

Chapter 1

Health Care

Joseph L. Bast and Matthew Glans

10 Principles of Health Care Policy

1. Repeal and replace Obamacare.
2. Reform Medicaid and Medicare.
3. Repeal existing regulations.
4. Expand health savings accounts.
5. Expand high-risk pools.
6. Encourage price transparency.
7. Expand the use of direct primary care programs.
8. Expand access to prescription drugs.
9. Remove regulatory barriers to medical innovation.
10. Reduce malpractice litigation expenses.

Introduction

Waste and inefficiency are easily identified in our hospitals, government programs, and private insurance markets (Bisu 2013). We see it in the number of people who lack health insurance, the lack of price transparency in much of the health care system, the high rate of medical mistakes in hospitals, and the massive transfers of income—often from the poor and uninsured to the well-to-do and insured—the current system generates.

A good health care system would not employ armies of gatekeepers to stand between doctors and their patients, wouldn't require lawsuits to ensure victims of malpractice get adequate compensation or incompetent providers lose their licenses, and wouldn't require patients to wait eight

to 10 years for potentially life-saving drugs.

There are two paths to reforming health care in the United States. The first is to double-down on the mistakes made in the past by adding more regulations, more subsidies, and more barriers to innovation and consumer choice. The second is to learn from past mistakes, repeal ineffective and often deadly regulations and subsidies, and start fresh (Bast, Rue, and Wesbury 1993). Sadly, beginning in 2010 policymakers opted for the first path by passing the Patient Protection and Affordable Care Act (more popularly known as “Obamacare”).

The good news is that policymakers can make health care more affordable and higher quality without increasing state budgets or the national debt, and without violating the freedoms of patients or health care providers. Enlightened legislators across the country are embracing parts of this “fresh start agenda.” They offer guidance and leadership for elected officials elsewhere and for everyone interested in improving health care in the United States.

Recommended Readings: John C. Goodman, *Priceless: Curing the Health Care Crisis* (Oakland, CA: Independent Institute, 2012); Rituparna Bisu, *The Broken State of American Health Insurance Prior to the Affordable Care Act: A Market Rife with Government Distortions* (Irvine, CA: Ayn Rand Institute, 2013).

1. Repeal and replace Obamacare.

Health care reform cannot proceed unless the Patient Protection and Affordable Care Act (Obamacare) is repealed and replaced.

Health care reform cannot proceed unless the Patient Protection and Affordable Care Act (Obamacare) is repealed and replaced.

President Barack Obama and Democrats campaigned for passage of Obamacare claiming it would reduce health care spending, expand insurance coverage, and preserve choice and innovation. Seven years later, it is clear Obamacare achieved none of these objectives. Instead, by destabilizing private insurance markets it has come close to paving the way for single-payer health care.

By 2017, Obamacare had caused average individual market premiums to more than double from \$2,784 per year in 2013 to \$5,712

on Healthcare.gov in 2017—an increase of \$2,928 or 105%, according to a report by the U.S. Department of Health and Human Services (HHS 2017). According to the report, “All 39 states using Healthcare.gov experienced an increase in individual market premiums from 2013–2017. Sixty-two percent of states using Healthcare.gov had 2017 premiums double what was measured in 2013. Three states—Alaska, Alabama, and Oklahoma—saw premiums triple from 2013–2017.”

Today, more than one thousand counties in the nation had just one insurer participating on an exchange (CBS News 2017). Obamacare caused at least 4.7 million policies in the individual market—possibly more than 6 million—to be canceled (Associated Press 2013). Up to 16.6 million people in the small-group market and 102.7 million people in the large-group market could lose their plans because they violate Obamacare’s stringent “grandfather” regulations (Hogberg 2014a; Conover 2013; Gabel *et al.* 2012; OFR 2010).

With President Donald Trump and the GOP intent on repealing and replacing Obamacare, a health care disaster has been averted (perhaps). The ball will soon be back in the hands of state legislatures, where it should have been all along.

Over-reliance on Third Party Payers

The principal reason Obamacare failed is that it did not challenge the current system’s biggest flaw: its over-reliance on third-party payers. Tax policy, entitlement programs, and regulations all encourage people to secure health insurance rather than pay cash or self-insure. Obamacare tilted the balance even further by encouraging reliance on two specific types of health insurance: that purchased via government health insurance exchanges; and that provided via Medicaid, the nation’s health care entitlement program previously available only to the poor.

As Milton Friedman explained many years ago, when we spend our own money on ourselves, we try to get the most value for our money. When we spend other people’s money either on ourselves or on others, we are far less diligent about the cost (in the first case) or the benefits (in the second case) (Friedman 2004). Most health care in the United States today is paid for with “other people’s money.”

