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HEALTH CARE NEWS

THE MONTHLY NEWSPAPER FOR HEALTH CARE REFORM

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The Pulse

Hospitals Abusing Drug Program

Hospitals around the country are abusing the federal 340B drug discount program intended for the needy, making big money in the process. **Page 4**

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Some doctors and activists are questioning whether high-priced drugs are worth the money. **Page 5**

Obamacare Auto-Enrollment

The Obama administration plans to automatically renew millions of people in Obamacare in 2015, causing massive out-of-pocket premium hikes for many. **Page 9**

Shreveport VA Hospital Scandal

An investigation into the VA hospital in Shreveport, Louisiana found staff and supervisors ignored patient needs, provided substandard care, and engaged in questionable spending. **Pages 10-11**

Union Rejects Hospital Reform

As state-run hospitals in Hawaii face closures and layoffs, the state government employees union touts its opposition to reform that includes privatization. **Page 12**

Subsidies Only for State Exchanges, Judge Rules

By Sean Parnell

A federal district court judge in Oklahoma ruled health insurance policies purchased through the federal health care exchange are not eligible for subsidies under the Affordable Care Act.

Judge Ronald White of the Eastern District of Oklahoma decided *Pruitt v. Burwell* on September 30. White's decision centered on the language of the Affordable Care Act, also known as Obamacare, which specifies subsidies are available for plans purchased on exchanges "established by a state under Section 1311." No similar language authorizing subsidies exists elsewhere in the Obamacare law regarding exchanges established by the federal government, leading White to conclude subsidies are available only for plans purchased through state-based exchanges.

"Today's ruling is a consequential victory for the rule of

SUBSIDIES, p. 6

Oklahoma Attorney General Scott Pruitt attends the 2014 Conservative Political Action Conference in Maryland.

Pa. Medicaid Expansion Could Prove Costly

By Loren Heal

Pennsylvania has announced it will expand its Medicaid program under an agreement reached with the Department of Health and Human Services (DHHS), even after the federal government rejected many of the state's proposed waiver requests that would have allowed it to craft a plan suited to its residents' needs.

Expanding Medicaid is optional for

states under the Affordable Care Act, better known as Obamacare.

The state had originally sought to enroll newly eligible persons in private insurance plans, but the agreement announced on August 28 instead required they be placed into managed care plans largely identical to the plans current Medicaid recipients are

MEDICAID, p. 14

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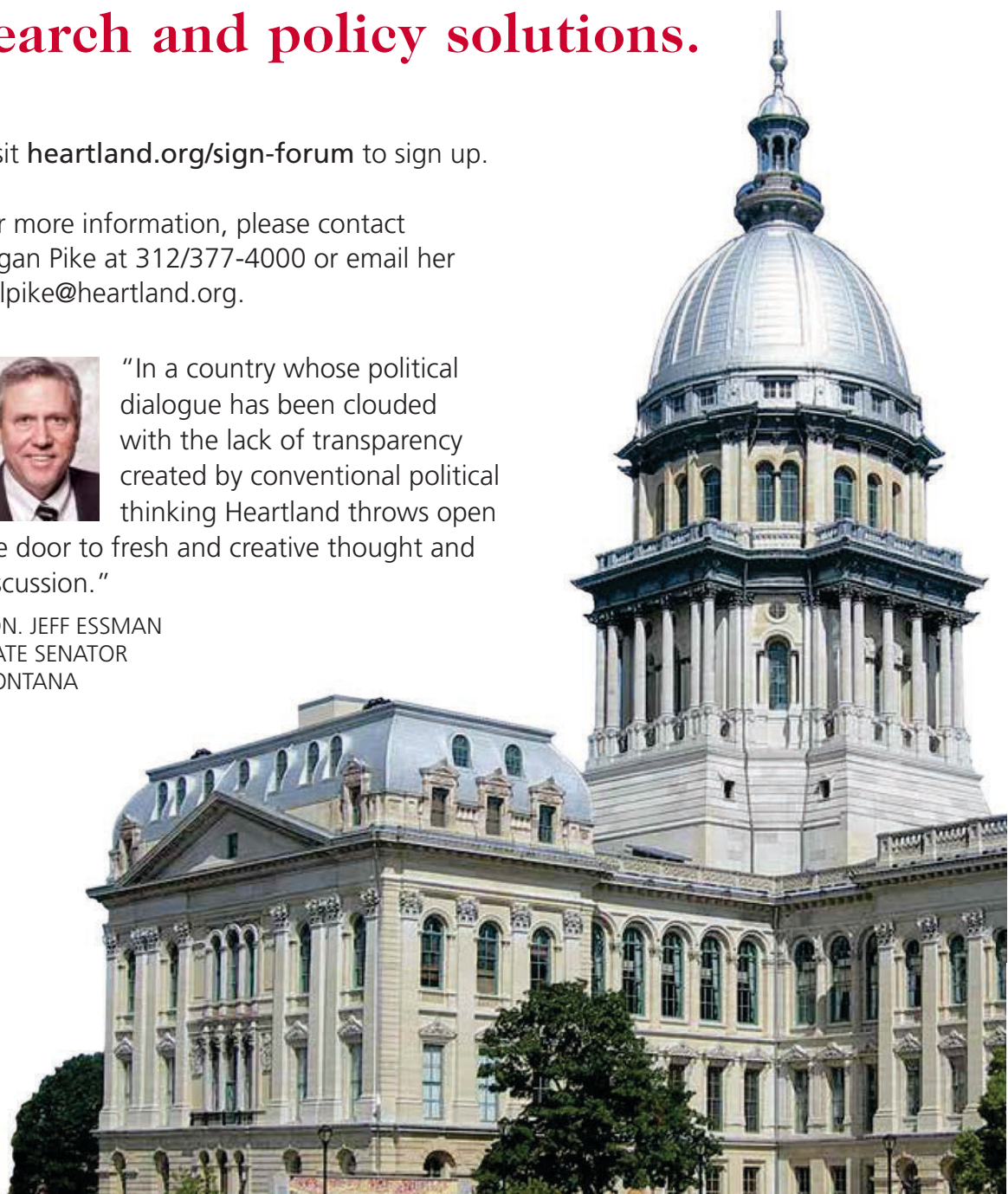
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Ebola Vaccine, Treatment Funding Draw Scrutiny and Accusations

By Alexander Anton

The arrival of the Ebola virus on American soil, including the first infections to occur in this country, has brought attention to the budgets of the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH) and has led to a barrage of charges, some politically motivated, that blame officeholders of the opposing political party for any potential U.S. outbreak of the disease.

Dr. Francis Collins, director of NIH, suggested in an October 12 interview with *The Huffington Post* that budget cuts have delayed development of a vaccine. Groups engaged in the 2014 election fight have joined the argument as well, pointing a finger at Republican-supported budget cuts in various campaign ads.

Romina Boccia, a research fellow at The Heritage Foundation, says she doesn't find the charges credible.

"The claim that budget reductions to the NIH are primarily responsible for the lack of an Ebola vaccine is misleading," she said. "The reality is that Ebola research has not been a strategic priority for either the NIH or private-sector pharmaceuticals. NIH Director Francis Collins is doing the public a disservice by claiming otherwise."

Not Among Funding Priorities

In *The Huffington Post* interview, Collins revealed an Ebola vaccine has been in the works for a decade, adding, "If we had not gone through our 10-year slide in research support, we probably would have had a vaccine in time for this that would've gone through clinical trials and would have been ready."

A look at spending at NIH over the past decade doesn't support the claim. NIH funds jumped early under George W. Bush's administration, rising from nearly \$26 billion per year in 2001 to almost \$34 billion by 2003. Funding has declined slightly since 2003, holding fairly steady at more than \$30 billion since. CDC funding has followed a similar pattern.



Tom Coburn
U.S. Senator - OK

Critics charge a more likely culprit for the lack of a vaccine or proven treatment is poor prioritization of spending by NIH and CDC.

Sen. Tom Coburn (R-OK) included in his "Wastebok



"The claim that budget reductions to the NIH are primarily responsible for the lack of an Ebola vaccine is misleading. The reality is that Ebola research has not been a strategic priority for either the NIH or private-sector pharmaceuticals. NIH Director Francis Collins is doing the public a disservice by claiming otherwise."

ROMINA BOCCIA, RESEARCH FELLOW, THE HERITAGE FOUNDATION

2013" examples of what NIH uses its money on, including \$325,525 to fund a study that concluded, "Wives would find marriage more satisfying if they could calm down faster during arguments with their husbands."

Other examples of NIH spending include studying why lesbians tend to be overweight whereas gay men do not (\$1.5 million), the sex life of fruit flies (\$1 million), and why people like "Seinfeld" reruns (\$688,000).

In addition, NIH's infectious disease branch failed to mention Ebola in its strategic plan, while mentioning malaria, hepatitis C, and influenza, the last of which was mentioned more than 14 times.

"Follow the NIH's spending, and it becomes very clear that HIV/AIDS is much more of a priority and yet there is no vaccine for it yet," Boccia observed. "Moreover, the NIH certainly diverted millions in funding to rather dubious projects that it could have put towards infectious disease research if the agency acted as a good steward for taxpayer dollars."

'Absurd' Attack Ad

Trying to use the funding controversy for political gain, the pro-Democrat group Agenda Project Action Fund aired an ad in mid-October blaming spending cuts, and Ebola deaths by

extension, on Republicans, using the slogan: "Republican cuts kill."

The ad and related claims drew swift rebukes from media, policy experts, and others noting the charges contradict the facts.

Glenn Kessler, who runs the "Fact Checker" site for *The Washington Post*, called the charges "absurd," saying there has been bipartisan support for the various measures that modestly scaled back NIH and CDC budgets over the past several years, including the White House-devised sequestration.

"Obama's Republican predecessor oversaw big increases in public-health sector spending, and both Democrats and Republicans in recent years have broadly supported efforts to rein in federal spending. Sequestration resulted from a bipartisan agreement," Kessler wrote in his October 15 report on the claims, stating the Democratic activists deserved "Four Pinocchios" for blaming Republicans for NIH and CDC funding cuts.

"In some years, Congress has allocated more money for NIH and CDC than the Obama administration requested," Kessler said.

Alexander Anton (alexanderanton4@gmail.com) writes from Chicago, Illinois.

Drug Program Creates Windfall for Hospitals

By Christopher Butler

Hospitals and clinics across Tennessee and the United States are reportedly using a federal entitlement to pad their profits and subsidize other operations, depriving pharmaceutical manufacturers of revenue and jeopardizing future drug innovation.

The program, known as the 340B Drug Pricing Program, passed into law in 1992 and was designed to help poor and uninsured people get prescription drugs. Under the program, drug companies give discounts to hospitals primarily serving poor and uninsured patients. But hospitals are allegedly using discounted drugs for patients who are not poor or uninsured, and charging them full price.

"Hospitals are purchasing the drugs at these 20 to 50 percent discounted prices and then they are charging patients the full price, so hospitals are making a profit. It's not helping the people it was designed to help," said Sally Pipes, president

of the Pacific Research Institute, a San Francisco-based think tank.

