OSC opened its investigation in 2014 after Wilkes sent a letter criticizing OIG's handling of his complaints.

"What I find astonishing is that the majority of the OIG's investigation is not into the allegations mentioned above but in only how I obtained the mental health waiting list," Wilkes wrote.

"Numerous employees ... have expressed an interest in speaking with the OIG and I have relayed this to the OIG, but still at this point OIG has not spoken with many of the mental health staff members that have information related to the manipulation of appointment times, etc.," Wilkes said.

"It has become apparent individuals within leadership have also made it very clear to others in the service that the whistleblower is under investigation in an effort to keep others not to come forward," Wilkes wrote. "As I also said in my previous complaint, there have been threats of legal action if leadership finds out who released or releases any information to me or the media."

John says recent communications with OSC have convinced him the agency is interested in solving the problems at VA facilities.



**"Basically, [the VA doesn't] want stuff coming out, because they are trying to cover everything up."**

**SHEA WILKES, MENTAL HEALTH SOCIAL WORKER  
OVERTON BROOKS VA MEDICAL CENTER, SHREVEPORT, LA. (SHOWN ABOVE)**

"They are concerned with the issues causing the problem and moving along because they have [investigative] deadlines to meet," John said. "There certainly have been a lot of investigators up there [at the hospital] the past eight or nine months. Whether it's the [OIG] or OSC I don't know, but there has been a lot of activity up there."

Wilkes, an Army veteran, has worked at the Shreveport VA for eight years. In May 2013, he discovered veterans were waiting months, even years for appointments. To mask the hospital's poor performance, Wilkes alleges staffers hid many veterans on a secret waiting list and the number of patients actually seen was falsely inflated. In addition, top administrators received bonus pay for high rates of patient care. Wilkes reported the problem to Assistant Chief of Staff Patrick McGauly, who was later promoted to chief and is now stepping down from that position.

## No Action on Complaint

Wilkes says nothing was done to correct the situation, and one month later Wilkes filed a complaint with OIG. In fall 2013, Wilkes saw a secret waiting list schedulers were using at a service window.

In May 2014, VA attorneys issued a memo to all staff, instructing them not

to disclose or distribute to outside parties any evidence on wait times.

"Basically, [the VA doesn't] want stuff coming out, because they are trying to cover everything up," Wilkes said.

The scandal came to a head in June 2014, when an employee at the Phoenix VA hospital reported a secret waiting list to the media. Emboldened, Wilkes came forward to reporters and to U.S. Sen. David Vitter (R-LA), who then sent a letter to OIG demanding an investigation.

"The next day, two criminal investigators from OIG showed up and spoke to Shea," John said. "He thought they were there at the request of Sen. Vitter, and they were not. They feigned not having knowledge of Shea being a whistleblower and they were there about how he had the list and why. They were not there to investigate the fact that a list was created."

Investigators even took the hard

drive from Wilkes' computer and asked him to submit to a polygraph, which he declined.

"They told me, 'We don't see anything illegal [being done by hospital officials],'" Wilkes said.

That's when Wilkes complained to OSC.

## Investigation Continues

OIG continues to investigate allegations related to wait times at various facilities, says Catherine Gromek, spokeswoman for OIG.

"While we will not comment on ongoing work, the OIG has many investigative tools that we use during any investigation, including interviews, document reviews, email reviews, and the use of polygraphs," she said.

John has instructed OIG not to contact Wilkes but to rather go through him as his attorney.

"I said I would talk to [OIG] about anything regarding the list, but not how he got it," John said.

John says OIG declined the offer.

*Tori Richards (tori@watchdog.org) is a reporter for Watchdog.org, where an earlier version of this article originally appeared. Reprinted with permission.*

## INTERNET INFO

"Special Memorandum: Certificate of Need Modernization; Core Principles," Kentucky Cabinet for Health and Family Services, October 8, 2014: <http://chfs.ky.gov/NR/rdonlyres/A8B19E4D-2B97-44C1-A461-9E8D3BEACD94/0/SpecialMemorandumCONModernization.doc>

# Nebraska Grants Nurse Practitioners Full Practice Authority



By Kenneth Artz

Nebraska has become the 20th state to lift restrictions on nurse practitioners (NPs), granting them the authority to evaluate patients; diagnose, order, and interpret diagnostic tests; and initiate and manage treatments, including prescribing medications.

This move by Nebraska is one of the ways government reforms can reduce the cost of health care, says Jessica Smith, director of research for the Platte Institute for Economic Research in Omaha, Nebraska.

“A nurse practitioner won’t be as expensive as a doctor, and this will provide more options to access quality care when needed,” said Smith.

With the new law, Nebraska joins Alaska, Arizona, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Iowa, Maine, Minnesota, Montana, Nevada, New Hampshire, New Mexico, North Dakota, Oregon, Rhode Island, Vermont, and Wyoming in granting NPs full practice authority.

## New Opportunities for NPs

NPs have been a recognized profession for 50 years. Many states are considering how they can better use their health care workforce to increase access and lower costs for health care, says Tay Kopanos, vice president of state government affairs for the American Association of Nurse Practitioners.

NPs must have the following qualifications and credentials in most states: A Bachelor of Arts degree in nursing, a Registered Nurse license, graduate nursing education, certification from the National Board, and licensure from a state agency. This amounts to six or more years of academic and clinical preparation.

With an increase in the population, aging baby boomers, and the newly insured under Obamacare, millions of new patients will be entering the health care system, Kopanos says. This presents opportunities for NPs, whose numbers are expected to rise from about 171,000 in 2013 to about 244,000 by 2025.

“Granting full practice rights to NPs is a no-cost, no-delay solution for states that opt to, unlike other options that require new schools, new residency programs, or telehealth infrastructure that increase state budget spending,” Kopanos said.

**“A nurse practitioner won’t be as expensive as a doctor, and this will provide more options to access quality care when needed.”**

JESSICA SMITH, DIRECTOR OF RESEARCH  
PLATTE INSTITUTE FOR ECONOMIC RESEARCH

Kopanos says another benefit is in states where NPs have full practice authority, more are working in rural and underserved areas, meaning those states are better able to provide earlier preventive health care services and access to primary care.

Retailers such as CVS Health and Walgreens Boots Alliance have hired thousands of NPs, Kopanos says. Nationally, Walgreens has 1,200 practitioners at more than 420 clinics, and CVS has 2,700 practitioners in 960 clinics.

Nebraska’s new law will also allow nurse practitioners to open their own clinics, Kopanos says.

## Must Understand Limitations

There is a shortage of physicians in many areas of the United States and in various specialties, creating special obstacles and opportunities, says Dr. Roger Stark, a health care policy analyst at the Washington Policy Center and a retired physician.

“Nurse practitioners can serve as physician-extendors as long as they practice within their scope of training,” Stark said. “They can replace physicians only in medical areas of their competency. NPs can make straightforward diagnosis and do basic treatments without supervision. The critical thing for NPs—like with any doctor—is to know when to refer a patient for more specialized care.”

We don’t know yet whether the use of NPs will generally be greater in rural areas, Stark says, but NPs will have a role wherever there is a real shortage of doctors.