Federal tax policies have long encouraged third-party prepaid medical care over individual insurance or direct payment. Under current tax law, employers can deduct the cost of health insurance premiums from their employees’ pre-tax income, so one dollar of earned income buys one dollar’s worth of health insurance.

People without employer-provided health insurance, and people with insurance but paying out-of-pocket for expenses below the deductible or for required copayments, typically must use after-tax dollars. This means one dollar of earned income may buy only 50 to 75 cents’ worth

(depending on a person's tax bracket) of health insurance or medical services. This encourages over-reliance on employer-provided insurance with low deductibles and copayments (Goodman and Musgrave 1992).

Government health care programs for the poor and elderly add greatly to the number of people who depend on third parties to pay for their health care. According to one study, the creation of Medicare and Medicaid caused about half of the increase in health expenditures nationwide since 1965 (Finkelstein 2007).

As a result of tax policy and the expansion of Medicaid and Medicare, the amount Americans pay out-of-pocket for health care has fallen precipitously. In 1970, Americans paid about 40 percent of their medical bills out-of-pocket. By 2012, less than 12 cents of every dollar was paid out-of-pocket (CMS 2012).

Obamacare doubled-down on past mistakes, imposing a mandate on individuals to buy insurance, expanding government subsidies for those buying private insurance from government insurance exchanges, and expanding enrollment in Medicaid. The number of uninsured fell, but only because Medicaid rolls were expanded. Obamacare caused insurance premiums to increase by close to 25 percent in 2016, making it unaffordable for millions of families (Alonso-Zaldivar 2016).

Confusing Insurance Coverage with Health Care

Obamacare's second major flaw was to confuse health insurance coverage with health care. The former is one method of financing access to the latter, but it is not the only or often the best way. Sometimes, having health insurance does not deliver access to quality health care.

While health insurance is obviously beneficial for many people and in many situations, so long as there are safety nets for the uninsured (and there are, described below), its main benefit is protecting people's assets in the event of a major or "catastrophic" medical incident. People without assets and people with sufficient assets to self-insure against the cost of a major medical incident do not benefit much from health insurance and may pay much more than it is worth.

Advocates of universal health insurance point to a series of studies produced by Families USA, an advocacy group for single-payer health care, claiming a lack of health insurance causes 45,000 deaths in the United States per year. But those reports were expertly debunked by Linda Gorman (2008), John Goodman (2009), and others. Better research by Steven Asch *et al.* (2006) and Helen Levy and David Meltzer (2008) found little evidence of a consistent relationship between health insurance and health outcomes.

In 2016, 27 million nonelderly people lacked health insurance coverage. According to the Kaiser Family Foundation, roughly 11.7 million of those uninsured were eligible for financial assistance to

gain coverage through either Medicaid or subsidized marketplace coverage (Garfield *et al.* 2016). Many of these individuals do not bother enrolling because they can always do so *after* they become sick.

At the other end of the income spectrum, many people are uninsured but could plainly afford insurance. According to the Kaiser Family Foundation, 47 percent of the nonelderly uninsured come from households with income greater than 200 percent of the federal poverty level (KFF 2015). Forty percent, or 19 million, of the uninsured are between the ages of 18 and 34 (DeNavas-Walt *et al.* 2013). These young people realize they probably will not incur any medical expenses in the coming year, making health insurance (especially at prices inflated by government regulations) a poor investment.

Finally, the uninsured on average receive care at a level similar to patients insured by Medicare, managed care, and fee-for-service (Asch *et al.* 2006). They receive less care than those on Medicaid but have no worse health outcomes (Baicker *et al.* 2013). Federal and state governments spend more than \$300 billion annually on public health insurance, such as Medicaid and state children's health insurance programs (SCHIP). Government and private charity spending on uninsured people total about \$1,000 per full-time uninsured individual (Thorpe and Goodman 2005).

By confusing or conflating health insurance with actual health care, Obamacare failed to target the real reason access to health care is too often limited: over-reliance on third-party payers resulting in high prices, a lack of price transparency, laws that try to limit spending by restricting supply and limiting competition, and more.

Repeal and Replace Obamacare

As of the time of this writing, the U.S. Senate had failed to adopt legislation to repeal or replace Obamacare. Liberal Senate members insisted on keeping some of the regulations and entitlement provisions of Obamacare, making repeal of other provisions (such as the individual mandate and taxes to pay for the "risk corridor" program) difficult or impossible. Conservative and libertarian members of the Senate wanted more than partial or cosmetic reforms and feared a compromise would result in an Obamacare 2.0 rather than real reform.