Raking in Undeserved Millions

According to a February 12, 2013 article in *The New York Times*, the practice of buying drugs at a discount while charging insured patients the full price has become lucrative for at least one Tennessee hospital and an oncology practice it is affiliated with.

"When a private oncology practice in Memphis formed a partnership with a nearby hospital in late 2011, the organizations proclaimed that the deal would 'transform cancer care' in the region," the *Times* article reported.

"What they did not emphasize was that the deal would also create a windfall for them worth millions of dollars a year, courtesy of an obscure federally mandated drug discount program. ...

"When the West Clinic teamed with Methodist Healthcare, the huge volume of chemotherapy drugs used by the



"Hospitals are purchasing the drugs at these 20 to 50 percent discounted prices and then they are charging patients the full price, so hospitals are making a profit. [The program] is not helping the people it was designed to help."

SALLY PIPES, PRESIDENT, PACIFIC RESEARCH INSTITUTE

clinic suddenly qualified for the hospital's discount, while reimbursement remained the same."

Lindsay Boyd, director of policy at the Beacon Center of Tennessee, says 67 percent of the hospitals in Tennessee that are enrolled in the 340B program provide less charity care than the national average of 3.3 percent, suggesting the program has gone well beyond simply helping the poor.

"As we see happen time after time with supposedly well-intentioned federal programs like 340B, what was once intended to directly benefit poor and uninsured patients has turned into a massive redistribution of wealth," Boyd said. "Hospitals are pocketing the savings that should be passed to needy patients."

Concern over Innovation Incentives

One of the concerns raised over hospitals using discounted drugs for patients for whom the 340B program was never intended is that reducing revenues for pharmaceutical companies leaves less money to invest in drug research and development.

"If these companies haven't gotten the financial incentive to do what they're doing, then they're going to stop, and that's going to hurt not just the people who are uninsured and low-income. All of us will be hurt," Pipes said. "It could be drugs for Alzheimer's, cancer, diabetes, or hepatitis C."

"Only about five drugs out of 5,000 actually make it to human trial, and

one of the five makes it to market," Pipes said. "It costs about \$1 billion from the start of an idea to putting a drug through all of the different phases. ... If they don't make a change to this, it's going to destroy the incentive for the pharmaceutical companies and biologics companies to continue to do research and development."

Lack of Oversight Cited

Critics point to a lack of oversight for the program as it has expanded beyond its original parameters.

Federal officials added pharmacies to the program in 1996. In 2010 the program began allowing hospitals to contract with an unlimited number of outside pharmacies. One in three hospitals in the United States now participates in the program.

Discussing proposed regulations that would rein in abuses, President Barack Obama's former secretary of Health and Human Services, Kathleen Sebelius, told *Health Affairs* the regulations will "try to codify this delicate balance: staying true to Congress's intent to extend federal dollars by leveraging these discounts, but also drawing brighter boundaries around which transactions are 'in' and which ones are 'out.'"

Christopher Butler (chris@tennesseewatchdog.org) writes for *Watchdog.org*, where an earlier version of this article first appeared. Reprinted with permission.

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FIXING PUBLIC PENSIONS

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

by Kim Crockett

THE MINNESOTA POLICY
BLUEPRINT
PRESCRIPTION FOR PROSPERITY

americanexperiment.org

High-Priced Drug Treatments—Worth the Cost?

By Yevgeniy Feyman

Drug manufacturer Merck won approval in September from the Food and Drug Administration (FDA) for its new “game-changing” treatment, Keytruda, a drug designed to treat late-stage melanoma, a deadly skin cancer.

Keytruda offers “unprecedented response rates” for patients with late-stage melanoma who otherwise face a death sentence, according to a September 8 analysis by Colin White, lead analyst for oncology at Datamonitor Healthcare.

Though the treatment is a potential lifesaver, the cost—\$12,500 per month over an average of six months—is likely to ruffle some feathers.

Similarly high-cost treatments for hepatitis C and a rare form of leukemia have generated anger from insurance industry trade groups, patients, and doctors. But focusing only on the cost of these drugs without considering their benefits may be misleading.

Tomas Phillipson, a public policy professor and health economist at the University of Chicago, says critics of high drug prices are missing the point. Discussing Gilead Pharmaceutical’s Sovaldi, which costs \$84,000 for a full treatment and has been praised as being nearly a cure for hepatitis C, Phillipson says “\$84,000 upfront is expensive, but not for living without hepatitis C.”

“On one hand, I recognize that everybody should be able to get reasonable medical [care], ... [but] if we decide that the cost doesn’t matter, ... then we’ve become irresponsible and irrational.”

DR. ARVIND GOYAL
MEDICAL DIRECTOR
ILLINOIS DEPARTMENT OF HEALTH
CARE AND FAMILY SERVICES



Clamping Down on Expensive Meds

Although the benefits to patients of high-priced medicines may seem obvious, not everyone is happy to see them. Insurance companies in particular have voiced concerns about the costs, as have

state Medicaid programs.

One state, Illinois, developed a set of 25 criteria to determine in what cases the state’s Medicaid program would pay for the drug. In an interview with *The Wall Street Journal*, Dr. Arvind Goyal, medical director of Illinois’ Department of Health Care and Family Services, defended the decision, saying, “On one hand, I recognize that everybody should be able to get reasonable medical [care], ... [but] if we decide that the cost doesn’t matter, ... then we’ve become irresponsible and irrational.”

According to Columbia Business School professor Frank Lichtenberg, “demonstrating benefits requires good data and careful analysis.” So although the value of new treatments may be significant—Lichtenberg argues in a forthcoming paper pharmaceutical innovation has resulted in savings “three times as large as the cost of new drugs consumed”—the prices are upfront and more visible.

Little Appetite for Price Controls

Despite the concerns about high drug prices, few are willing to suggest price controls on prescription drugs.

“I don’t think our country is ready to stomach drug negotiations and drug regulations to that extent,” drug industry consultant Lauren Barnes, senior vice president of Avalere Health, said in a CNBC article.

Instead, payers in the insurance and

benefits industries are trying to use their market power to force the drug companies to lower prices. Such tactics include plans to switch patients to lower-cost options expected to be approved by FDA in coming months and years.

Innovative Financing Options

Another possible way to address the high cost of drugs may be through the development of innovative financial products.

In a July 2014 *Forbes* op-ed, former FDA Commissioner Dr. Andrew von Eschenbach and Phillipson contend credit markets can help defer some of these large costs over time.

Although there already are some credit instruments for health care, the interest rates are often very high. Better financing mechanisms, which might even include government guarantees, could help make the interest rates less burdensome, the writers say.

“Just as there would be fewer homes purchased if the full value of a house had to be paid up front without mortgages,” personal financing of drug costs can be a huge burden, von Eschenbach and Phillipson said. “Public and personal health will suffer needlessly unless we develop better credit mechanisms for patients and payers in health care.”

Yevgeniy Feyman (yfeyman@manhattan-institute.org) is a fellow at the Manhattan Institute.

More Virginians Lose Insurance Coverage

By Kathryn Watson

Another quarter of a million people in Virginia will likely lose their health insurance plans by the end of the year.

Virginia’s Health Insurance Reform Commission learned on September 10 that 250,000 Virginians will receive notices stating their health insurance plans are being canceled as a result of the Affordable Care Act (ACA). That’s in addition to the thousands of Virginians who had already been notified over the past year their plans are no longer compliant with President Barack Obama’s signature health care law.

“I am deeply concerned that, at a time when families are already struggling to make ends meet, another 250,000 policy holders will have to trim their budgets back even further,” Delegate and Commission Chairman Kathy Byron (R-VA) said in a statement.

Those who lose their health care plan can purchase another that complies with the ACA—but it is likely they’ll pay higher premiums.

The Manhattan Institute, a free-market think tank, found older men around the age of 64 are the only general group benefitting from lower rates than before because of the ACA. Young men, especially those in their mid-20s, are suffering the most from higher premiums as a result of Obamacare, witnessing an average monthly increase of 67 percent.

Kathryn Watson (kwatson@watchdog.org) writes for Watchdog.org, where an earlier version of this article first appeared. Reprinted with permission.

Subsidies Only for State Exchanges, Judge Rules

Continued from page 1

law,” Oklahoma Attorney General Scott Pruitt, who initially brought the lawsuit, said in a statement after the decision was announced. “The administration and its bureaucrats in the IRS handed out billions in illegal tax credits and subsidies and vastly expanded the reach of the health care law because they didn’t like the way Congress wrote the Affordable Care Act. ... Today’s ruling vindicates what we recognized early on, and that is the administration can’t rewrite the Affordable Care Act by executive fiat.”

Actual Wording vs. Presumed Intent

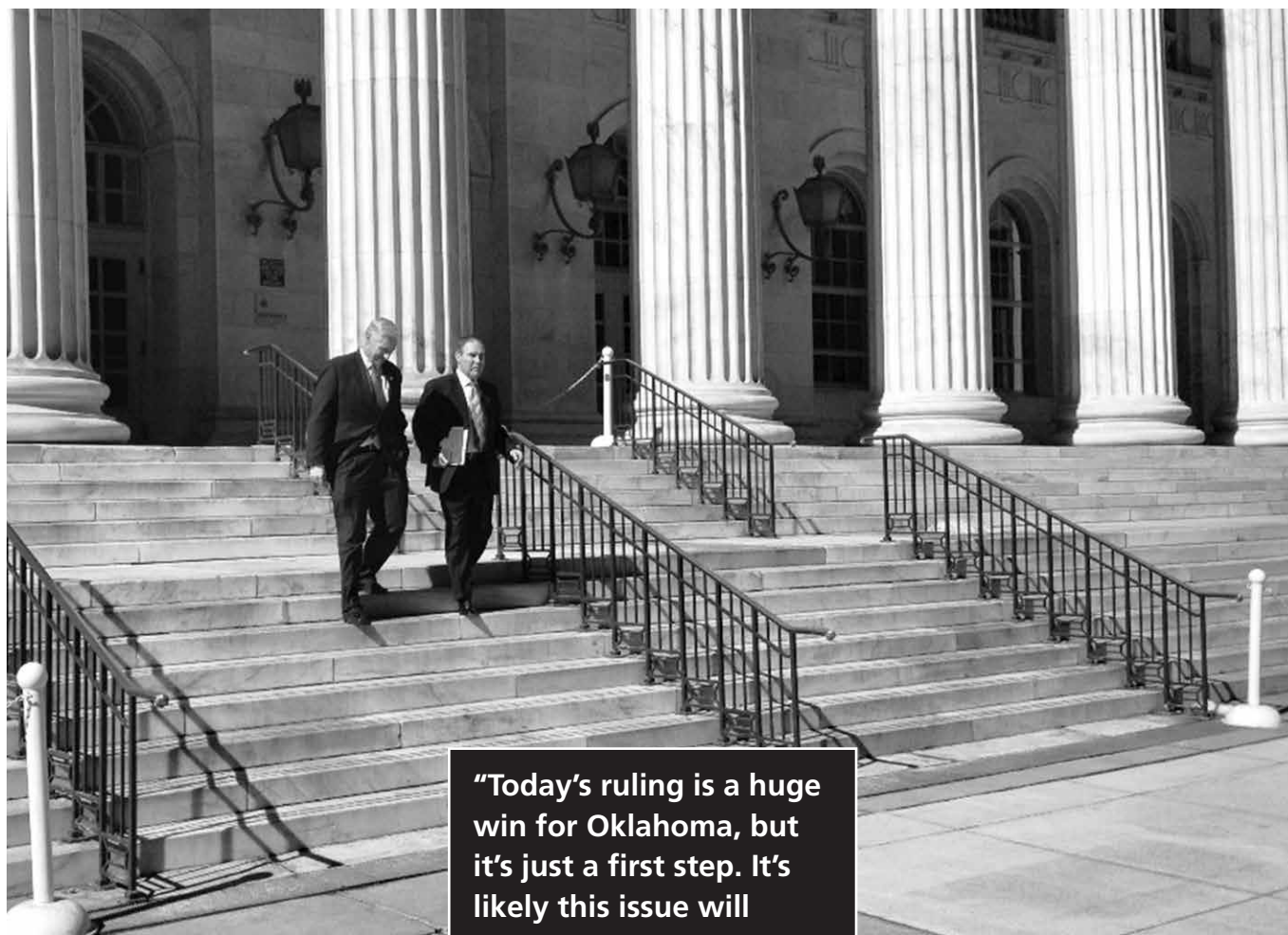
The heart of the dispute was whether the federal government can provide subsidies for individuals purchasing health plans through the federal exchange. Although the text of the law authorizes subsidies only on exchanges established by states, the IRS determined in May 2012 the statute allowed subsidies for plans bought on exchanges not created by states.