While many applaud the easing of restrictions on NPs, the American Medical Association (AMA) argues

physicians should continue to lead health care teams.

“We encourage physician-led health care teams that utilize the unique knowledge and valuable contributions of nurse practitioners, physician assistants, and other health care clinicians to enhance patient outcomes,” AMA said. “Innovative physician-led team models used by some of the nation’s top health care systems across the country are achieving improved care and patient health, while reducing costs.

“The AMA looks to these systems as evidence that physician-led, team-based models of care are the future of American health care,” said AMA. “Patients win when each member of their health care team carries out the role for which they are educated and trained.”

## Need to Scrutinize Training

Because of gender and political agendas, NPs end up with a truncated medical education that does not include hospital rotations, says Dr. John Dale Dunn, an emergency physician, attorney, and policy advisor to The Heartland Institute, which publishes *Health Care News*. They also have very limited exposure to diagnostic situations, which means they are more likely to make mistakes on occasion due to a lack of experience.

“We need to be asking what types of training NPs are getting and if they should be treating sick people without getting training with sick patients,” said Dunn. “Are they doing clinical rotations in hospitals with sick patients? Do they get any courses in pharmacology? It’s not the routine cases but the ability to distinguish the non-routine cases that matters; otherwise, medicine would be nothing more than a cookbook.”

Tough cases present some risks in having NPs care for patients independently and prescribe medicine, Dunn says.

“Most of the time it will probably be OK, but it will not save money in the long run because they will over-prescribe tests, etc.,” said Dunn.

Ken Artz ([kartz@heartland.org](mailto:kartz@heartland.org)) is managing editor of Health Care News.

# Insurer Expands Its Global Payment System in Massachusetts

By Devon Herrick

Blue Cross Blue Shield in Massachusetts (BCBSMA) is greatly expanding its capitated, also referred to as “global payment,” form of medical reimbursement.

Although this payment arrangement is common for health maintenance organizations, it is not common for preferred provider networks.

Under the traditional system, known as fee-for-service, doctors are paid for every office visit, test, and procedure. Under the new payment system, Blue Cross will essentially pay doctors a set fee. Doctors will profit based on how little care patients use instead of the number of patients they see and volume of services they provide.

The move will cover more than one million health plan members in Massachusetts, making it the biggest rollout of its kind in the state and possibly the nation.

## Awaiting Details of Plan

Although BCBSMA is proceeding with the initiative, many doctors are unhappy with the move. Josh Archambault, a senior fellow at the Foundation for Government Accountability and formerly a senior fellow in health care policy at the Pioneer Institute in Boston, Massachusetts, says BCBSMA has not been very forthcoming with its metrics necessary to judge the merits of the new system and is leaving some very important questions unanswered.

“In Massachusetts, we already have a lot of high-cost providers—big hospital systems, which on average are significantly more expensive—so you don’t want to bake this into the cake when you move to a global payment system,” Archambault said. “We need to know how these providers will control their prices. Will they limit their network or perhaps provide a financial incentive to patients when they find a better value?”

Archambault says every payment system has strengths and weaknesses, but in this one there’s also a fear providers will underprovide services.

“This is something the patient needs to be fully aware of and doctors need to be up front about,” Archambault said.

## Smoothing the Rough Edges

Barbara Anthony, a senior fellow in health care at the Pioneer Institute and

**“Unfortunately, even if you see a nurse practitioner or a physician assistant, the hospitals still bill everything at M.D. levels, which is very expensive.”**

**BARBARA ANTHONY  
SENIOR FELLOW  
PIONEER INSTITUTE**

a senior fellow at Harvard’s Kennedy School of Government in Cambridge, Massachusetts, says the jury is still out on global payment systems because there is simply not enough empirical data to show they work.

“Also, Boston is very hospital-centric, and they tend to overcharge,” Anthony said. “Maybe we need to coordinate care so the right medical hand knows what the left medical hand is doing.”

She suggests making sure care is delivered in the right setting. Boston has a number of teaching and academic hospitals, and community hospitals and clinics in the suburbs feed patients back into the Boston teaching hospitals whenever patients need more than primary care.

“Unfortunately, even if you see a nurse practitioner or a physician assistant, the hospitals still bill everything at M.D. levels, which is very expensive,” Anthony said. “If my kid has a fractured arm, why should he have to go to a teaching and academic hospital? We should be trying to get the patients treated in an appropriate setting, but the devil is always in the details.”

## More Power for Insurer

Merrill Matthews, a resident scholar with the Institute for Policy Innovation, says Blue Cross will not release its data because it is proprietary information.

“The whole goal of Blue Cross is to go to a global budget with fixed prices,” Matthews said.

Matthews says there is nothing wrong with a global budget as long as the prices are being set by the provider, but in this case the prices are being set by Blue Cross and the hospitals.

One example of a global payment sys-



tem that does work is cosmetic surgery, says Matthews.

“They come up with global payments all the time,” Matthews said. “The patient comes in and knows what the cost of a tummy tuck is going to be, the cost of the anesthesiologist if there is one, the cost of the room, etc., and if the patient is not satisfied, they can go down the street and talk to another plastic surgeon if they want to.”

Matthews says BCBSMA and the hospitals are selling ways to manipulate the price, provide the appropriate level of care, and pocket the difference.

## Disadvantages Best Specialists

Under this system, providers will want to avoid taking on the most difficult cases because they might exceed their budget treating them and then would be liable for the difference, Matthews says. In effect, global payment systems hurt the best specialists out there.

“For instance, if you were the top specialist, would you want to take on

difficult cases under this system?” Matthews said. “It’s very predictable for insurers because they can plan their budgets. In fact, it’s like the old capitated model on steroids, with more incentive to take the patient with the least complicated form of the illness you are treating, or limiting the number of patients you treat, or simply ‘upcoding’ [billing for services they don’t provide].”

Massachusetts was the first place to implement Romneycare and Obamacare, and during the debate over implementation, critics said the insurers would find a way to implement price controls. That’s what they’re doing with these global budgets, Matthews says.

“All we’re seeing here is a way to implement price controls without having to call them price controls,” Matthews said.

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

# Doctors Endorse Direct-Pay Primary Care

By Bruce Parker

At a public event in Vermont, physicians from Kansas, Maine, New Jersey, and Vermont discussed how they deliver top-quality, inexpensive, and hassle-free health care directly to patients without the expenses and red tape associated with third parties.

The event is indicative of the quiet physician-patient revolution underway to bypass health care middlemen and pass the savings on to consumers, known as patient-driven health care.

Dr. Alieta Eck, a private practice physician from Piscataway, New Jersey and the conference's keynote speaker, says care based thoroughly on the doctor-patient relationship delivers the ultimate in health care service.

"The goal is to offer patients the most choice possible so that they can choose their doctor, health plan, deductible, and what's covered," Eck said in a conversation before the event. "Just give them the highest degree of choices. Then doctors become the coaches, and the patient feels in control. [That] changes the whole dynamic."

## Eliminating Third-Party Payers

Eck, a past president of the Association of American Physicians and Surgeons and an internist who runs the Zarephath Health Center, which serves many poor and uninsured patients, says direct primary care is a model for how health care should work.