While the details are difficult to work out in the political arena, the broad outline of reform is relatively easy to see. National legislation to repeal and replace Obamacare should include the following provisions:

- Eliminate the individual mandate to purchase insurance and the financial penalties associated with it.
- Replace the current tax exclusion of employer-provided health

insurance and the tax deduction for individuals with high medical expenses with an age-adjusted individual tax credit large enough to make private health insurance affordable.

- Repeal burdensome insurance regulations (community rating, guaranteed issue, and “essential benefits”) of Obamacare while giving the Department of Health and Human Services Secretary leeway to alleviate the burden of other regulations.
- Abolish the nearly one trillion dollars per decade in taxes that are part of Obamacare.
- Abolish Obamacare’s risk corridor program, which was intended to transfer funds from profitable insurers to unprofitable ones during the first three years of the insurance exchanges.
- End the Medicaid expansion program, either all at once or by gradually reducing the federal subsidy from 100 percent of medical bills to no more than the federal matching percentage for every other category of recipients, and then excluding nonpoor adults.
- Block grant Medicaid to the states through a per-capita allotment, giving states options to improve the efficiency of the program and control enrollment as local voters and policymakers see fit.

Some of these changes can begin without congressional action. The Affordable Care Act gives the Health and Human Services Secretary considerable latitude in how or even whether to implement many provisions. The Heritage Foundation’s Robert Moffit observed, “state officials can take advantage of Obamacare’s Section 1332, and apply to the secretary of health and human services for a five-year waiver from 11 statutory requirements of the national health law” (Moffit 2017).

Recommended Readings: Peter Ferrara, *The Obamacare Disaster* (Chicago, IL: The Heartland Institute, 2010); Association of American Physicians and Surgeons, “White Paper on Repeal/Replacement of the Affordable Care Act,” January 6, 2017.

2. Reform Medicaid and Medicare.

America's health care system cannot be improved without changing Medicaid and Medicare.

America's health care system cannot be improved without changing Medicaid and Medicare, the nation's two largest government-run health care finance systems. Neither program provides health care directly. Instead, they pay hospitals, physicians, nursing homes, managed care plans, and other health care providers for covered services they deliver to eligible patients.

Both programs insulate the insured from the cost of medical services, contributing to over-utilization of services and rising spending without commensurate benefits. By using price controls to under-pay providers, both programs result in cost-shifting to privately insured individuals and businesses that provide health insurance. The good news is that reforms being discussed in Washington, DC would dramatically change these programs for the better.

Why Medicaid Fails

Medicaid is the national health care entitlement program for the poor, including low-income children, parents, women who are pregnant, and seniors. Taxpayers finance Medicaid through a formula whereby the federal government picks up about 60 percent of the cost and states pay the rest. Obamacare used a higher reimbursement rate (100 percent, dropping to 90 percent over time) to reward states that expanded Medicaid to cover all individuals whose income is equal to or less than 138 percent of the federal poverty level (\$16,642 for individuals and \$33,948 for a family of four in 2017, higher in Alaska). Thirty-two states chose to expand their Medicaid enrollment.

Unsurprisingly, federal spending on Medicaid soared from \$200 billion in 2008, the last year of President George W. Bush's term, to \$376.6 billion in 2017. By 2024, spending is expected to reach \$552 billion due to enrollment expansions encouraged by Obamacare. State spending is soaring as well.

National restrictions on how states can use Medicaid dollars have resulted in a system that insulates patients from the cost of the care they receive, making them insensitive to prices and inclined to over-utilize services. Policies as simple and promising as allowing Medicaid recipients to have health savings accounts or imposing a work requirement on able-bodied recipients are prohibited. Physicians and other care providers are limited in how they can innovate to deliver care

by a rigid system of price controls and eligibility rules.

The perverse incentives extend to the government agencies administering Medicaid, which would rather tolerate waste and fraud than invest in the kinds of fraud detection and prevention systems that private insurers use routinely. One consequence: \$36 billion in improper payments by Medicaid in 2016, up from \$29.1 billion in fiscal year 2015 (GAO 2017).

Medicaid attempts to remain financially sustainable despite perverse incentives, waste, and fraud by imposing low reimbursement rates on providers, typically 40 percent less than what doctors and hospitals charge private insurers and individuals without insurance. According to Scott Gottlieb, then of the New York University School of Medicine and now commissioner of the Food and Drug Administration, “In some states, they’ve cut reimbursements to providers so low that beneficiaries cannot find doctors willing to accept Medicaid. ... Dozens of recent medical studies show that Medicaid patients suffer for it. In some cases, they’d do just as well without health insurance” (Gottlieb 2011).

Once again, Obamacare doubled down on a problem rather than solve it. Cuts to Medicaid promised in the Obamacare legislation would reduce payment rates to doctors and hospitals to just one-third what is paid by private insurance and only half what is paid by Medicare (Shatto and Clemens 2010). This would have catastrophic effects for people who rely on Medicaid for their health care.