Advocates of Obamacare claim it was not Congress’s intent to provide subsidies only to plans bought on exchanges established by the states, and that the language of the law suggesting otherwise is a drafting error.

Opponents argue Congress knew exactly what it was doing, or at least that it’s not clear lawmakers intended to offer subsidies for health plans purchased on federal exchanges.

In a report for American Action Forum, a nonprofit organization that opposes Obamacare, Health Care Policy Analyst Brittany La Couture documents Idaho and Indiana contemporaneously understood the law to mean no subsidies would be available in their states if they relied on a federal exchange, leading the former to establish a state-based exchange and the latter to reject one.

“What is clear is that state legislators who spent a reasonable amount of time and resources to gain a thorough understanding of the law consistently recognized the true effect of establishing an exchange on subsidy eligibility for their citizens,” La Couture said. “These legislators understood the plain text of the law to say that eligibility for federal subsidies arises only from an exchange established by a state under Section 1311, and *not* from an exchange established by the federal government on behalf of the state. This understanding did ultimately contribute to states’ decisions on whether or not to establish their exchanges.”



Obamacare Architect: State-Only

Contradicting the argument for interpreting the letter of the law as an unintentional drafting error are several statements by one of the chief architects of the law, MIT professor Jonathan Gruber, stating subsidies were intended only for state-based exchanges.

In July, videotapes of Gruber speaking to different groups about state exchanges and subsidies surfaced. In one video, he tells the group, “That is really the ultimate threat—will people understand that, gee, if your governor doesn’t set up an exchange, you’re losing hundreds of millions of dollars in tax credits to be delivered to your citizens? ... [T]he other threat ... is will states do what they need to do to set it up?”

In another more explicit statement caught on tape, Gruber says, “What’s important to remember politically about this is if you’re a state and you don’t set up an exchange, that means your citizens don’t get their tax credits—but your citizens still pay the taxes that support this bill. So you’re essentially saying [to] your citizens you’re going to pay all the taxes to help all the other states in the country. I hope that

“Today’s ruling is a huge win for Oklahoma, but it’s just a first step. It’s likely this issue will ultimately be decided by the U.S. Supreme Court. We look forward to making our case and continuing the effort to hold federal agencies accountable to their duty to enforce the laws passed by Congress.”

**SCOTT PRUITT
ATTORNEY GENERAL - OKLAHOMA
(AT RIGHT, WITH FIRST ASSISTANT
ATTORNEY GENERAL TOM BATES)**

that’s a blatant enough political reality that states will get their act together and realize there are billions of dollars at stake here in setting up these exchanges.”

Gruber, who was paid \$400,000 by the Obama administration to consult on the law’s development, has since claimed he didn’t mean what he said, that his comments were a “speak-o,” the verbal equivalent of a typo.

Headed for Supreme Court?

White’s ruling shows he was not

swayed by the Obama administration’s argument that it was simply a drafting error.

“... [T]he court is upholding the Act as written,” White wrote in his ruling, citing a 1993 case that found “... vague notions of a statute’s ‘basic’ purpose are nonetheless inadequate to overcome the words of its text ...”

White immediately stayed his order prohibiting subsidies for plans purchased on federal exchanges, assuming there would be an appeal. Appeals were filed over rulings in the DC Circuit Court of Appeals, which also ruled subsidies were available only through exchanges established by states, and in the Fourth Circuit, which reached the opposite conclusion.

“Today’s ruling is a huge win for Oklahoma, but it’s just a first step,” Pruitt concluded. “It’s likely this issue will ultimately be decided by the U.S. Supreme Court. We look forward to making our case and continuing the effort to hold federal agencies accountable to their duty to enforce the laws passed by Congress.”

Sean Parnell (sparnell@heartland.org) is managing editor of Health Care News.

Wis. Expands Medicaid, but Garner's Criticism from State Democrats

By Devon Herrick

Wisconsin Gov. Scott Walker's (R) decision to expand the number of Medicaid recipients while diverting others into subsidized plans obtained through the federal exchange has drawn sharp criticism from his 2014 gubernatorial rival, highlighting different approaches to expanding access to care for the most vulnerable.

Walker issued a statement in May, saying, "Our entitlement reforms make sure Medicaid is a safety net for our state's neediest citizens and protect Wisconsin's taxpayers from the uncertainty surrounding the federal government's implementation of the Affordable Care Act (ACA).

"Due to our reforms, 81,731 people living in poverty now have health care through Medicaid, and Wisconsin is the only state to not take the expansion with no health coverage gap."

In August, the Wisconsin Legislative Fiscal Bureau estimated the state may forgo more than \$100 million in federal dollars annually by not expanding Medicaid eligibility. In response to the estimate, Democratic gubernatorial challenger Mary Burke released a statement criticizing Walker's Medicaid move, saying, "Gov. Walker's fiscally irresponsible approach ... has resulted in a state budget picture that is a mess."

Brett Healy, president of the Wisconsin-based John K. McIver Institute for Public Policy, says the governor's office is correct in arguing continued long-term federal funding is far from certain. "With the federal government \$17 trillion in debt, it is absurd to assume the federal government can continue to pay for 90 percent of the cost to expand [ACA] indefinitely," he said.

Unique Medicaid Expansion

Under ACA, the federal government promises to reimburse most of the costs for newly eligible enrollees in states that expand Medicaid. The catch: Eligibility must be expanded to 138 percent of the federal poverty level (FPL), or about \$16,105 per individual and \$32,913 for a family of four. Any less than the 138 percent of FPL and a state's old matching rate is all the feds will pay, about 59 percent in Wisconsin.

Prior to ACA, Wisconsin had expanded its Medicaid eligibility well beyond

the levels advocated by the new health care law, with many residents earning up to 200 percent FPL eligible for coverage under BadgerCare, as Medicaid is called in Wisconsin. However, enrollment was capped because of budget constraints when state funds ran low—making many of those who were eligible for BadgerCare unable to enroll.

In response to ACA, Wisconsin uncapped its enrollment and also began covering childless adults earning up to 100 percent of FPL while dropping from BadgerCare adults who were eligible for subsidies on the health insurance exchange.

As a result, nearly 97,509 individuals living below the poverty level were added to Medicaid rolls, and an estimated 62,776 were moved onto the exchange.

"The major difference for the people who are eligible for federally subsidized coverage is that they are immediately eligible for premium subsidies and are no longer subject to the waiting lists created by Wisconsin's BadgerCare Plus enrollment caps," said Linda Gorman, a state health policy expert at the Colorado-based Independence Institute.

Access for All Uninsured

Wisconsin's approach has resulted in a net gain of roughly 35,000 additional Medicaid enrollees. Most were childless adults.

Healy says Wisconsin is the only state that rejected Medicaid expansion while ensuring all uninsured residents had access to subsidized health coverage.

"Gov. Walker must be doing something right if everyone in Wisconsin has access to affordable health care," said Healy.

The Wisconsin Legislative Fiscal Bureau argues the state is forgoing millions in federal Medicaid dollars, because states that expand Medicaid to 138 percent of FPL can expect the federal government to pay nearly all the costs in the first three years.

Healy disputes this characterization. "While critics of Gov. Walker's plan like to assert that taxpayers will save money by expanding a federal program, they conveniently ignore the fact that this plan is a net spending increase of

"Our entitlement reforms make sure Medicaid is a safety net for our state's neediest citizens and protect Wisconsin's taxpayers from the uncertainty surrounding the federal government's implementation of the Affordable Care Act."

SCOTT WALKER
GOVERNOR - WI

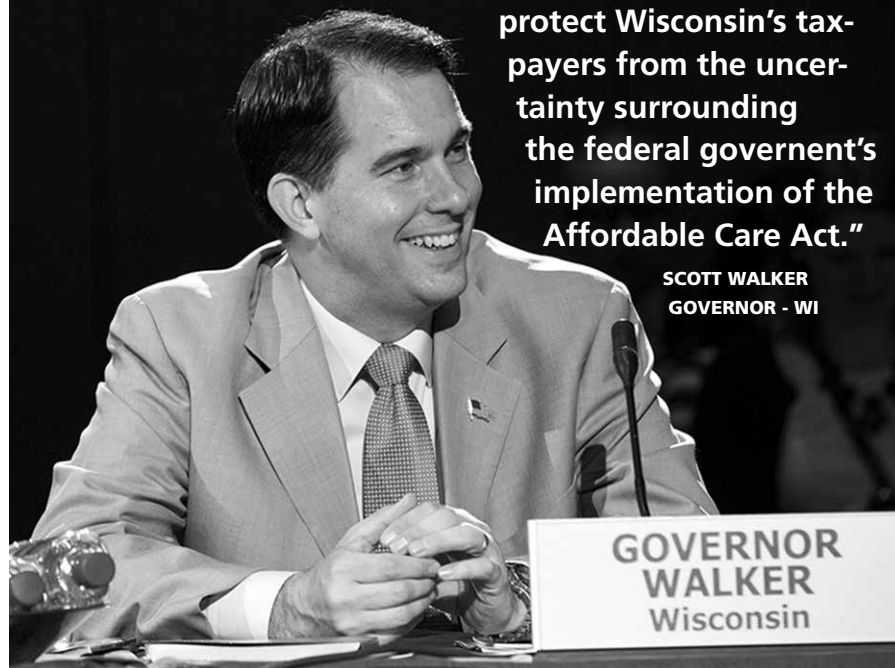


PHOTO COURTESY NATIONAL GOVERNORS ASSOCIATION

\$750 million. Taxpayers are going to pay for this one way or another," he said.

Devon Herrick, Ph.D. (Devon.

Herrick@ncpa.org) is a health economist and senior fellow at the National Center for Policy Analysis. He is the author of the report, Medicaid Expansion: Wisconsin Got it Right.