Under direct primary care, patients pay a monthly fee of about \$50 to receive personalized health care services from doctors. For that fee, they get same-day office visits for acute conditions, managed care for chronic medical problems, minor surgical procedures, blood and urine tests, generic medications, EKGs, and more. Patients and doctors also stay connected through social media.

"There are doctors across the country now who are saying, 'Look, buy a membership into my practice,'" said Eck. "For between \$50 and \$100 a month, you will be accessible to me by visits, e-mail, phone, and we'll figure out the best way to care for you.' That's leaving the insurance company out of everything. Now it's between you and your doctor."

Dr. Michael Ciampi, a family medicine doctor from South Portland, Maine, quit working with insurers and Medicare in 2013 and now works directly with patients. Ciampi's service charges \$50 per month for individuals and \$140 for families.

"The direct primary care model has been very successful around the country, so we decided to transition to that," Ciampi said.

Ciampi says eliminating the middleman in health care could transform medicine all across New England.

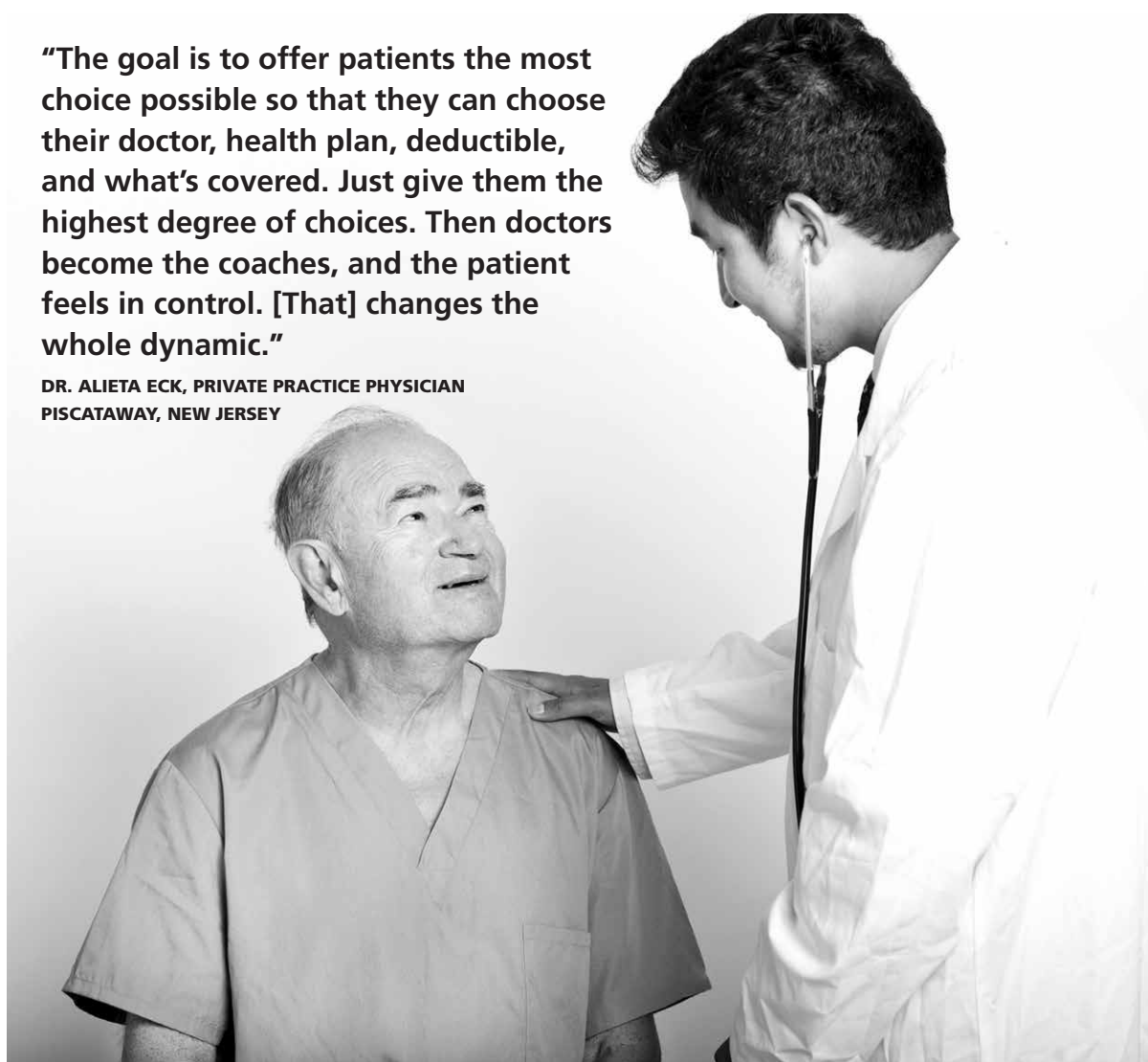
"It will stabilize the income of practices so they are financially viable, it will allow physicians to spend more time with patients and do less tests, and it will increase patient satisfaction," Ciampi said. "It also saves doctors from getting burned out."

Ciampi says he was burned out when he was part of the third-party payer system. His overhead costs were soaring due to Affordable Care Act regulations, and he increasingly found the system did not give private doctors a level playing field.

"We were finding that there's a lot of unfair

**"The goal is to offer patients the most choice possible so that they can choose their doctor, health plan, deductible, and what's covered. Just give them the highest degree of choices. Then doctors become the coaches, and the patient feels in control. [That] changes the whole dynamic."**

**DR. ALIETA ECK, PRIVATE PRACTICE PHYSICIAN  
PISCATAWAY, NEW JERSEY**



competition with hospital practices," Ciampi said. "When I was taking insurance, I was allowed to bill a patient for professional services. But a doctor who works at a hospital would bill for that as well as a facility fee of about the same amount. So hospital practices were making twice what we could, and hospital practices are nonprofit, so they weren't paying taxes. That puts private practices at a really unfair disadvantage in the revenues we could bring in."

## Still Need Insurance

Direct primary care advocates are quick to point out their patients still need insurance for big-ticket medical concerns such as major surgeries and hospitalization, but it's possible the direct-pay model could transform big-ticket medicine as well.

Surgery Center of Oklahoma (SCO), a physician-owned, state-of-the-art medical center in Oklahoma City, takes its payments directly from patients and employers. SCO's surgery menu ranges from ankles and spines to cardiovascular, urology, and gynecology. According to SCO's online pricing, most surgeries range between \$1,000 and \$6,000. SCO's most expensive surgeries, including spines and full knee and hip replacements, can cost as much as \$25,000.

It can be difficult to find what hospitals charge, and they often charge inflated amounts for the same pro-

cedures. The uninsured typically end up getting stuck with the highest prices.

Eck says direct-pay health care works because the insurance-based health care system is broken.

"They've gotten the insurance companies and the government involved in the decision making, even for the very smallest of health care needs," Eck said. "You have to ask permission for this antibiotic and that medication. We doctors need prior authorization for medicine that costs \$10. Why in the world is the insurance company bothering us with that? It's very odd the way insurance is overreaching and trying to make all the decisions."