One more problem facing Medicaid is how middle-income and even upper-income families use the program to pay for nursing home care. “Medicaid long-term care benefits do not require impoverishment,” wrote retirement benefits expert Stephen Moses (2017). “Virtually unlimited income does not obstruct eligibility if medical and long-term care expenses are high enough, as they usually are for people in need of formal, paid long-term care.” He concludes: “Easy access to Medicaid after care is needed has caused most of long-term care’s problems.”

Why Medicare Fails

Medicare is the nation’s health care entitlement program for the elderly, disabled, or individuals with end-stage renal disease. It is projected to provide health insurance to 58 million individuals and to cost \$709 billion in 2017. Medicare spending, like Medicaid, is soaring: Spending in 2008 was \$469 billion. Obamacare was projected to cut Medicare spending by \$716 billion over 10 years versus forecasts, mostly by cutting payments to doctors and hospitals, but experts almost unanimously believe Congress would act to prevent such draconian cuts.

Like Medicaid, Medicare tolerates waste and fraud. According to the Government Accountability Office (GAO), improper payments reached an estimated \$60 billion in fiscal year 2016 (GAO 2017).

Medicare is not insurance, at least not the kind of insurance one would find in a real marketplace for health care. As Dr. Jane Orient writes, “Premiums are not risk-based, and benefits are determined by the discretion of the managers, not an indemnity table agreed to by contract. The payment and delivery systems are commingled. The system benefits by restricting service. With the passage of MACRA (the Medicare Access and CHIP Reauthorization Act), our single-payer system for seniors—Medicare—is being turned into the equivalent of a giant, capitation-based HMO. Physicians are gatekeepers who profit by rationing care and are punished for providing too much” (AAPS 2017).

According to Medicare’s Office of the Actuary, the Obamacare cuts to Medicare would result in payment rates to doctors and hospitals being only one-third what is paid by private insurance and half what is paid by Medicaid (Shatto and Clemens 2010). It goes on to say, “the large reductions in Medicare payment rates to physicians would likely have serious implications for beneficiary access to care; utilization, intensity and quality of services; and other factors.”

Such draconian Medicare cuts would wreak havoc in health care for seniors. Doctors, hospitals, surgeons, and specialists providing critical care to the elderly—surgery for hip and knee replacements, sophisticated diagnostics through MRIs and CT scans, and even treatment for cancer and heart disease—will either have to withdraw from serving Medicare patients or eventually go into bankruptcy.

Reform Agenda

Medicaid and Medicare can be reformed to make them part of the solution to, rather than the problems facing, health care in America today. One model for Medicaid reform is the State Health Flexibility Act of 2016. The Congressional Budget Office (CBO) scored it to save nearly \$2 trillion over 10 years.

A comprehensive reform agenda for Medicaid would include:

- End the Medicaid expansion program that is part of Obamacare.
- Replace the federal matching formula with fixed, finite block grants. Each state would be free to use the funds for its own redesigned health care safety net program for the poor.
- States could replace insurance with vouchers that would allow the poor to help pay for the private health insurance of their choice in the competitive marketplace.
- Medicaid vouchers should be subject to a work requirement for the able-bodied. Each state could set work requirements as it prefers.

- States could have the authority to establish health savings accounts (HSAs) for the poor, which maximize consumer choice over their own health care and consumer control over the funds.
- States could experiment with different ways to pay for care, such as the direct primary care model (see Principle 7) and payment bundles for all the costs of a procedure.
- States should implement enhanced eligibility checks, possibly including drug tests for able-bodied patients and increased asset recovery efforts directed at those seeking aid for long-term care.

A reform agenda for Medicare would include the following steps:

- Allow workers under age 55 today to choose when they retire a private plan competing alongside traditional Medicare. Medicare would provide these seniors with a voucher they could use to pay for or offset some of the premium of the private plan they choose.
- Seniors should be free to choose health savings accounts (HSAs) for their Medicare coverage, maximizing the control they have over their own health care.
- Workers should be free to put the Medicare payroll taxes they and their employers currently pay into own personal retirement accounts, similar to what is in place in Chile and has been proposed for reforming Social Security (Ferrara 2015, Goodman and Cordell 1998).
- Patients and physicians alike should be allowed to opt out of Medicare and Medicaid *on a per-service basis*, just as participants in other entitlement programs can.
- The Centers for Medicare and Medicaid Services could issue a new regulation directing insurance carriers to reimburse Medicare beneficiaries—patients, not “providers”—who receive services from a nonenrolled or disenrolled physician and submit their own claim with an itemized bill, without imposing any claims submission requirement on the physician.
- Repeal the rules that people cannot leave Medicare Part A without losing their Social Security benefits, and that enrolled providers must file claims for all covered services rendered to Part B beneficiaries.