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Former, Current Wis. Medicaid Recipients Get Better Access

By Devon Herrick

Gov. Scott Walker's (R-WI) decision to remove from Wisconsin's Medicaid program 62,776 people who earned more than 100 percent of the federal poverty level (FPL) made them eligible for highly subsidized private coverage in the health insurance exchange.

According to Linda Gorman, a state health policy expert at the Colorado-based Independence Institute, "The major differences for the people who are eligible for federally subsidized coverage is that they are immediately eligible for premium subsidies and are no longer subject to the waiting lists created by Wisconsin's BadgerCare Plus enrollment caps."

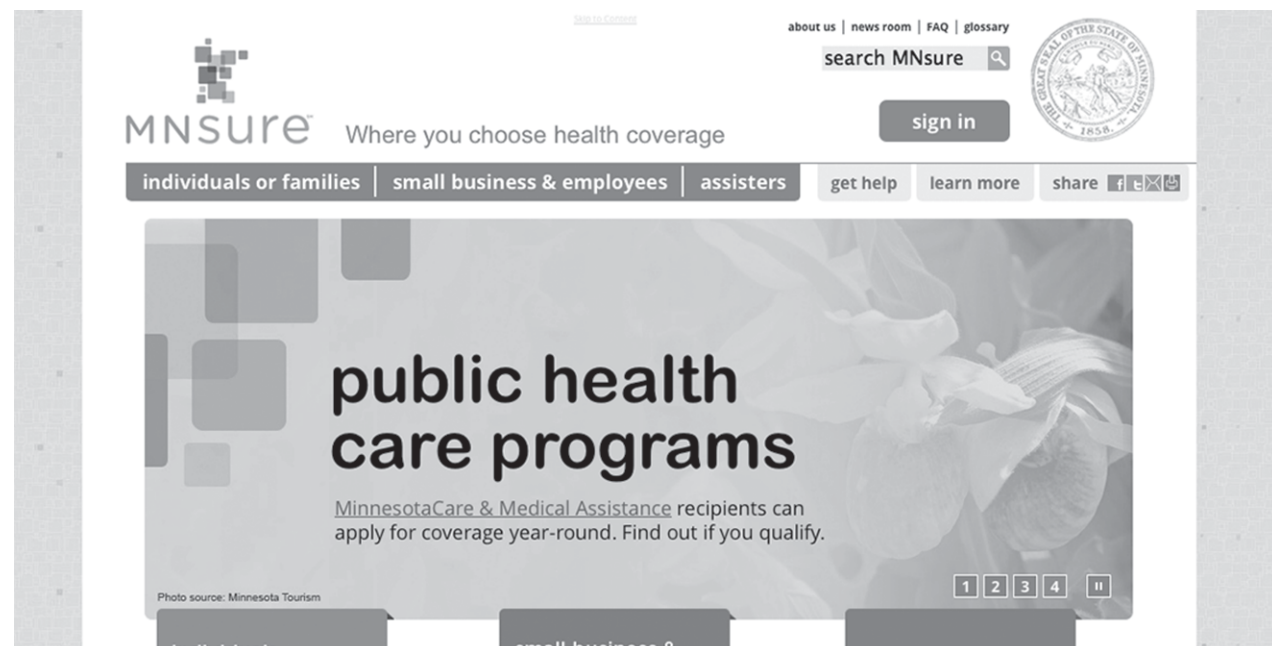
While Medicaid is free, the most a low-income individual in the exchange will have to pay is 2 to 3 percent of income toward a private health plan, with premiums running into the thousands of dollars, depending on age. In many cases, premiums would be far less, even \$0 depending on the plan selected.

For example, a 43-year-old in Milwaukee earning \$17,000 would have four bronze-level plans available at no cost after subsidies, and two more with monthly premiums of \$5 or less.

Another advantage to expanding private coverage is that private plans tend to pay provider fees much higher than what Medicaid pays. According to Gorman, doctors are generally more willing to treat privately insured patients than Medicaid enrollees, allowing for better access to care.

The people who remain on Medicaid or who gained coverage through Walker's expansion also may get better access to care with so many of the former recipients moving to private coverage. Gorman says Wisconsin's current BadgerCare enrollees would likely get much worse coverage if those now eligible for exchange-based coverage remained in Medicaid while more people were added to the rolls and the new Medicaid patients flooded doctors with requests for appointments.

Devon Herrick, Ph.D. (Devon.Herrick@ncpa.org) is a health economist and senior fellow at the National Center for Policy Analysis. He is the author of the report, Medicaid Expansion: Wisconsin Got it Right.



Minnesota's Largest Exchange Insurer Drops Out

By Sean Parnell

Officials and political leadership in Minnesota were stunned in late September by news PreferredOne, a large health insurance company that had captured more customers on the Minnesota exchange than all others combined, decided to drop out of the state exchange.

Continuing to offer individual coverage on the exchange is "not administratively and financially sustainable," PreferredOne spokesman Steve Peterson told local KSTP television news.

Annette Meeks, CEO of the free-market think tank Freedom Foundation of Minnesota, says the news came on the heels of a disastrous launch for the exchange website in October 2013, with customers experiencing problems as severe as those experienced by users of the federal exchange website.

"I hope that the PreferredOne news serves as a wake-up call for the [Gov Mark] Dayton administration to call together a bipartisan team of legislators to work together to fix the website before consumers are forced to find another health insurance plan in November on a website that doesn't work as planned and now will offer a very limited number of alternatives for taxpayers," Meeks said.

Director Vacationed During Disaster

MNsure, the Minnesota state health care exchange, was one of four state exchanges that failed upon launch on October 1, 2013. The site did not go online until after 3 p.m. the first day, and a critical server allowing customers to create accounts subsequently crashed. Problems only grew from there, including the failure of exchange call centers to sufficiently assist Minnesotans seeking help and information.

The exchange director, April Todd-Malmlov, resigned in mid-December after the failed launch and her own ill-timed vacation to Costa Rica in the middle of it.

The exchange site is still plagued by problems, including a process for life changes such as the birth of a child or marriage, which the current chief operating officer described as "cumbersome" in a report to the MNsure board on September 17, according to a Minnesota Public Radio report. Users have to enter whether a baby is mar-

ried, for example, and it takes about 45 minutes to make a life change update.

Sixteen Percent Premium Hike

Although premiums for 2015 are unlikely to be affected because they have already been filed and approved, the decision by PreferredOne will likely lead to higher premiums for Minnesotans.

For example, a 43-year-old in the Minneapolis region shopping for the lowest-price bronze-level plan would currently spend about \$122 per month before subsidies on PreferredOne's least expensive plan. The second- and third-lowest premiums are also PreferredOne plans, and the least expensive plan offered by another insurer is \$142 per month, 16 percent more.

Even higher premiums are likely ahead in 2016, when the remaining insurers selling on the exchange won't face competition from PreferredOne.

'It Never Made Sense'

The exit of PreferredOne from MNsure has caused some in the state to question the whole notion of state-run exchanges.

"PreferredOne's exit certainly calls into question whether MNsure adds any value for Minnesota consumers," said Peter Nelson, a health care policy expert for the Center of the American Experiment, a pro-consumer think tank based in the Gopher State. "It never made sense to layer on a brand new marketplace when brokers and insurers already provided an effective and efficient sales force."

State Sen. Mary Kiffmeyer (R), who sits on the Health, Human Services and Housing subcommittee, expanded on Nelson's concerns. "It is not just that MNsure is failing. The whole concept of nationalizing health care is a faulty policy, so of course that leads to failure," Kiffmeyer said. "Especially in Minnesota we had such a good system, and this disruption through Obamacare is so sad and unnecessary."

Sean Parnell (sparnell@heartland.org) is managing editor of Health Care News.

Obamacare Auto-Renewal Could Raise Costs

By Sean Parnell

A significant problem looms for the Affordable Care Act (ACA) when the next open enrollment period begins in November, according to many experts in health care and media.

The administration announced on June 26 those currently enrolled would be automatically renewed in the same plan for 2015.

There is a growing concern this will cause many who received subsidies through the federal exchange to be hit with sharp rises in after-subsidy insurance premiums due to the way subsidies are calculated.

"Many who are auto-enrolled will end up paying more than they needed to for coverage because they will not realize that last year's best choice won't be this year's best choice—either because HealthCare.gov has failed to educate them on this point or because they don't have hours to squander on the exchange trying to make price comparisons," said Christopher Conover, Ph.D., a research scholar at Duke University's Center for Health Policy and Inequalities Research.

Automatic Premium Increase?

The automatic renewal of plans for people already enrolled through the federal exchange was intended to allow greater focus on enrolling the uninsured and ease pressure on the HealthCare.gov website, which suffered catastrophic failures when it first launched in October 2013.

But many people who do nothing and allow their plans to be automatically renewed will face a substantial increase in what they have to pay. Subsidies for plans sold through the exchanges are determined according to a person's income and the premium of the second-lowest silver-level plan available in each market, called the benchmark plan.

The 2014 benchmark plan in most states will be replaced with a different plan in 2015, and some of the new plans have lower premiums than the 2014 plans. However, most of the 2014 benchmark plans will have higher premiums in 2015. This will lead to much higher out-of-pocket costs for many who are auto-enrolled in the same plan, as the Obama administration intends to do.

Possible \$90 Monthly Premium Hike

For example, in Indiana, the 2014 benchmark plan for the Indianapolis area was from Anthem Blue Cross and Blue Shield, with a monthly premium of \$354 for an individual 40 years

"Many who are auto-enrolled will end up paying more than they needed to for coverage because they will not realize that last year's best choice won't be this year's best choice—either because HealthCare.gov has failed to educate them on this point or because they don't have hours to squander on the Exchange trying to make price comparisons."

CHRISTOPHER CONOVER
CENTER FOR HEALTH POLICY AND INEQUALITIES RESEARCH



old. In 2015, the same plan will cost approximately \$363 according to rate approval information available on the Indiana Department of Insurance website.

It's unclear what the benchmark plan will be in 2015, but it won't be Anthem's. Two other insurers offering coverage in the Indianapolis region, CareSource and Coordinated Care, have both filed rates for silver plans lower than Anthem.

Writing in the *Indiana Business Journal* on September 12, reporter J. K. Wall noted, depending on which plans are offered and what the final approved rates are, "the value of tax credits available in the exchange could fall by \$20 to \$90 per month."

If the tax credit drops by \$90, then someone automatically re-enrolled in the 2014 benchmark plan from Anthem could see his or her monthly premium increase by nearly \$100 or more once the premium increase for the former benchmark plan is included.

'New Pitfalls for Consumers'

"Every time the Obama administration has changed the law to make it less onerous for consumers—like automatic re-enrollment—it winds up creating new pitfalls for consumers. In this case, millions of consumers could face higher premium[s] and out-of-pocket costs because the plan they selected for this year might not qualify for extra subsidies next year," said Grace-Marie Turner, president of the Galen Institute, a health care policy organization located in Alexandria, Virginia.

"The law's endless administrative complexity shows the impossibility of trying to centrally plan one-sixth of the economy. We need to put the market and consumers in charge of choices, not bureaucrats, politicians, and regulators," she said.