"We don't do any insurance, because I don't want that third party getting between my patient and me," Eck said. "Patients are willing to pay a very reasonable fee to come to us. We just bypass the insurance. We're primary care. I'm an internist, and my husband is a family doctor. We don't charge more than Jiffy Lube."

Precise numbers are hard to come by, but an estimated 4 to 6 percent of doctors have left conventional third-party payer medicine and instead offer their services in practices similar to Ciampi's and Eck's.

*Bruce Parker (bparker@watchdog.org) writes for Watchdog.org, where an earlier version of this story appeared. Reprinted with permission.*

## COMMENTARY



# Obamacare Program Is Floundering Because of Poor Product Quality

By Robert Laszewski

My sense has always been Obamacare appeals to people very differently depending on their incomes.

I will call it the “Obamacare dichotomy”: The impoverished receive by far the lowest premiums and deductibles from Obamacare, and wealthier Americans, who pay very high premiums for high-deductible plans, get very little from it. This explains why most people express dissatisfaction with Obamacare in a majority of polls conducted to measure the program’s approval and why so many voters cast ballots in the 2014 election against the Democrats who have supported the plan since its creation.

It all has to do with who benefits and

who does not. We know that people who are having their premiums and deductibles disproportionately subsidized are happy with their coverage. This is hardly surprising because if you paid for most of my insurance and cut my deductibles from standard levels, I’d be pretty happy too.

## Data Confirm Gap

Not everyone is getting large subsidies, and few middle-income and upper-income people are using government exchanges. Even fewer are actually benefiting from them.

In March, consulting firm Avalere found the government exchanges have done little for most Americans.

“New analysis finds that while

exchanges have succeeded in enrolling very low-income individuals, they continue to struggle to attract middle and higher income enrollees,” the Avalere report stated. “Exchanges will need to attract higher income consumers to ensure enrollment continues to grow over time.”

Avalere’s analysis accurately describes the Affordable Care Act’s effect on the health care market, but the report’s conclusions for improving participation in the market are completely misguided.

“So far, tax credits do not appear to be enough to entice participation, so greater emphasis on individual mandate penalties may be needed to help increase enrollment among low- and middle-income individuals,” the report’s authors wrote.

I totally disagree. As Avalere has reported before, the average Silver Plan deductible is now up to almost \$2,700 a year. The problem for those not having their premiums and deductibles heavily subsidized is that Obamacare offers a lousy product, not that the penalties are too low.

## Bad Deal for Most

We don’t need to put more emphasis on the penalties for not buying Obamacare; we need attractive insurance products people want to buy.

Looking at the available data, only 20 percent of those eligible making between 251 percent and 300 percent of the poverty level bought Obamacare. Why?

According to the Kaiser Calculator, a family of four making \$60,300 per year would still have to pay out premiums of \$4,934 a year, which amounts to 8.18 percent of household income, for the second-lowest-priced Silver Plan after their Obamacare subsidies. This is about half the price of an unsubsidized policy, but it still costs this family \$4,934 a year for a policy with a deductible of almost \$2,700. How many families making \$60,000 have an extra \$4,934 in their budget for a policy that will likely pay them almost nothing?

Apparently, many of these families have concluded they are better off staying uninsured and paying for their

**“We don’t need to put more emphasis on the penalties for not buying Obamacare; we need attractive insurance products people want to buy.”**

health care costs out-of-pocket.

Of course if someone in the family is really sick, this insurance can be a great deal. And therein lies the challenge. The Obama administration must sign up enough healthy people to offset the cost of the sick, but so far it has been unsuccessful.

## Better Product, Not Penalties

What can be done to make Obamacare more attractive to consumers? President Barack Obama and Democrats have been wracking their brains over this question, to no avail.

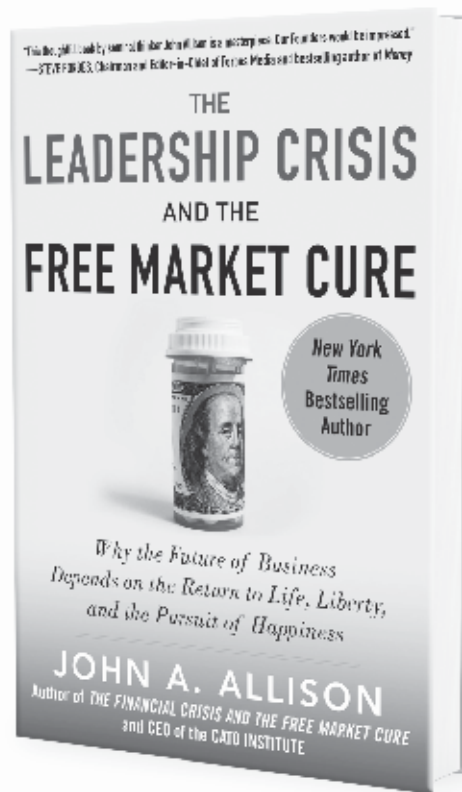
Placing greater emphasis upon individual mandate penalties so that more people will be forced to buy health insurance is one solution that’s been discussed, but some consumers will still choose not to buy insurance because it’s more than they can afford and it’s still a lousy product.

Others have suggested placing greater emphasis on outreach so consumers will realize how good Obamacare is for them. This won’t work either because many think Obamacare’s value proposition, which is an innovation, service, or feature intended to make a company or product attractive to customers, stinks.

The answer then is to give people health insurance choices they find appealing and worth the cost.

Robert Laszewski ([robert.laszewski@healthpol.com](mailto:robert.laszewski@healthpol.com)) is a contributing editor to Health Care News and a nationally recognized health insurance expert. He runs the Health Care Policy and Marketplace Review blog, where an earlier version of this column originally appeared. Reprinted with permission.

## New Book from John A. Allison, President and CEO of the Cato Institute



**“Not reading *The Leadership Crisis* would be irrational.”**

—P. J. O’ROURKE

**“This book is an invaluable guide for all those who believe that the surest path to happiness is following your own vision.”**

—JOHN P. MACKEY, Co-CEO, Whole Foods Market

John Allison reveals the fundamental principles he sees as critical to the success of any leader, to all organizations, and to the United States. Most importantly, Allison gives you the time-honored keys to self-leadership—the ability to lead yourself—the most valuable skill you will ever have.

Mc  
Graw  
Hill  
Education

AVAILABLE  
NATIONWIDE

# Illinois Changing Medicaid Payment System

By Loren Heal

Illinois is sending 2.2 million of its 3.1 million Medicaid patients to managed care, a system where the state pays a fixed amount for each patient instead of reimbursing providers for each test and treatment.

Some patients are reporting difficulties keeping their doctors and confusion navigating plans under the new payment structure.

Naomi Lopez Bauman, director of health policy at the Illinois Policy Institute, says the key to success for Illinois will be for the program to let market forces work unimpeded.

"Competition for patients among insurance carriers is vital," Bauman said. "Where you're seeing more success and a better approach to Medicaid managed care is where you have multiple competitors in each geographic area, not where it's just one provider. This will be a big key for Illinois. Is there robust competition amongst these plans, or is it going to be the worst example of managed care?"

## More Reform Needed

When there are too few companies competing, Medicaid managed care can devolve into a source of political favors and insider deals for territory, Bauman says.