- Expand the current “opt out” provision to allow physicians to work outside the system on a patient-by-patient basis without an all-or-none opt-out.
- Institute a *patient-value-based* system by repealing the Resource-Based Relative Value Scale for nonparticipating physicians.

Recommended Readings: Chris Jacobs, “States Need Freedom From Washington To Transform Their Medicaid Programs,” *The Federalist*, June 29, 2017; Association of American Physicians and Surgeons, “White Paper on Repeal/Replacement of the Affordable Care Act,” January 6, 2017.

3. Repeal existing regulations.

Many existing federal and state laws should be repealed before implementing any new laws and programs.

Obamacare, Medicaid, and Medicare do more to disrupt and damage health care in America than any other government program or regulation, but myriad other federal and state laws also contribute to the problem. Policymakers should repeal such laws and programs *first*, before implementing any new laws and programs.

Mandated Benefits

In the United States, there are 2,271 laws mandating insurers cover specific health providers, procedures, or benefits (Bunce 2013). These laws often are billed as being pro-consumer, but they mostly benefit the special-interest groups that lobby for them. They needlessly raise the cost of health insurance premiums by as much as 24 percent (Gohmann and McCrickard 2009). On average, each state-mandated benefit causes an increase in the number of uninsured by .25 percent (Graham 2008). Repealing these mandates would lower the cost of premiums and allow millions of people to get back into the private insurance marketplace.

Mandated benefit laws disproportionately affect those who are self-employed or unemployed, or who work for companies too small to afford insurance benefits for their employees. Big businesses typically self-insure and are exempt from such regulations.

Guaranteed Issue Laws

Guaranteed issue laws require insurance companies to provide insurance to anyone who seeks it. The 1996 Health Insurance Portability and Accountability Act (HIPAA) required insurers to offer guaranteed issue policies in the small group (2–50 insured persons) market. Some states also try to impose guaranteed issue on their individual markets, with disastrous effects (Meier 2005a). Obamacare made guaranteed issue a requirement for any insurance offered through state insurance exchanges.

Guaranteed issue drives up the price of health insurance by creating an incentive for people to wait until they are sick before buying insurance. Insurance companies raise premiums to guard against the larger claims of the insured population that tends to be less healthy at any given time. Each round of premium increases causes a new group of healthy people to drop its coverage, causing the insured population to become still more expensive to insure. The results are soaring premiums and rising numbers of uninsured people (Bast 2004).

Community Rating Laws

Community rating laws require insurers to charge similar rates to all members of a community typically without regard to age, lifestyle, health, or gender. Because an insurer cannot adjust its premiums to reflect the individual health risks of consumers, the healthy majority see their premiums rise.

Community rating means insurance premiums paid by young and healthy individuals are higher than the benefits they are likely to receive, encouraging them to drop their coverage. Like guaranteed issue, this results in an insured population with higher health care expenses than the average population, requiring higher insurance premiums. Once again, premiums increase because more healthy people choose to go without health insurance.

States that have adopted guaranteed issue and community rating have higher premiums and fewer insurers competing for customers than states that have not. Guaranteed issue and community rating laws have been especially harmful in states where they have been applied to the individual insurance market (Meier 2005a; NAHU 2005).

Other Regulations to Repeal

Mandated benefits, guaranteed issue, and community rating are the three most destructive regulations states impose on health insurance companies. Other regulations on insurers and health care providers that limit competition and consumer choices and ought to be repealed or reformed include:

- *Certificate of need.* Thirty-five states require health care providers to obtain certificates of need before expanding facilities or opening new centers (Glans 2014b). Extensive research demonstrates certificate of need laws reduce competition and result in higher prices (Barnes 2006; Conover and Sloan 1998; Cordato 2005).
- *Clean claims and prompt pay laws.* Some states mandate health insurers pay 95 percent or more of all claims within a certain amount of time after receipt of the claim by the insurer. Such laws can be reasonable, but if the percentage of claims is set too high or the time period too short, compliance costs can soar (Bunce 2002).
- *Impediments to interstate competition.* Consumers are unable to purchase insurance from out-of-state companies because of the McCarran-Ferguson Act of 1945, which grants states the right to regulate health plans within their borders. The patchwork of 50 different sets of state regulations makes it costly and time-consuming for insurers to enter new states (Bast 2005; Flowers 2007).
- *Prohibitions on exclusionary waivers.* Some states prohibit insurers in the individual health insurance market from offering policies with either temporary or permanent medical waivers for pre-existing conditions. Such waivers enable insurers to offer affordable coverage for all but one or two known conditions that would otherwise require much higher premiums (Wieske and Matthews 2007).
- *Rate reviews and bands.* Most states regulate the rates insurers charge for insurance products in the small group market either by requiring prior approval of rates or by prohibiting insurers from offering rates more than 25 percent above or below a base rate. Rate reviews and narrow bands stifle innovation and competition (Wieske 2007).
- *Unnecessary licensing standards.* Restrictions on what nurse practitioners, dental therapists, and midwives are allowed to do, and whether they can operate without a medical doctor present, unnecessarily restrict the supply of medical services and consequently raise the price (Hamilton *et al.* 2016).
- *Overregulation of dental service organizations.* First launched in the late 1990s, dental service organizations (DSOs) allow dentists to focus on patients by providing, on a contract basis, routine office