Some critics say the auto-enrollment plan goes against the idea people should be actively involved in selecting their health insurance.

"A passive auto re-enrollment can be useful, but we shouldn't coddle consumers," said Yevgeniy Feyman, a health care policy fellow at the Manhattan Institute and contributing writer for The Heartland Institute, which pub-

lishes *Health Care News*.

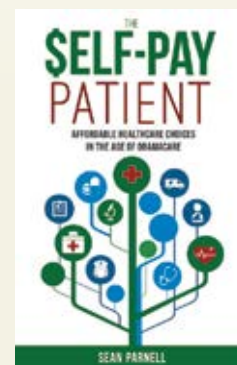
"If we want patients to be good consumers when it comes to purchasing health insurance, some level of administrative burden will be necessary," Feyman said.

Sean Parnell (sparnell@heartland.org) is managing editor of Health Care News.

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Shreveport Veterans Hospital Provides Substandard Care

"The patients don't complain; they are wonderful. They are so appreciative of the care. That's the least of their problems, these ratty, torn pajamas. ... I can't tell you how many times a blanket will be opened and there will still be the electrode pads stuck to it from the last patient. And the pajamas still have tape on them from the last person's IV."

**ANONYMOUS EMPLOYEE
OVERTON BROOKS VA
MEDICAL CENTER**

By Tori Richards

Veterans at the Veterans Administration hospital in Shreveport, Louisiana have had to contend with substandard care as many nurses spend less time on work than on cell phones, iPods, or accessing personal data on hospital computers, according to an investigative report by Watchdog.org.

Patients at the Shreveport hospital have been going without toothbrushes, toothpaste, pajamas, sheets, and blankets while department officials spend money on flat-screen TVs and solar panels, sources inside the hospital told Watchdog.org.

Rep. Jeff Miller (R-FL), chairman of the House Committee on Veterans' Affairs, told Watchdog.org, "These are disturbing allegations that, if true, constitute a serious disregard for the well-being of patients and an organizational climate that puts employees—rather than veterans—first."

"VA continues to assert that once a veteran has access to care, it is excellent," Miller said. "I want to believe that. But these allegations do not represent quality care, and I expect VA leadership to not only investigate but immediately correct and hold accountable anyone who does not embrace a culture of service toward veterans."

Basic Necessities Lacking

Shreveport's Overton Brooks VA Medical Center was built in 1950, and its linens look like they've been around just as long. Sheets and blankets often have holes or are threadbare. Pajamas are missing buttons or snaps and are ripped. But patients who get even these items are the lucky ones.

By the weekend, the hospital runs out while waiting for its supply of laundry to arrive from 125 miles away, where it is cleaned at another VA hospital in Pineville, Louisiana. The VA said it doesn't contract with a local vendor because the employees in Pineville are veterans.

"The patients don't complain; they are wonderful," said one employee who asked not to be identified because he feared repercussions. "They are so appreciative of the care. That's the least of their problems, these ratty, torn pajamas."

The VA says in a statement that laundry is inspected before it is delivered. Told this, the employee laughed in amazement.

"I can't tell you how many times a blanket will be opened and there will still be the electrode pads stuck to it from the last patient," he said. "And the pajamas still have tape on them from the last person's IV."

Kathy Scott, a former nurse at the facility, echoed the first employee's complaints. She recalled, "I know there were times when we didn't have any sheets and we would put a pillowcase over the patient."

Nurses, Volunteers Fill Gaps

The scarcity of supplies drives nurses to hoard. Toiletries are kept in a locked cabinet on another floor, accessible by an employee who works the day shift. Scott worked nights, so she purchased items with her own money and kept them in her own locker for her patients.

The VA "does not furnish those. Volunteers come through and drop off toothbrushes, deodorant, mouthwash, and combs," the first employee said. "We run out, so all we have available are pre-moistened sponges for oral care."

Overton Brooks has "volunteers who pass out comfort-item kits daily to newly admitted veterans," and after hours, a supervisor can unlock the cabinet, the VA noted. The first employee disputed this.

"This is the first I've heard of that," he said. "Volunteers only come by a certain number of days to stock the drawer with toothbrushes. When it runs out, it's out. Nurses call around to other floors looking for some, but it's the same situation with everyone else."



The Overton Brooks VA Medical Center in Shreveport, Louisiana.

The employee said it's also common knowledge several nurses and aides will bring their own toiletries for patients.

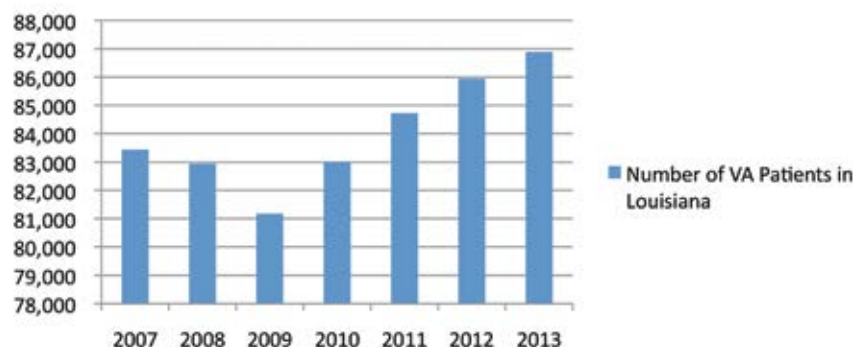
Staff Members Ignore Patients

Overton Brooks, a 10-story, 111 hospital-bed facility, serves approximately 37,000 veterans each year and another 462,000 outpatients.

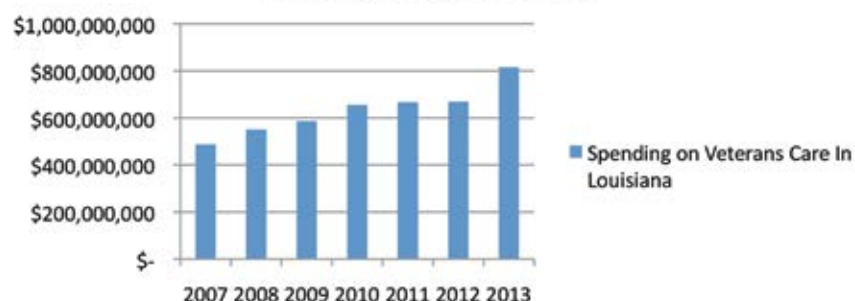
Scott says she left her job in December 2012, afraid "something bad would eventually happen to one of the patients and I could be implicated."

"Nurse assistants were allowed to sit around, disappear, and talk on the phone or listen to headphones," Scott said. "Supervisors never supervised and didn't know what

Number of VA Patients in Louisiana



...While Spending on Veterans Care In Louisiana Has Risen





"These are disturbing allegations that, if true, constitute a serious disregard for the well-being of patients and an organizational climate that puts employees—rather than veterans—first."

JEFF MILLER
U.S. REPRESENTATIVE - FLORIDA



was going on on the floor and didn't want to hear about it. If I wanted something done, I had to do it myself."

She recalled some nurses sitting at a computer doing personal business for an entire eight-hour shift while aides refused to bathe patients.

Scott said aides complained patients often waited hours to be bathed. She said one aide complained it was useless to keep patients clean early in a shift. The aide told her, "If I have to do it now, I will just have to do it again before the end of my shift."

A third employee, who also requested anonymity, confirmed the lack of nursing oversight. She recalled a patient who was left unattended in a room for nearly 24 hours, wishing to take a shower but unable to make the trek alone to the hallway where the facilities were located.

Instead, a nurse merely dropped towels onto his in-room sink and told the patient to wash himself.

"Nobody paid attention to him," she said. "Nurses just shrugged their shoulders."

Investigations and Outrage

The VA health care system has come under fire as whistleblowers have detailed secret lists of veterans waiting—and dying—to receive care. The VA Office of Inspector General (VA OIG) has had its hands full looking into claims of lax supervision and falsification of records to cover up lengthy waits at

many of the nation's 1,700 facilities.

The inspector general included Overton Brooks on a list of 110 hospitals requiring investigation.

Fallout over the scandal cost VA Secretary Eric Shinseki his job, and his replacement, Bob McDonald, has vowed to right the numerous wrongs. McDonald did not respond to repeated requests for comment regarding the problems at Overton Brooks.

A report issued on March 31 by the VA OIG outlined several deficiencies at Overton Brooks, but nothing unearthed in Watchdog.org's investigation was discussed. VA OIG spokesperson Cathy Gromek said the agency's focus was determined before inspectors arrived. She says she was unaware of the employees' complaints and anyone can anonymously call the OIG hotline to report concerns.

"If they have concerns about the quality of care for the veterans, of course we want to hear about them," Gromek said.

Flat-Screen TVs, Solar Panels

Employees questioned whether hard-earned tax dollars should be funding televisions and solar panels at the expense of veterans care.

"They put those flat-screen TVs all over the hospital—at every elevator in the east wing—and we have 10 floors," the first employee said. "All it has is the weather, and then it has these uplifting sayings by Martin Luther King and Maya Angelou and

advice by Michelle Obama. Like 'Be Safe,' 'Move,' 'Eat Less,' and 'Exercise.'"

The flat-screen TVs "[offer] an easy way to spread information to a wide audience in a short amount of time. It also provides a way to inform ... [about] Medical Center activities, future events, and specific health-related topics," according to a VA statement.

The price tag for solar panels was \$9.25 million for Overton Brooks and two other VA hospitals, part of a nationwide push to make federal buildings more environmentally friendly, as required by a 2009 presidential order.

"It shouldn't be like this. These are our veterans," the first employee said. "When I saw those solar panels out there and they waste money on things like new TVs that just play [public service] announcements, it really made me angry."

According to the VA, the department spent \$74,412 on 24 flat screen TVs for "patient/employee information"—one 50 inches wide and the others 42 inches—and the solar project cost approximately \$3 million.

American Legion Steps Up

Following the initial revelations by Watchdog.org about the Shreveport hospital, the American Legion announced it would send \$5,000 worth of emergency supplies.

"If more is needed, more will be provided," Legion National Commander Michael D. Helm said in a statement. "While the American Legion family is more than happy to provide this assistance, it is very disturbing that such help is needed."

"We are outraged," said William Detweiler, past national commander of the American Legion. "This is something the VA should be providing, but if they aren't, we are prepared to come in and provide the basic essentials. According to your story, these veterans have been denied."

VA Denies Allegations

In response to allegations regarding lack of care, the VA said in a statement, "Each veteran has an assigned registered nurse to ensure he/she receives appropriate and timely care. In addition, nursing staff conduct veteran care rounds on all inpatient units at designated intervals to ensure needed care is provided."

Rep. John Fleming (R-LA), whose district includes Shreveport, said, "The care of our veterans is crucial and has been under an intense microscope since reports of veterans dying while waiting for care."

Fleming says he has "engaged with" the hospital's interim director about "concerns" at Overton Brooks.

"It is the sad reality that patients are often the ones who fare the worst under government-run health care, as is the case with the VA system," Fleming said.

Tori Richards (tori@watchdog.org) writes for Watchdog.org, where an earlier version of this story originally appeared. Reprinted with permission.