"We always have to watch out for this, especially here in Illinois," Bauman said.

Bauman says some of the legitimate

**"You can look at this as a possible half-measure to solve some of the problems in Medicaid, but it falls far short of what would be needed to fundamentally reform health services for the needy in our state."**

NAOMI LOPEZ BAUMAN, DIRECTOR OF HEALTH POLICY  
ILLINOIS POLICY INSTITUTE

complaints against managed care are that it often leads to too much rationing, undermines care, and does not actually save much money.

"You can look at this as a possible half-measure to solve some of the problems in Medicaid, but it falls far short of what would be needed to fundamentally reform health services for the needy in our state," said Bauman.

## Ohio vs. Illinois

Bauman says a lot of states offer better managed care systems than the one offered by Illinois. One of those states is Ohio, which has more robust competition among plans.

"Ohio has a fairly smooth managed care market now, but [it] experienced some bumps. Illinois will experience similar bumps, especially during the rollout phase," said Rea S. Hederman, Jr., executive vice president and chief operating officer of the Buckeye Institute.

Hederman says even the best-run Medicaid managed care program is like

a well-maintained bicycle with square wheels.

"The design of this bicycle and Medicaid is flawed, and you will never have a smooth ride," Hederman said. "Managed care works best if there are competitors in the Medicaid market to help control costs, or in the case of the bicycle, round the wheels."

## Problems with Eligibility

Medicaid is plagued by fluctuating incomes among those likely to be served by the program, Hederman says. Providers and insurers often can't tell whether a person should be on the program or not.

"It is no surprise that plans will be

unable to determine eligibility," Hederman said. "The churning process in Medicaid has long been a concern for policy experts. Medicaid and Obamacare anticipate that people have perfect future knowledge of their income and job status. An unexpected raise or layoff will of course affect eligibility."

## Cost-Reduction Factor

Hederman says managed care is seen as a better form of administering health care because organizations have an economic incentive to provide only the most effective care. A fee-for-service plan can reward too much medical care and lead to growing health care costs. Competition between plans should help reduce costs and improve quality.

"Managed care is superior to fee-for-service because of this. However, Medicaid managed care is not the end solution but a Band-Aid for the overall problem of Medicaid's rapidly rising budgetary costs, which are squeezing out other programs," said Hederman.

Loren Heal (loren.heal@gmail.com) writes from Neoga, Illinois.

## Is U.S. Health Care System Getting 'Too Big to Fail'?

"Too big to fail" was the phrase used to describe the institutions affected by the 2008 financial crisis, and the U.S. health care system appears to be headed in the same direction, with 95 hospital mergers and acquisitions in 2014, a record number. Some fear these government-incentivized regional monopolies will behave like monopolies and increase prices by banishing competition from the markets.

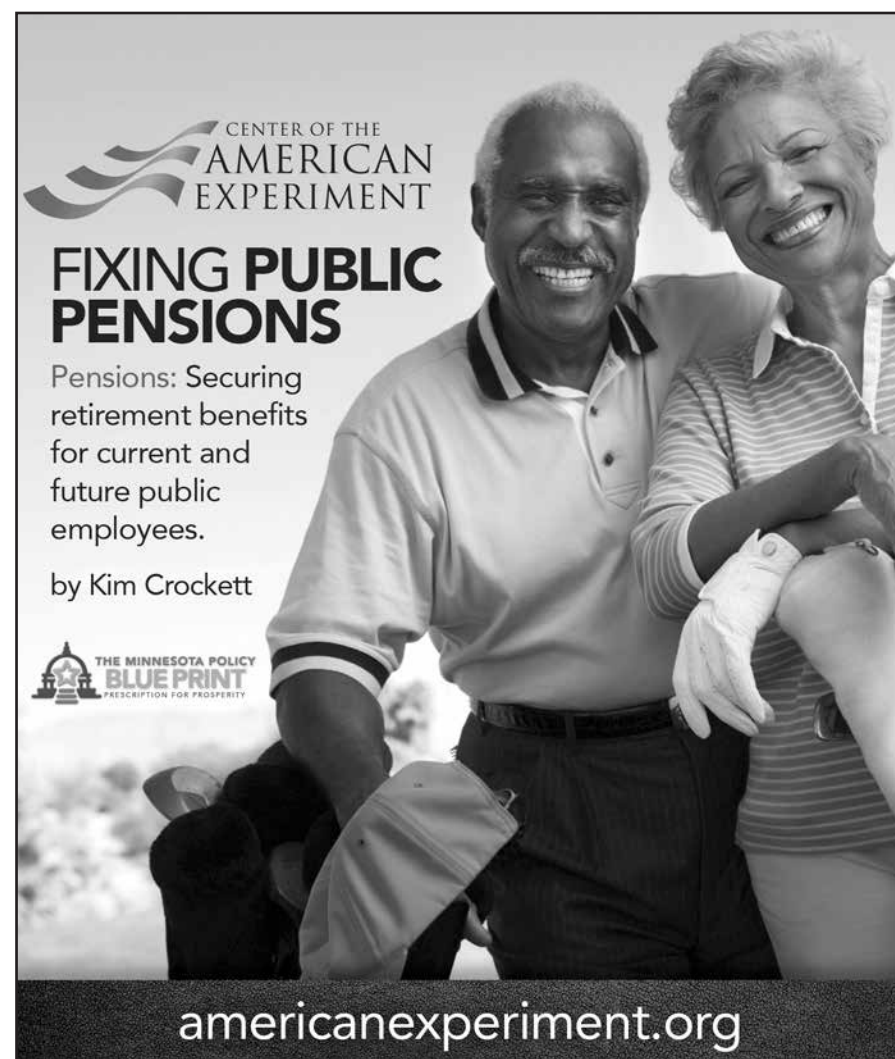
In fact, there is a greater danger in this scenario, says Dr. John Dale Dunn, an emergency physician and policy advisor to The Heartland Institute, which publishes *Health Care News*.

"There are two trends being driven by the [Patient Protection and Affordable Care Act]: Hospital mergers in the form of Accountable Care Organizations, and physicians leaving private practice to become employees of the ACOs," said Dunn.

"By controlling physicians as employees, the ACOs will force them to control costs by telling them how they will practice medicine," Dunn said. "They will do this with penalties and incentives and thus eliminate the physician's role as an advocate for the patient."

## INTERNET INFO

Marty Makary, "The Obamacare Effect: Hospital Monopolies," *The Wall Street Journal*, April 19, 2015: <http://www.wsj.com/articles/the-obamacare-effect-hospital-monopolies-1429480447>



CENTER OF THE  
AMERICAN  
EXPERIMENT

## FIXING PUBLIC PENSIONS

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

by Kim Crockett

THE MINNESOTA POLICY  
BLUE PRINT  
PRESCRIPTION FOR PROSPERITY

americanexperiment.org

# Kentucky Considers Certificate of Need Reforms

By Jim Waters

Pointing to a need to “modernize” the Certificate of Need program,” the Kentucky Cabinet for Health and Family Services (KCHFS) indicated in a public memo it plans on “exempting services for which [it] is no longer necessary.”

Kentucky’s certificate of need (CON) law requires state government approval of any new construction or expansion of medical facilities or the purchase of major medical equipment.