operations such as accounting, insurance, scheduling, and purchasing equipment and supplies. State Dental Boards often oppose DSOs and try to over-regulate them (Glans 2017c; Palmieri Heck 2017).

- *Maintenance of certification (MOC) requirements.* While a certain degree of certification will always be necessary, physicians should not be required to pass through a quagmire of costly and expensive tests that may be unnecessary (Glans 2016b). Oklahoma provides a model other states can follow: It forbids the requirement of MOC as a condition of licensure, reimbursement, employment, or admitting privileges at a hospital in the state (Hamilton 2016a).
- *Interstate licensure reciprocity.* Reciprocity laws would allow a physician in one state to use his license in another state without needing to reapply. According to the Mercatus Center at George Mason University, reciprocity laws are “the easiest and least controversial ways for states to minimize restraints on physicians, yet a substantial number of states do not allow reciprocity” (Bryan *et al.* 2016).

Recommended Readings: Matthew Glans, “Certificate of Need Reform,” *Research & Commentary*, The Heartland Institute, November 13, 2014; J.P. Wieske and Merrill Matthews, *Understanding the Uninsured and What to Do About Them* (Washington, DC: Council for Affordable Health Insurance, 2007); Conrad F. Meier, *Destroying Insurance Markets: How Guaranteed Issue and Community Rating Destroyed the Individual Health Insurance Market in Eight States* (Washington, DC: Council for Affordable Health Insurance and Chicago, IL: The Heartland Institute, 2005).

4. Expand health savings accounts.

Health savings accounts (HSAs) are the key to reducing reliance on third-party payers.

Health savings accounts (HSAs) are the key to reducing reliance on third-party payers. They level the tax treatment of dollars used to pay directly for health care and dollars used to purchase health insurance.

They also can (but do not yet) level the tax treatment of dollars spent by businesses on health insurance for their employees and dollars spent by individuals for their own health insurance (Emanuel 2008).

HSAs, similar to 401(k) retirement plans, are privately owned savings accounts funded with pre-tax dollars used to pay for future medical expenses. By law, HSAs must be paired with high-deductible health plans (HDHPs). Since those policies cost much less than the usual comprehensive insurance provided by employers, the premium savings can be deposited into the account and used to pay routine medical bills up to the deductible. Any money left in the account at the end of each year “rolls over” to the next year.

The number of people enrolled in HSA plans continues to increase over time. As of January 2016, 20.2 million people were enrolled in HSA/HDHP plans (AHIP 2017). HSAs held more than \$37 billion in assets in 2016 and the average account balance was \$14,971 (American Funds 2017).

Benefits of HSAs

HSAs primarily benefit people who pay income taxes, since they generate tax savings. Low-income people therefore do not stand to benefit from the accounts unless their employers (or the government) contribute to them. The higher deductibles that come with an HSA can be difficult for some individuals and families to cope with, at least until enough money has accumulated in their HSAs to help cover the expenses.

Premiums for HSA plans cost about 17 percent less for a family and 14 percent less for a single person compared to the next cheapest alternative (Claxton *et al.* 2013). Surveys, including one conducted in 2014 by the Employee Benefit Research Institute, find people with HSA/HDHP plans have lower satisfaction rates than those with traditional insurance plans, but the gap is not large and is narrowing with time. Forty-six percent of HSA/HDHP enrollees said they were extremely or very satisfied with their overall health plans, while 61 percent of traditional-plan enrollees said the same of their plans (Employee Benefit Research Institute, 2015).

Because they spend their own money, patients with HSAs shop more wisely for medical care than do people with conventional low-deductible insurance coverage. Two surveys have found people with HSA plans are about twice as likely to ask about drug costs and 50 percent more likely to inquire about the overall cost of care (Agrawal *et al.* 2005; Blue Cross and Blue Shield Association 2005). HSA patients were 20 percent more likely to manage chronic conditions and 25 percent more likely to use preventive care and engage in health and wellness programs.