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JEFF MILLER
U.S. REPRESENTATIVE
FLORIDA

Hospital Reform? Union Boss Offers F-Bomb

By Andrew Walden

Executives of Hawaii's state-owned Hawaii Health Services Corporation (HHSC) say their hospitals have only enough cash on hand to last a few more days and, as a result, they may have to close Oahu nursing care facilities such as Leahi Hospital and Maluhia Long-Term Care Health Center, throwing hundreds of elderly patients onto the street with nowhere else to go.

Maui Memorial Hospital, the island's only acute-care facility, is closing its adolescent mental health clinic. Oncology and dialysis could be next, forcing patients to fly to Oahu for treatment.

At a Health Committee briefing for the Hawaii legislature, Scott McFarland, CEO of HHSC-Kauai region, told legislators, "If there is one hiccup, we will not meet payroll."

Gary Yoshiyama, board chair of HHSC-East Hawaii region, pointed to the hospital's inability to pay for its collective bargaining agreements, explaining, "We cannot absorb the cost without deep harm to our community."

Hawaii Government Employees Association (HGEA) President Randy Perriera's response to HHSC's troubles and

proposals to save the near-insolvent system?

"F*** you."

Perriera's remarks came to light in a recently uncovered video of his keynote address to the union's May 2014 biannual convention. There, he told delegates, "We helped defeat a bill that would have sold off our HHSC hospitals to the private sector. ... For people ... who look to sell our jobs out from under us; people who look to outsource services, deny what we have earned, try to cut our wages and benefits, and keep us down, I have a very simple two-word reaction: F*** you."

The remarks are not surprising to those who have been working to solve HHSC's multimillion-dollar financial shortfalls. In at least one private meeting, HGEA officials suggested they would prefer to close Kona Community Hospital than take HHSC out of the civil service system. Kona Community Hospital is the only hospital on the west side of the island of Hawaii (also known as the Big Island), serving approximately 45,000 residents.

Perriera also stated in his remarks, "Uninformed journalists ... continue to blame HGEA for the failure of the bill

to pass to privatize HHSC," seemingly at odds with his boast they had helped defeat the privatization bill and his later rhetorical question-and-answer, "Is HGEA partially responsible for the failure of that bill to pass? Yes, and I'm damn proud to admit that."

At 43,000 members, HGEA is Hawaii's largest union. HHSC's 4,000 employees are divided between HGEA and the United Public Workers union.

Hawaii is unusual in that the state-owned HHSC hospitals provide most of the beds and emergency care outside of Oahu. On the Big Island, Kamuela's North Hawaii Community Hospital (NHCH), a previously money-losing private hospital, has joined the Honolulu-based private nonprofit Queens Healthcare System. In sharp contrast to HHSC, NHCH is now in the black, recruiting MDs, and adding about 20 new positions.

A central point of contention between the union and those seeking reform is the recommendations in a report by Stroudwater Associates in 2009. The report takes direct aim at government employee union work rules and benefits: "The first 'essential change' calls for a

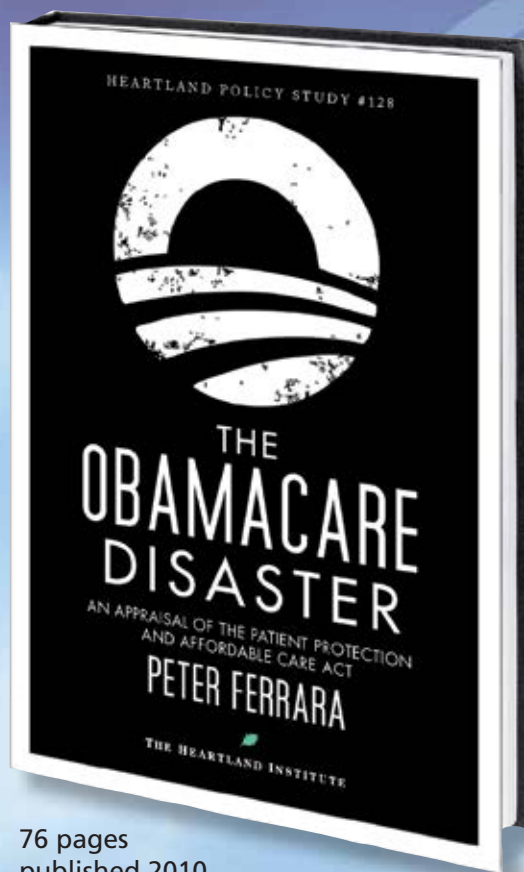
conversion of HHSC from a public benefit corporation to a private non-profit 501(c)(3) corporation. By definition, this change would end HHSC's status as an agency of the State, disqualifying it from remaining part of the State's civil service employment structure."

The report goes on to note privatizing HHSC would save nearly \$50 million in annual operating costs, and it says work rule changes and the state assuming liability for retiree health benefit costs could reduce HHSC's annual operating costs by another \$31 million.

In the five years since the Stroudwater Report, legislative efforts to authorize HHSC management to negotiate partnership agreements with privately run nonprofit hospital chains have come up short. With his island's main hospital on the line, House Speaker Joe Souki (D) has asked for an emergency special session to respond to the HHSC crisis.

The next regular session of the Hawaii legislature does not begin until January.

Andrew Walden (uuhcr@email.com) writes at Hawaii Free Press, where an earlier version of this article first appeared. Reprinted with permission.



76 pages
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Rather than liberate the American health care system from bureaucracy and waste, Obamacare blankets it with more of both, suffocating innovation and destroying freedom.

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Study Shows Obamacare Hurts Business Growth, Employment

By Brady Cremeens

A new study shows the Affordable Care Act (ACA) may be detrimental to business growth and employment across the country.

In a survey conducted by the Federal Reserve Bank of Philadelphia, more than 18 percent of U.S. businesses stated they have cut the number of employees and reduced hiring due to expenses incurred by the law, also known as Obamacare.

The study asked hundreds of businesses across the nation about the effects of Obamacare on their hiring practices, benefit packages, and compensation rates.

Three percent responded they had increased their payroll as a result of ACA.

"The problem is really twofold," said Josh Archambault, a senior fellow at the Foundation for Government Accountability, based in Florida. "It hurts small-business employers because it dis-incentivizes expansion and growth, and it hurts employees because employers are forced to shift higher insurance costs onto them."

Businesses Reluctant to Expand

Archambault says many businesses may decide against attempting to grow and hire new employees

because it's now too costly.

"Especially those employers who are nearing the 50-employee mark," he said. "If they break 50, they get a bunch of new costs and requirements thrust onto them. Many will decide to just stay where they are, which is bad for job growth and the economy in general."

Businesses employing fewer than 50 full-time-equivalent employees have access to the Small Business Health Operations Program (SHOP) under the ACA. Companies with more than 50 full-time-equivalent employees must meet other regulations.

Eighteen percent of businesses indicated they had reduced workers' hours by decreasing the number of full-time employees and increasing the number of part-time employees.

"A lot of the stagnant economic growth and reduction in hiring is a result of this law," Archambault said. "It puts too heavy a burden on employers, and the average working man is paying, both figuratively and out of his own pocket."

Cutting Employment, Hours Worked

The study by the Federal Reserve Bank of Philadelphia is only the latest piece of evidence that the

"Given the way Obamacare supporters publicly criticized employers who announced that they were cutting back hours in response to the health care law, it would not surprise me if many employers are still doing so but not telling anyone about it."

MICHAEL CANNON

**DIRECTOR OF HEALTH CARE POLICY STUDIES
CATO INSTITUTE**

employer mandate and other requirements of the ACA are forcing employers to scale back hiring and reduce employee hours.

A survey in April 2013 by the Society for Human Resource Management found 41 percent of small businesses had put off hiring new employees, while 20 percent had cut hours and reduced payroll.

These studies come in the wake of announcements by business owners they would be forced to cut employee hours as a result of the ACA.

In October 2012, Darden Restaurants, which operates Olive Garden and other restaurant chains, announced it would experiment with cutting employee hours below the 30-hour-per-week threshold that would require them to offer health benefits. The move drew intense criticism, and Darden later said it would not cut employee hours.

Several other restaurant franchisees also announced they would have to cut employee hours. In an August 14, 2013 report by NBC News, several small business owners shared they too would be cutting hours in response to the employer mandate.

"To tell somebody that you've got to decrease their hours because of a law passed in Washington is very frustrating to me," Loren Goodridge, who owns 21 Subway franchises, told NBC News.

Cutting Employment, Keeping Quiet

Small businesses that have spoken publicly have faced an intense backlash among supporters of the law. Darden endured a firestorm of criticism after its announcement, and owners of Denny's, Papa John's, and Applebee's franchises were also hit with negative attacks because of reports that employee hours may be cut.

In light of that backlash, health policy experts say employers who have to cut employee hours or jobs will simply keep quiet. "Given the way Obamacare supporters publicly criticized employers who announced that they were cutting back hours in response to the health care law, it would not surprise me if many employers are still doing so but not telling anyone about it," said Michael Cannon, director of health care policy studies at the free-market Cato Institute.

Brady Cremeens (bcremeens@illinoispolicy.org) writes for the Illinois News Network, where an earlier version of this article first appeared. Reprinted with permission. Sean Parnell (sparnell@heartland.org), managing editor of Health Care News, also contributed to this story.



Pa. Medicaid Expansion Could Prove Costly

Continued from page 1

enrolled in.

Critics contend the agreement omits needed reforms and will prove costly both for Pennsylvania and for the nation's taxpayers.

"Pennsylvanians deserve better," said Senior Policy Analyst Elizabeth B. Stelle of the Commonwealth Foundation, a Pennsylvania-based free-market think tank. "The federal government refused to give us the flexibility we requested to reform Medicaid. The best thing we can do for Pennsylvanians in need of care is to walk away and pursue other ways to expand access to care."

Flexibility Denied

The centerpiece of the expansion proposed by Pennsylvania Gov. Tom Cor-



Tom Corbett
Governor - PA

bett (R) would have provided premium support to those previously ineligible for the state's Medicaid program, allowing them to purchase plans on the federal exchange while themselves paying a small premium.

For example, a childless adult with income between \$11,490 and \$15,289 would have paid a monthly premium of

"Rather than fixing Medicaid for the truly needy, Obamacare's Medicaid expansion overloads the safety net with able-bodied adults and prioritizes them over the nation's most vulnerable patients."

JONATHAN INGRAM
FOUNDATION FOR
GOVERNMENT ACCOUNTABILITY



\$25 under Corbett's plan.

DHHS rejected that proposal, also scuttling work requirements and a \$10 co-pay for nonemergency use of an emergency room. Instead, the newly eligible must enroll in a plan from a managed care organization (MCO) that agrees to provide Medicaid benefits in

exchange for a monthly payment from the state.

The newly enrolled will still pay a small monthly premium, and those who participate in work search activities are eligible for reductions in the premium. Getting a yearly checkup or otherwise engaging in healthy activities can also lead to reductions in enrollees' premiums.

"The federal government proved unwilling to grant Pennsylvania even minor reforms, like work search requirements or meaningful cost-sharing," Stelle said. "Given the lack of flexibility, it's in the best interest of Pennsylvanians to walk away from a new entitlement and pursue other avenues that truly expand health care access."