Although KCHFS has yet to state specifically what exemptions could occur, those reforms could have a big impact on cities like Nicholasville. Although it’s less than 20 miles south of Lexington, the town is separated from the state-of-the-art medical facilities in Kentucky’s second-largest city by U.S. 127, a busy thoroughfare that can be a matter of life and death for patients who must be transported.

For years, CON restrictions have blocked Nicholasville from building an acute care hospital.

“How many people have died *en route* to Lexington on 127 with a heart attack who could have been saved?” asked Dr. Cameron Schaeffer, a pediatric urologist in Lexington. “If the community thinks it can afford a hospital, what gives anyone the right to deny that? This is really all about the hospitals, and quite frankly, it’s evil.”

## Better Care, More Jobs

Nicholasville received a license from the state to build an ambulatory care center in 2009, and loosening the commonwealth’s CON restrictions could help that facility expand and serve more patients as an acute care facility.

“We’ve been steadily trying to improve the standard of health care here,” former Nicholasville Mayor John Martin said. “Changes in these restric-

tions could help us bring good doctors here and create local jobs in the health care field.”

The ambulatory care center was built by the late railroad tycoon R.J. Coorman.

“[Coorman] used to say there are 26 stoplights between Nicholasville and the nearest hospital,” Martin said.

Dr. Kevin Kavanagh, a Somerset, Kentucky physician who chairs Health Watch USA, says changes are needed to ensure profits gained by hospitals through the integration of health care systems are used to improve affordability.

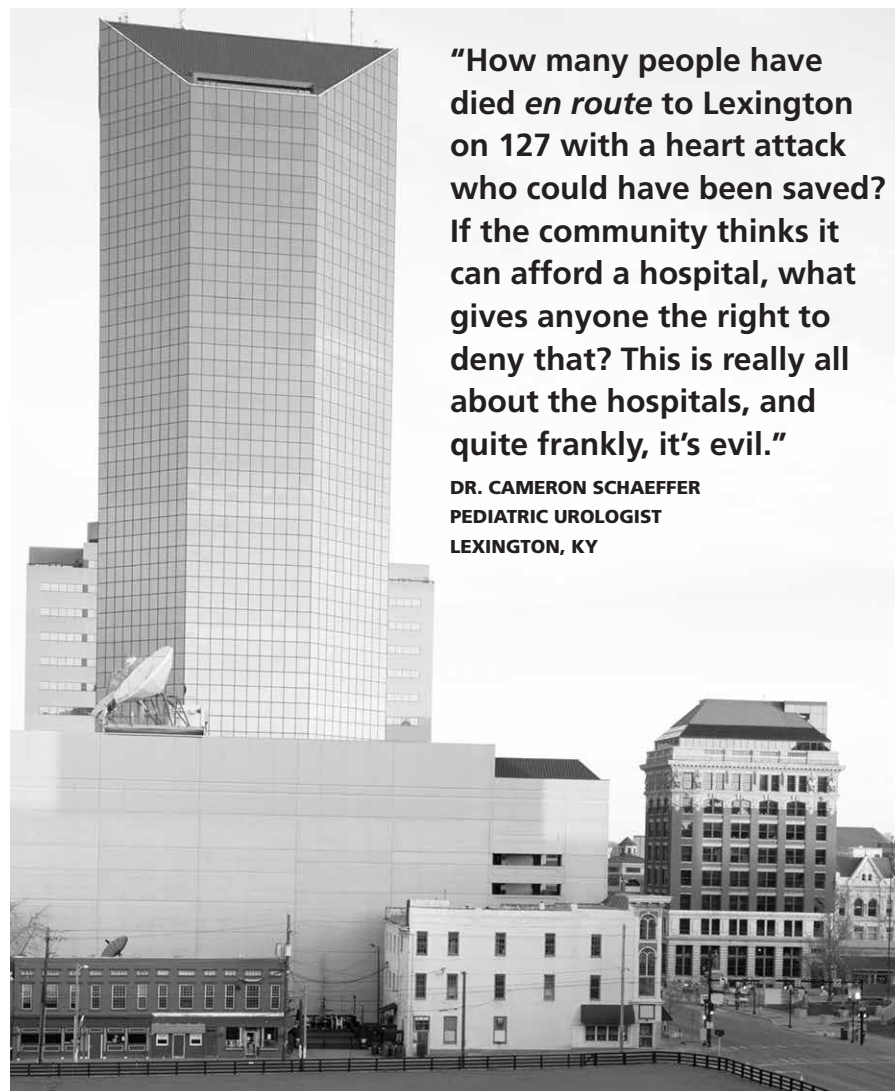
“Revising the CON or even eliminating it may be one of the ways we can see cost savings,” Kavanagh said. “Insurance premiums are still going up 10 percent annually. The idea of the Affordable Care Act was to reduce costs, and there’s a lot of concern among all that it’s not affordable.”

## Hospitals Split on Reform

In addition to written comments, KCHFS officials accepted oral statements at two “listening sessions” on March 16 and 17. They have heard from people on both sides of the issue.

Victor Dipilla, vice president and chief business development officer for the Christ Hospital Health Network, noted in his comments to the cabinet his system’s flagship hospital in Ohio is “only two miles from the Ohio River,” on the other side of which is the Northern Kentucky market and plentiful opportunities for providing care that have yet to be realized.

Dipilla says 14 percent of Christ Hospital’s business comes from consumers living on the Kentucky side of the river, up 2 percent from 2012, which indicates a solid demand for more providers in that part of the Greater Cincinnati market.



**“How many people have died *en route* to Lexington on 127 with a heart attack who could have been saved? If the community thinks it can afford a hospital, what gives anyone the right to deny that? This is really all about the hospitals, and quite frankly, it’s evil.”**

**DR. CAMERON SCHAEFFER**  
PEDIATRIC UROLOGIST  
LEXINGTON, KY

“Currently, patients in northern Kentucky do not have much choice, as there is only one health system providing health care in the community,” Dipilla said to KCHFS.

“We have listened to the public, and they are asking for choice—choice of physicians and choice of where they receive their care,” Dipilla said.

## Both Reform, Abolition Considered

In its memo, KCHFS indicated it is considering exempting certain CON-required services, citing a recent study by Deloitte of the state’s health care facilities. The Deloitte report recommends the state relax its CON regulations for ambulatory surgery centers (ASC) and “allow more free-standing ASCs to be built in order to

increase market competition and provide viable alternatives to hospital based care.”

Kavanagh would like to see the CON process abolished altogether, but if that’s an impossibility, he suggests the state should consider auctioning CON approvals to build new facilities.

“As a very valuable commodity, because it virtually guarantees a market share to a facility, the CON should not be given away by the state,” Kavanagh said. “The money raised from such an auction could be matched with federal funds and put back into patient services.”

*Jim Waters (jwaters@freedomkentucky.com) is president of the Bluegrass Institute.*

## Repealing CON Would Open NC Health Market

North Carolina state Sen. Tom Apodaca (R-Henderson County) has introduced a bill to eliminate the state’s certificate of need laws. The CON program, intended to prevent excessive spending on facilities and equipment, requires hospitals and other medical providers to get state approval for expansions and major acquisitions.