National Reform Agenda

The American Health Care Act (AHCA), passed by the U.S. House of Representatives in May 2017 but not approved by the Senate, would have abolished several taxes on HSAs. It also would have expanded the contribution limits for HSAs to \$6,550 for individuals and \$13,100 for families, so they could cover more medical costs. The bill also allowed more flexibility by allowing spouses to make catch-up contributions to HSAs and allowing HSAs to cover certain medical expenses incurred before the savings account has been established. These are all good reforms that policymakers should consider.

Health savings accounts would be even more successful if federal laws allowed unlimited contributions to HSAs and permitted such accounts to wrap around third-party insurance—paying for any expense the insurance plan does not pay. Other national reforms that would improve HSAs include:

- Allow people over the age of 65 and eligible for Medicare to have HSAs.
- Allow people who do not have employer-sponsored health insurance to pay for health insurance with funds from their HSAs.
- Let insurers offer a portable, nationally regulated HSA high-deductible health plan.
- Permit insurers to design plans with different deductibles and copayments for different medical services: high deductibles for services where patient discretion is possible and low or no deductibles where patient discretion is inappropriate.

State Reform Agenda

States can help expand HSAs by adopting policies recommended by the Council for Affordable Health Insurance (2007):

- Ensure the state's definition of income conforms to the Internal Revenue Code for HSA purposes. Among the states that do not accept or follow the federal tax treatment for HSAs are Alabama, California, and New Jersey (HSA for America 2017).
- Adopt laws exempting HSA high-deductible health plans from state-mandated benefit requirements. States with mandated benefits that

conflict with HSAs include California, Illinois, Maine, Missouri, New York, and Ohio.

- Add an HSA option for persons who buy insurance through the state's high-risk pool (12 states have done so already), for state and municipal employees (13 states have done so already), and for Medicaid (until the Obama administration shut it down, Indiana had a very successful Medicaid program that included HSAs).

Recommended Readings: Jeff Emanuel, "Health Savings Accounts," *Research & Commentary*, The Heartland Institute, May 15, 2008; John Goodman, "Making HSAs Better," *Brief Analyses* No. 518, National Center for Policy Analysis, 2005.

5. Expand high-risk pools.

High-risk pools serve people with pre-existing conditions and help stabilize the rest of the health insurance marketplace.

High-risk pools offer affordable health insurance to people with pre-existing conditions who otherwise could not find affordable health insurance in the private marketplace. They offer a safety net narrowly targeted to those who need public assistance. By removing from the insurance pool people with very high known health care costs, high-risk pools help stabilize the rest of the marketplace and lower premiums for healthy people.

High-risk pools are state-chartered, nonprofit associations offering health insurance through the private sector. Premiums range from 125 percent to 200 percent of the premiums charged for standard coverage. Under the provisions established in 2002 by the Trade Adjustment Assistance Act (TAAA), which provided modest federal funding for high-risk pools, a state must cap the premium at 150 percent of standard in order to qualify for federal funding.

It is inherent in the design of a risk pool that it will lose money. It simply is not feasible to pool a group of individuals known to have major health problems and expect their premium contributions to cover the entire cost of their care. For this reason, risk pools need some form of subsidy, often an assessment charged to insurance carriers in the state.

Risk pools are overseen by appointed boards of directors usually including representatives from the insurance industry, consumers, and medical professionals. The pools often are supervised by the state insurance departments. A private third-party administrator typically handles day-to-day claims and administrative operations.

A Proven Solution

In 2011, the most recent year for which statistics are available, “the top 1 percent of health care spenders accounted for 23 percent of overall spending, and the top 20 percent were responsible for 82 percent of the total,” according to Pew Trusts (Ollove 2017). These people are difficult to insure by private insurers, since their inclusion in a group of generally healthy insureds can result in rate increases for all members of the group in order to cover the expense, causing the healthier insureds to search for cheaper insurance, i.e., a group without a high-cost person in it.

One proven solution for covering patients with pre-existing conditions is the creation of high-risk pools. Risk-pool insurance exists in 35 states. Prior to passage of Obamacare, high-risk pools covered more than 222,000 uninsurable people nationwide. This seemingly small number is actually a large part of the total population of “uninsurable” individuals in the 35 states with high-risk pools.

High-risk pools give the insurance industry and the general public a way to share and spread out the costs of insuring medically risky people on a broad and predictable basis. Studies of the individual insurance market have found states with risk pools have had more success in keeping their individual health insurance markets competitive, keeping insurance rates affordable, reducing Medicaid enrollments, and increasing private coverage (Meier 1999).