Budget Concerns Raised

Pennsylvania's taxpayers will have to pay for the premium reductions for the newly eligible, which will put increased strain on the state's budget. There is also some doubt whether the federal government will be able to pay its share of the expansion in the future.

"The expansion of taxpayer-funded health care in Pennsylvania will have major budget impacts on both the state and nation for years to come," Stelle said. "In Pennsylvania, our Medicaid program is already growing faster than residents' income and consumes about a third of every dollar sent to Harrisburg. Unfortunately, expanding taxpayer-funded health care will only

exacerbate this trend.

"Very soon," Stelle added, "lawmakers will have to make a tough choice between taking resources from other priorities, like education, or raising taxes to fund this expanded entitlement."

Current Beneficiaries Vulnerable

Because Medicaid is typically a state's largest budget item, future budget cuts will likely target the program. Jonathan Ingram of the Foundation for Government Accountability argues when it comes time to cut costs, the new expansion population will likely emerge unscathed, and poorer, needier persons already enrolled will suffer.

"Rather than fixing Medicaid for the truly needy, Obamacare's Medicaid expansion overloads the safety net with able-bodied adults and prioritizes them over the nation's most vulnerable patients," Ingram wrote in a July 2014 report, "Who's On the Obamacare Chopping Block."

With the federal government picking up 90 percent or more of the new expansion population's Medicaid costs, compared to about 52 percent for the current population, states risk losing more funding if they reduce spending on the expansion population than if they reduce it for existing beneficiaries, Ingram says.

Loren Heal (loren.heal@gmail.com) is a freelance reporter for *The Heartland Institute*.

Medicaid Expansion Increases ER Visits

By Sean Parnell

One of the many promised benefits of expanded Medicaid coverage, according to advocates of the Affordable Care Act (ACA), was a reduction in emergency room visits; seeking treatment in the emergency room is typically far more costly than visiting a primary care doctor for treatment.

Recent research, however, shows the opposite: Emergency room (ER) use has climbed, instead of fallen, as a result of Medicaid expansion.

According to a report by the Colorado Hospital Association, "The average number of emergency department (ED) visits to hospitals in expansion states increased 5.6 percent from second-quarter 2013 to second-quarter 2014 ... In comparison, hospitals in non-expansion states reported a 1.8 percent increase in emergency department visits between the second quarters of 2013 and 2014."

Other reports have found similar increases in ER use by Medicaid patients in California, Massachusetts, and Oregon, in addition to numerous media reports documenting increased use since the Medicaid expansion went into effect.

"[M]edical problems that cause them to go to the ER could often be dealt with in a doctor's office," wrote John R. Graham of the National Center for Policy Analysis in an August 15 blog post. "Medicaid patients use expensive Emergency Departments because Medicaid's low physicians' fees discourage doctors from seeing them."

Sean Parnell (sparnell@heartland.org) is managing editor of Health Care News.

Medicare Drug Plans Need Tools to Fight Abuse

By Devon Herrick

In August, Rep. Kevin Brady (R-TX), chairman of the House Ways and Means subcommittee dealing with issues related to health, introduced a bill, the Protecting Integrity in Medicare Act of 2014.

One form of Medicare program abuse is diversion of drugs by beneficiaries who abuse or resell prescription pain relievers. Drug diversion costs insurers nearly \$75 billion per year, about two-thirds of it from public programs such as Medicare and Medicaid.

More than 16,000 people die annually from abusing pain relievers, according to the Centers for Disease Control and Prevention (CDC), double the number that die from abusing cocaine and heroin combined.

Current law prohibits Medicare drug plans from restricting the benefits of beneficiaries thought to be abusing or reselling prescription painkillers. The bill introduced by Brady would change that, allowing the drug plans to lock-in suspected abusers to a single doctor and pharmacy for pain medications.

"Every senior in America is affected by Medicare fraud, waste, and abuse," Brady said when releasing a draft of his bill. "It is devastating for those personally harmed, drives up premiums, and hastens insolvency for others. ... [W]e must do more to protect the Medicare program and our nation's seniors."

Growing Problem of Abuse

Abuse of opioid pain relievers is a growing problem for Medicare drug plans. The most common way enrollees obtain large numbers of addictive pain relievers is by "doctor shopping." This involves seeing multiple doctors with complaints about chronic pain, having redundant medical tests performed, and asking each physician seen to prescribe pain medication.

To avoid detection, beneficiaries generally fill their prescriptions at mul-

multiple pharmacies, hoping no doctor or pharmacy will question them. Although doctors and pharmacies may not realize a given patient is abusing prescription pain relievers, drug plans can detect it, but Medicare drug plans lack the authority to prevent this abuse.

Express Scripts is the largest pharmacy benefit manager (PBM) in the country. It has studied prescription drug abuse extensively in the plans it manages. According to Express Scripts, for every \$1 worth of narcotic pain relievers lost to fraud, 41 more dollars are wasted due to unnecessary physician visits, unnecessary tests, and unnecessary emergency room visits to obtain unnecessary drugs.

On September 29, the Alliance for Health Reform and the Pharmaceutical Care Management Association cosponsored a Capitol Hill briefing to highlight the problem of prescription opioid drug abuse and to discuss ways to reduce fraud.

Speaker Jo-Ellen Abou Nader, senior director of fraud, waste, and abuse services at Express Scripts, explained to attendees: "PBMs ...

are uniquely positioned to not only identify but to investigate these cases for fraud, waste, [and] abuse and to collaborate with our payers."

She says a program to restrict the activities of drug-seeking enrollees would help Medicare drug plans reduce waste, fraud, and abuse.

"We would love to see one in the Medicare world because our payers are really struggling. They are struggling because they do not have a way to control the behavior and the tools to be able to do that."

'Lock-In' Cuts Abuse

The restriction program Abou Nader mentioned is Safe Pharmacy "lock-in," a program virtually every state Medicaid program has implemented to protect public health and reduce fraud. The program would require a change



in federal law to allow Medicare drug plans to lock in enrollees suspected of abusing narcotic pain relievers.

Under a lock-in program, drug plans identify enrollees with suspicious claim patterns. Suspicious claims would likely involve Medicare enrollees shopping for narcotic pain relievers at multiple doctors and filling prescriptions at multiple pharmacies. Once identified, suspected enrollees would be locked into a plan with a specific doctor for pain management and a specific pharmacy to fill pain medication prescriptions. No other physician or pharmacy could prescribe or dispense pain medications,

but all other Medicare benefits would remain unaltered.

In August 2014, the U.S. Department of Health and Human Services Office of Inspector General issued recommendations to reduce questionable usage of narcotic pain relievers by Medicare beneficiaries. One of the recommendations was to establish a lock-in program.

Devon Herrick, Ph.D. (Devon.Herrick@ncpa.org) is a health economist and senior fellow at the National Center for Policy Analysis. He is the author of the report, Medicaid Expansion: Wisconsin Got it Right.



"Every senior in America is affected by Medicare fraud, waste, and abuse. It is devastating for those personally harmed, drives up premiums, and hastens insolvency for others. ... [W]e must do more to protect the Medicare program and our nation's seniors."

KEVIN BRADY
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Insurance Premiums Are Rising Despite Obama's Claims

By Kenneth Artz

Insurance affordability was the great promise of President Barack Obama's Affordable Care Act (ACA) when he signed the law in 2010.

On the campaign trail in 2008, Obama promised his plan would "lower premiums by up to \$2,500 for a typical family per year." Four years later, Obama still touts the savings for Americans from his law, claiming his signature legislation is making health care premiums more affordable.

"If we hadn't taken this on, and premiums had kept growing at the rate they did in the last decade, the average premium for family coverage today would be \$1,800 higher than they are," Obama told an audience at Northwestern University on October 2. "That's like an \$1,800 tax cut."

Rising Premiums for Most

There's little support for the president's claims, however. Instead of reducing health care costs as promised, Obamacare has led to increases in health insurance premiums.

Among recent studies that have identified such increases, a June 2014 Morgan Stanley report found the premium increases are attributable largely to changes under the ACA, with women facing premium increases ranging from 23 percent to 237 percent. A new study by PricewaterhouseCoopers found year-2015 individual-market health insurance premiums had increased an average of 15.4 percent.

In Alaska, the Division of Insurance announced in September, "as a direct result of the ACA, insurers offering health plans in the individual market require historic rate increases, as high as 37 percent in 2015."

Merrill Matthews, a resident scholar with the Institute for Policy Innovation, says health insurance costs are rising because Obamacare creates incentives for more people to use more care.

"It's an indication of just how

"It's an indication of just how much the health insurance reform debate has changed that Obamacare defenders are now thrilled that premiums are going up on average only 7 percent or 8 percent. They now proudly claim that's no worse than it was before Obamacare, even though the promise had been that premiums would go down."

MERRILL MATTHEWS
INSTITUTE FOR POLICY INNOVATION

much the health insurance reform debate has changed that Obamacare defenders are now thrilled that premiums are going up on average only 7 percent or 8 percent. They now proudly claim that's no worse than it was before Obamacare, even though the promise had been that premiums would go down," Matthews said.

Devon Herrick, a senior fellow with the National Center for Policy Analysis and contributing writer for *The Heartland Institute*, which publishes *Health Care News*, says the cost of employer-provided coverage is also rising.

"The Obama administration admits that about two-thirds of employers will see their costs rise due to new regulations, while only one-third will see their costs fall slightly," said Herrick.

Ken Artz (iamkenartz@hotmail.com) is a freelance reporter for *The Heartland Institute*.

BOOK REVIEW

How the American Diet Was Ruined

The Big Fat Surprise: Why Butter, Meat, and Cheese Belong in a Healthy Diet

By Nina Teicholz

Simon & Schuster, 2014

496 pages, \$17.95

ISBN 1451624425

By Jay Lehr, Ph.D.

In her outstanding book *The Big Fat Surprise: Why Butter, Meat, and Cheese Belong in a Healthy Diet*, investigative journalist Nina Teicholz reveals everything we think we know about dietary fat is wrong.

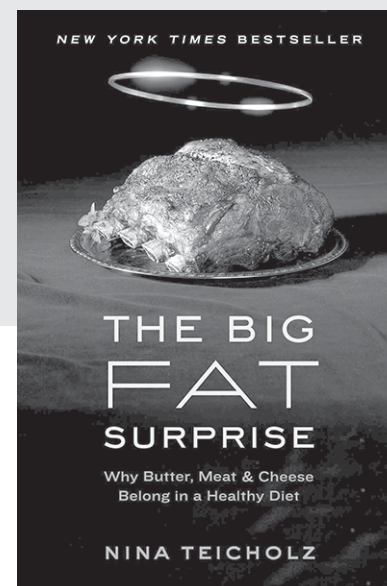
She documents extensively how the low-fat nutrition advice of the past 60 years has amounted to a vast uncontrolled experiment on our nation's entire population, with disastrous consequences for our health.