Katherine Restrepo, health and human services policy analyst at the John Locke Foundation in North Carolina, says getting rid of the entire CON process would open up the state’s health care market to competition; increase access to health care, even in rural areas; and lower health care costs for consumers.

“Repealing the law would give providers more autonomy and allow surgeons to open up their own ambulatory surgical centers, or outpatient clinics, giving patients more choices and lower prices,” said Restrepo.

## INTERNET INFO

“Special Memorandum: Certificate of Need Modernization; Core Principles,” Kentucky Cabinet for Health and Family Services, October 8, 2014: <http://chfs.ky.gov/NR/rdonlyres/A8B19E4D-2B97-44C1-A461-9E8D3BEACD94/0/SpecialMemorandumCONModernization.doc>

## COMMENTARY

# What's Next for Obamacare After *King v. Burwell*

By Peter J. Ferrara

When the U.S. Supreme Court determines the outcome of *King v. Burwell* this summer, it will probably strike down Obamacare benefits in 36 states because the Obama administration did not follow its own law passed by congressional Democrats and signed by President Barack Obama.

The law provides for federal benefits to help pay for health insurance purchased “through an Exchange established by the State,” but only 14 states set up their own health insurance exchanges. In the other 36 states, the exchanges were established by the Department of Health and Human Services (HHS).

The law establishing Obamacare, the Patient Protection and Affordable Care Act (ACA), pointedly leaves out any mention of federal benefits for health insurance when it discusses exchanges established by HHS. The architects of Obamacare have already publicly explained the law was written in this way to provide irresistible incentives for states to establish exchanges so their residents could get Obamacare benefits. Obamacare specifically defines “State” as “each of the 50 states, plus the District of Columbia.” There is no mention of HHS.

But not to worry, Obama simply ordered the Internal Revenue Service to issue a regulation that Obamacare health insurance subsidies, which are in the form of tax credits, would be provided for health insurance purchased on either exchanges established by the states or by HHS, a clear violation of the law.

In response, four individuals from

**“Republican governors and state legislatures should exclaim relief the job-killing and cost-increasing individual and employer mandates no longer apply in their states.”**

Virginia who claim they are harmed by this regulation because it makes them subject to Obamacare’s individual mandate, which requires people to enroll in comprehensive health insurance coverage or pay a tax penalty, sued. The plaintiffs are asking the courts to strike down this HHS regulation as contrary to explicit passages of the law.

## Repealing State Exchanges

There are still at least five justices on the Supreme Court who recognize the purpose of the federal courts is to enforce the law as written and that Congress must approve any changes in federal statutes, so it’s likely the court will rule in favor of the plaintiffs.

Another provision of ACA where Obamacare health insurance benefits do not apply is the counterproductive individual and employer mandates. When the Supreme Court strikes down Obamacare health insurance subsidies in 36 states, the individual and employer mandates will be removed from those states as well.

Democrats and their party-controlled

members of the media will then surely pressure the prevailing Republican governors and state legislatures to establish state exchanges so citizens in their states can get the Obamacare benefits their taxes are paying for. They will also pressure congressional Republican majorities to reestablish Obamacare in all 50 states.

But Republicans must not betray their own voters.

Republican governors and state legislatures should exclaim relief the job-killing and cost-increasing individual and employer mandates no longer apply in their states. Republicans should also pressure Democrat governors and legislators to repeal the state exchanges in the 14 states that have them.

## Letting States Opt Out

Since states without state exchanges will have opted out of the Obamacare benefits, Republicans in Congress should pass legislation confirming the citizens of those states have opted out of Obamacare tax credits. The new federal legislation should also repeal all of the Obamacare regulations in states without state exchanges.

The key implication here is all the Obamacare increases in the cost of health insurance will be reversed, and without those Obamacare cost increases, the Obamacare health insurance subsidies will no longer be necessary.

## Block Grants Needed

Block grants should also be established in any legislation that is designed to replace Obamacare. Block granting Medicaid to the states, as was the case

with the 1996 welfare reforms, would allow state governments to use their resulting new control over Medicaid to provide benefits in the form of health insurance vouchers impoverished Americans could use to help buy their own health insurance, including health savings accounts.

This would vastly improve health care for the poor, who cannot get timely, essential health care through Medicaid because the government so badly underfunds payments to doctors and hospitals that accept Medicaid patients.

This isn’t a problem in a truly free market because private insurers must adequately compensate doctors and hospitals to attract health insurance customers.

Sure, Obama could veto such a post-*King v. Burwell* fix for his broken Obamacare disaster, but he and his cronies would then have to live with a crashed health care system for another year, when another president will be elected.

An Obama veto would further clarify what is at stake in that election.

*Peter Ferrara (pferrara@heartland.org) is senior fellow in entitlement and budget policy at The Heartland Institute. He previously served in the White House Office of Policy Development under President Ronald Reagan and as associate deputy attorney general of the United States under President George H. W. Bush. He is the author of Power to the People: The New Road to Freedom and Prosperity for the Poor, Seniors, and Those Most in Need of the World’s Best Health Care.*

# Kasich Claims on Obamacare Money Challenged

By Jason Hart

Ohio Gov. John Kasich (R) has argued rejecting the Medicaid expansion authorized and paid for under the Affordable Care Act (ACA) would be a loss for the state's taxpayers, claiming federal tax money paid by Ohioans would be spent in other states instead of coming back through federal matching funds.

According to the Congressional Research Service (CRS), rejecting the Medicaid expansion would not send Ohio tax dollars to other states.

CRS, a department of the Library of Congress providing policy guidance to members of Congress, answered questions about the ACA, also referred to as Obamacare, in a January memo published by the free-market think tank Foundation for Government Accountability.

"If a state doesn't implement the ACA Medicaid expansion, the federal funds that would have been used for that state's expansion are not being sent to another state," CRS said in its memo. "There is not a set amount of federal funding for Medicaid."

"The CRS memo is very important,

**"The CRS memo is very important, as it highlights how Medicaid is actually structured—it is an entirely open-ended program with no defined limits. It is flat-out inaccurate to say our money will go to other states."**

GREG LAWSON, POLICY ANALYST, BUCKEYE INSTITUTE

as it highlights how Medicaid is actually structured—it is an entirely open-ended program with no defined limits," said Greg Lawson, a policy analyst with the Buckeye Institute, in an e-mail to *Ohio Watchdog*.

"It is flat-out inaccurate to say our money will go to other states," Lawson said.

## Of-Stated Claim

Kasich has repeatedly described expanding the state's Medicaid program as a way to bring tax dollars back to the state. Speaking to George Stephanopoulos on ABC's *Good Morning America* in December 2014, Kasich said, "Now, on Medicaid expansion, I'm able to bring Ohio money back to Ohio.

... Why wouldn't I do that, George? That's common sense to me."

During his 2013 State of the State speech, Kasich said, "If we don't do what we should do on Medicaid, they'll be spending it in California." Kasich called the expansion "an unprecedented opportunity to bring \$13 billion of Ohio's tax dollars back to Ohio to solve our problem."

The CRS report explains the funding stream doesn't work the way Kasich suggests it does.