For decades, we have been told the best possible diet involves cutting back on fat, especially saturated fat, and that if we are not getting healthier or thinner, it must be because we are not trying hard enough. In fact, there is now undeniable proof the low-fat diet is itself the problem and the very foods we have been denying ourselves, including butter, eggs, milk, and meat, are the keys to reversing the virtual epidemic of heart disease, obesity, and diabetes.

Nine-Year Investigation

Teicholz's nine-year investigation of this subject uncovered how misinformation about saturated fats took hold in the scientific community and the public imagination and how recent findings have overturned these beliefs. History demonstrates how nutrition science got it wrong: Through a combination of ego, bias, and premature institutional consensus, overzealous researchers made dangerous misrepresentations of available evidence into a set of dietary dogmas.

Instead of animal products, we're supposed to eat plants, according to the advice we have been living with for decades. New research shows plants are the least nutrient-rich foods, and animal meat is far and away the most



nutritionally dense.

She quotes story after story of centuries-old cultures that thrived on diets of meat and fat alone. In Africa and Asia, explorers, colonists, and missionaries in the early twentieth century were repeatedly struck by the absence of degenerative disease and cancer among isolated populations they encountered on this diet. Although life expectancy was not long, death came from the infectious diseases readily cured today by modern medicine not available then.

Teicholz notes, "The idea that fat and particularly saturated fat are unhealthy has been so ingrained in our national conversations for so long that we tend to think of it more as 'common sense' than a scientific hypothesis."

Years of Bad Information

The destructive campaign against animal fat began in the 1950s, when Ancel Benjamin Keyes, a biologist and pathologist from the University of Minnesota, came up with the theory that consumption of animal fat was the cause of heart disease.

He ran numerous studies, now known to be flawed, to prove his point, including a well-funded study of seven countries where he already knew meat intake was low. That is to say, he cherry-picked his data, determined to prove his theory. With his arrogant and highly persuasive personality, he succeeded in getting the American Heart

“But the greatest proof of the scam foisted on us by the purveyors of high carbohydrates in our diet is the mounting evidence described in detail in this book, that ultimately sugar is our problem, because all carbohydrates, complex or otherwise, end up becoming sugar in our bodies. These sugars cause our pancreas to generate more insulin than our bodies can handle, leading to a tidal wave of health issues.”



Association to adopt his theory and recommendation for a low-fat diet in 1961.

Years later, when scientists studied a random collection of the diets in 22 countries, the correlation between heart disease and animal fat Keys thought he found in his seven countries was nonexistent, refuting his earlier studies.

Teicholz methodically eviscerates Keys' research in the manner of a spy novel. She was able to find dozens of counter studies, but as Keys' ideas spread and were adopted by powerful institutions, anyone who challenged him faced an extremely difficult battle. Professional lives suffered, and jobs, research funding, speaking engagements, and often prestige were lost.

Teicholz also tells the complete 50-year story of how cholesterol came to be erroneously seen as the primary indicator of potential heart problems, and how it was clearly established cholesterol-laden food did *not* raise levels of cholesterol in the blood.

Early Cover-up of Science

Early on, Teicholz provides a simple tutorial on the chemical bonds that differentiate the saturated, unsaturated, polyunsaturated, and monounsaturated fats that confuse most of us, and further on she explains the chemistry behind the more recent trans-fat scares.

One surprising item of information is that as early as 1957, scientist Fred Kummerow had discovered all the damage trans-fats can do to the human body. Created by hydrogenating vegetable oil to make a stable compound for ease of industrial production of food and consumer use, trans-fats accumulate in fat tissue. There, they supplant normal fatty acids, which are the building blocks in every cell membrane and carefully regulate everything going in and out of the cell.

Kummerow found when trans-fats occupy cell membrane positions, they obstruct the normal functioning of the body. This was such a threat to the reigning paradigm, however, that he was effectively shut out of work and had difficulty publishing. This cover-up lasted almost 50 years.

Lessons from History

Teicholz documents the American diet of the nineteenth century in great detail, including insights from the writings of many who visited our nation from abroad, all of whom were amazed by the tremendous quantities of red meat and the absence of vegetables, when heart disease was rare.

She goes on to describe the decreased consumption of red meats and fat over the past 50 years of the twentieth century, as the government and the American Heart Association falsely claimed *increasing* intakes of red meat and fats were the causes behind skyrocketing rates of heart disease and diabetes.

The author describes the unfortunate negative effects of a low-fat diet on children and exposes one of the great fallacies: that breast cancer is related to a high-fat diet. As far back as 1987, epidemiologist Dr. Walter Willett at the Harvard School of Public Health had found no positive link between fat consumption and breast cancer. In fact, Willett found just the opposite to be true among the nearly 90,000 nurses whose health records he had followed for five years.

A fat-starved public eagerly jumped to the highly touted Mediterranean diet, which heaped praise on olive oil and brought back to the American diet nuts, eggs, cheese, lots of seafood and chicken, and a little red meat, Teicholz notes. She says the new popular diet “... offered a corrective to mistaken low-fat policies. It demonstrated a more relaxed attitude toward dietary fat.”

But the greatest proof of the scam foisted on us by the purveyors of high carbohydrates in our diet is the mounting evidence, described in detail in this book, that ultimately sugar is our problem, because all carbohydrates, complex or otherwise, end up becoming sugar in our bodies. These sugars cause our pancreas to generate more insulin than our bodies can handle, leading to a tidal wave of health issues.

The crowning blow against the low-fat, high-carb diet was a 2008 review of all studies of this diet by the United Nations' Food and Agriculture Organization. It concluded there is “no probable or convincing evidence” a high level of fat in the diet causes heart disease

or cancer. Then, in 2013, after reviewing 16,000 studies, an expert health advisory group in Sweden concluded a low-fat diet is an ineffective strategy for tackling either obesity or diabetes.

‘Terrible, Costly Mistake’

It is not possible to read this book without concluding our national diet was never properly scientifically tested and, as a result, the information Americans have received has been a terrible, costly mistake.

The author reports that these facts have been available for quite some time. As early as 2001, Frank Hu, a nutrition professor at Harvard, wrote, “It is increasingly recognized that a low-fat campaign has been based on little scientific evidence and may have caused

unintended health consequences.”

With this growing pile of evidence on the table, Teicholz writes, “health authorities clearly see the need to update their advice. Yet, they are understandably reluctant to reverse course too loudly on fifty years of nutrition recommendations.”

The Big Fat Surprise could prove to be one of the most important books written in the twenty-first century. It has received a great deal of deserved attention, and only time will tell if the government and the food industry will ultimately relent and bring America back to a healthier diet.

Jay Lehr, Ph.D. (jlehr@heartland.org) is science director at The Heartland Institute.

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COMMENTARY

Quiet Period for Obamacare Is About to End

By Robert Laszewski

Obamacare has largely been out of the news cycle for a couple of months, but that is about to change as we head towards the 2014 election.

Here are some of the things we can expect to see in the news.

Modest 2015 Rate Increases

The 2015 rate increases were largely modest. Does that prove Obamacare is sustainable? No. My previous prediction was for increases of 9.9 percent.

With almost no valid claims data yet, insurers have little if any useful information on which to base 2015 rates, and the reinsurance program protects the carrier from losing money through 2016.

We won't know what the real Obamacare rates will be until we see the 2017 rates—when there will be plenty of valid claims data and the Obamacare reinsurance program, now keeping rates low, will have ended.

This fall's 2015 Obamacare open-enrollment period will likely be very problematic. The HealthCare.gov backend is not built yet—a year and counting after it

should have been.

How many people are enrolled in Obamacare? Without the backend accounting system, no one knows.

Auto-Enrollment Surprises Likely

The administration says it is going to auto-renew existing Obamacare policyholders. But while the administration tells policyholders their automatic renewal will go smoothly, every one of these subsidy-eligible people needs to go to the exchange website and re-enroll.

The biggest reason is in most cases, the baseline second-lowest-cost silver plan has changed, and with it, the subsidy participants are eligible for. The only way a participant will know the impact of this is to re-enroll. If they do not, participants could be surprised by a big jump in their 2015 out-of-pocket premiums come January, or a big tax bill a year later.

Actuarial firm Milliman put the impact of silver baseline plan changes this way in a recent issue brief: "Even modest premium increases by market leaders of 5% could lead to materially higher net premium contribution increases of 30% to near 100% for low

"We won't know what the real Obamacare rates will be until we see the 2017 rates—when there will be plenty of valid claims data and the Obamacare reinsurance program, now keeping rates low, will have ended."

income [subsidy-eligible] enrollees during 2015."

Milliman also says, "If consumers choose to auto-enroll because of the simple process versus evaluating their options by going to the federal exchange, individuals who auto-enroll may have unexpected materially higher net premium contributions relative to payments in 2014 for the same plan."

Bottom-Feeders Changing

In September, the Kaiser Family Foundation released a report stating average premiums will decline slightly for the silver baseline plans in 16 markets. That conclusion could be incredibly misleading.

The new 2015 silver baseline plan may have a lower premium than the 2014 silver baseline plan, but that is almost always because the insurance company that held that slot in 2014 significantly increased its rates for 2015. Another insurance company, which didn't write much business and is eager to increase market share, then decreased its rates and has become the 2015 baseline plan. The second company was able to decrease its rates without much fear because the Obamacare reinsurance scheme protects them from losses. Once the reinsurance scheme expires, permanent rate increases will be here to stay.

Although open enrollment is not scheduled to begin until 11 days after the November election, there were plenty of renewal and cancellation letters going out in October, including many pre-Obamacare policies being cancelled this year now that their one-year extension is up.

Confusion Reigns

Does this all sound confusing? Just wait until we approach the next open-enrollment period, when there will be millions of Americans aware of this complexity and left with only four weeks to get enrolled for January 1 coverage. The Obamacare anxiety index is going to be off the charts well before November 15.

The last couple of months have been very quiet for Obamacare. That is about to end.

Robert Laszewski 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.



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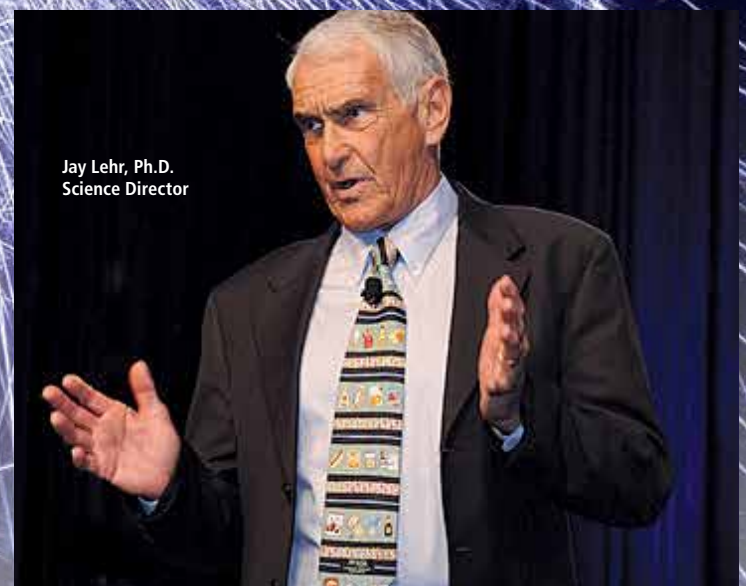
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