"If a state hasn't implemented the ACA Medicaid expansion, the state would not receive any federal Medicaid funding for the expansion," CRS wrote. "However, this doesn't mean any additional federal Medicaid funding would

be allocated to states that have implemented the expansion."

Each state's Medicaid expansion is paid for with new federal spending. The nationwide cost of Medicaid expansion increases with every state that opts in.

"The Buckeye Institute made this case throughout 2013 during the Medicaid debate, and this report validates our position," Lawson said. "The report undermines claims that if Ohio doesn't expand Medicaid, it will lose tax dollars to other states."

"This reinforces the urgency of reforming Medicaid and getting recipients off of it as quickly as possible," Lawson said. "Medicaid expansion in Ohio not only did not keep money in Ohio but instead ensured that Ohio citizens will eventually face higher taxes to pay for this program."

The Kasich administration declined to respond to a request for comment on the CRS memo.

Jason Hart ([jhart@watchdog.org](mailto:jhart@watchdog.org)) writes for Watchdog.org, where an earlier version of this article first appeared. Reprinted with permission.

## ADVERTISEMENT

### Market Competition Can Revive Cities

Some say cities and towns achieve success through government central planning and regulation.

Bankrupt Detroit was once considered a model of urban planning. The city nonetheless lost investment, jobs, taxes, and population.

That's because it didn't *sell* to "free to choose" businesses and families in the face of competition from the rural South and its own suburbs.

But how can you sell places like Detroit and other older cities today? Maybe by learning from a company that sold the unsellable.

### The "Unsellable" Best-Seller

The original Volkswagen Beetle--Hitler's car--was thought to be unsellable in the U.S.

But VW made it the best-selling car of all time--by Thinking *Small*.

*Marketing Big...by Thinking Small: How Anything You Sell Can Be Helped by the Greatest Marketing Achievement of the 20<sup>th</sup> Century* tells the story.

It shows how Thinking Small marketing worked. How VW's success can help cities like Detroit. And how it can boost any hard-to-sell product, cause, or service--and *make any marketing more productive and less expensive.*

### Marketing for Growth

It's a 43,000-word user-friendly manual by John L. Gann, Jr., who consults, trains, and writes on marketing for economic growth.

Called "a Cadillac in marketing expertise," he's written manuals on marketing college towns and bypassed hamlets and on evaluating marketing programs.

### Compulsion vs. Persuasion

Get a copy for your own business. And because it shows the power of persuasion over compulsion, send copies to your mayor, city manager, planner, and elected officials.



It's just \$59.75 print or \$49.75 electronic edition. Find out more at [salesjobsandtaxes.com/thinksmall1.html](http://salesjobsandtaxes.com/thinksmall1.html). Or contact John at (800) 762-GANN or [citykid@uwalumni.com](mailto:citykid@uwalumni.com).

JULY 8 -11 2015 - PLANET HOLLYWOOD VEGAS

# TOP TEN REASONS!

TO COME TO

## Freedomfest™

The World's Largest Gathering of Free Minds.

COME SEE WHY WE'RE  
THE #1 LIBERTY  
CONFERENCE

#freedomfest  
#newamericandream

#1

BECAUSE  
HEARTLAND INSTITUTE  
WILL BE THERE!

The  
*Heartland*  
INSTITUTE

Plus all the major think tanks...Cato, FEE, Heritage, more...



Dream Debate of the Century!

PAUL KRUGMAN  
VS  
STEVE MOORE

Austerity vs Stimulus...Red State vs Blue State... and More!



JOHN  
MACKEY

VS

PETER  
THIEL

"Monopoly Power! Has Competition Been Oversold?"



\$50,000 AMERICAN  
DREAM AWARD!

Join the competition  
for the best new business idea!

FREEDOMFEST CASH VAULT



TOP MEDIA COVERAGE  
JOHN STOSSEL  
(FOX BUSINESS)  
INTERVIEWS  
STEVE WYNN  
(WYNN RESORTS)

Reason.TV, CSPAN-Book TV, Newsmax and many more



DINESH D'SOUZA  
VS  
THE LATE, GREAT  
CHRISTOPHER HITCHENS

"What's So Great about God"



ANTHEM FILM FESTIVAL!

JOANN SKOUSEN  
(PRODUCER)

World's Only 100% Liberty Film Festival



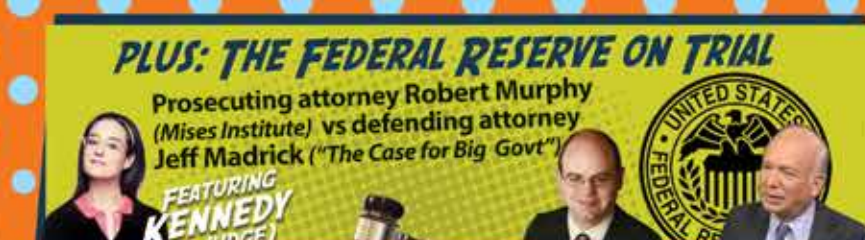
INVESTORS' SUMMIT  
PETER SCHIFF  
(EUROPACIFIC)  
ALEXANDER GREEN  
(OXFORD CLUB)

"Is the Golden Age of Investing Over?"



MICHAEL SHERMER  
(SCIENTIFIC AMERICAN)  
AND  
CONGRESSMAN  
ALLEN WEST

Debates on War, the American Dream, Moral Progress, and more...



PLUS: THE FEDERAL RESERVE ON TRIAL

Prosecuting attorney Robert Murphy  
(Mises Institute) vs defending attorney  
Jeff Madrick ("The Case for Big Govt")

FEATURING  
KENNEDY  
(AS JUDGE)

Steve Forbes and John Allison as star witnesses

Call us today or go to our website to register. We expect to sell out this year with over 2,500 attendees!

[www.FreedomFest.com](http://www.FreedomFest.com)

1-855-850-FREE

# When you need the latest news on...

Budgets and Taxes · Education · Environment · Health Care

Subscribe to one or all four of The Heartland Institute's monthly public policy newspapers. Each month, you will receive news and commentary you can rely on concerning public policy debates and decisions taking place in all 50 states.

- **Environment & Climate News** corrects the inaccurate and misleading coverage of environmental issues that appears in newspapers and magazines and on television.



Subscribe online for free or pay only \$36 to receive ten issues by mail. Go to [heartland.org/subscribe](http://heartland.org/subscribe) or call Tonya Houston at 312/377-4000.

- **School Reform News** advocates for parental choice, distance learning, and breaking the hold of teachers unions on public schools.



Can't wait? Articles that appear in these newspapers are also posted online in real time at [news.heartland.org](http://news.heartland.org).

- **Health Care News** keeps up with policy and technology in the health care field and is actively following the ongoing debate over Obamacare and its implementation.



- **Budget & Tax News** features news and commentary on ways to lower taxes and cut government spending.



**THE HEARTLAND INSTITUTE**   
HEARTLAND.ORG

The Heartland Institute is a 31-year-old national nonprofit organization based in Chicago. Its mission is to discover, develop, and promote free-market solutions to social and economic problems. For more information, visit our Web site at [heartland.org](http://heartland.org) or call 312/377-4000.