Better than Obamacare

According to Curtis Dubay, a research fellow with The Heritage Foundation, “The problem of providing access to individuals with pre-existing conditions, while very real, did not necessitate the massive changes in America’s health care system included in Obamacare” (Dubay 2013). While the Obama administration claimed as many as 129 million Americans with pre-existing conditions were “at risk” and “could be denied coverage” unless Obamacare were adopted, Dubay notes the real number of people truly uninsurable due to pre-existing conditions was vastly smaller.

Individuals with employer-sponsored coverage are not subject to pre-existing condition exclusions, and since they amount to approximately 90 percent of the people with private insurance, the number of people genuinely “at risk” could not be greater than 10 percent of those with private insurance. Only 134,708 individuals have enrolled in the

supplemental federal high-risk pool program since it was created under Obamacare to cover individuals with pre-existing conditions, a good indication of how small the problem actually is.

Whereas Obamacare attempted to transform the entire health care financing system in the name of helping the uninsured, high-risk pools tailor the solution to the needs of the small number of people with real problems, thereby helping the rest of the insurance system work the way it should, covering individuals whose future medical needs are generally unknown.

Reform Agenda

Embracing high-risk pools and encouraging them to thrive would allow states to abandon guaranteed issue and provide health insurance to a vulnerable population while helping to keep health insurance prices down. During the debate over how to repeal and replace Obamacare, House Republican leaders proposed a national \$15 billion high-risk pool, an idea with considerable merit.

Recommended Readings: Conrad F. Meier “Extending Affordable Health Insurance to the Uninsurable,” *Heartland Policy Study* No. 91, The Heartland Institute, August 27, 1999; Matthew Glans, “State High-Risk Pools for Health Insurance,” *Research & Commentary*, The Heartland Institute, May 25, 2017.

6. Encourage price transparency.

Over-reliance on third-party payers means providers have little incentive to be transparent about prices for their services and consumers have little incentive to ask.

Over-reliance on third-party payers for health care has resulted in a system in which health care providers have little incentive to advertise or even share prices for their services. Most health care consumers, insulated from price considerations by private insurance, Medicaid, or Medicare, simply do not care about prices: They pay the same copay regardless of the services they choose and are not penalized for ineffective choices.

This system might seem to work well most of the time since no one wants to be shown a menu of prices during a health emergency, and the

absence of price transparency helps create the illusion that much of the health care we consume is “free.” But upon closer inspection it does not work well at all.

Lack of Transparency

Consumers seeking price estimates for basic medical services often have great difficulty obtaining any information from providers in a timely manner. The Pioneer Institute, a think tank in Pennsylvania, surveyed 54 hospitals in six metropolitan areas across the United States and found consumers seeking a price estimate for a routine medical procedure face a “difficult and frustrating task” (Pioneer Institute 2016).

Pioneer researchers contacted hospitals in and around Dallas-Ft. Worth, Des Moines, Los Angeles, New York City, Orlando, and Raleigh-Durham to request price information for a fictional patient looking to receive an MRI. Their results show in 57 percent of the hospitals, “it took more than 15 minutes to get a complete price that included the radiologist’s fee for reading the MRI,” said the study’s authors. “Two-thirds of the time, researchers had to call a separate number or organization to obtain an estimate for the reading fee.”

A poll conducted in 2006 by the Council for Affordable Health Insurance (CAHI) found 84 percent of consumers would like to see health care prices published, and 79 percent said they would use this information to “shop for the best price” (as reported by McKeown 2011). As use of the internet, smart phones, and apps used for finding the lowest prices for all sorts of goods and services has expanded dramatically since then, one can assume nearly everyone today would respond positively to such a poll.

The lack of price transparency results in dramatic variation, from practice to practice and hospital to hospital, in prices for identical tests and procedures (Ungar 2013). Even someone with generous insurance would benefit from knowing at least some prices before choosing a doctor or hospital for non-emergency care. For the uninsured, such information could mean the difference between a minor financial setback and bankruptcy.

Why Prices Are Important

Lulled by the illusion of “free health care,” many patients over-utilize medical services. This imposes unnecessary costs on health care providers, which ultimately are paid for by others either directly (through insurance premiums, direct payment, or taxes) or indirectly (by having to wait for a service or even be denied access altogether). It can also endanger the lives of patients who ask for and receive multiple prescriptions for drugs, unnecessary invasive tests, and even unnecessary surgeries.

Many consumers are shocked to receive bills for costs not covered by their insurance—the part they are responsible for up to their deductible, and then through copays for higher amounts. People without insurance are exposed to the entire cost of services. Patients often are not told how much they owe until weeks and even months after the services have been delivered. In the case of even a routine hospital visit, a dozen bills or more arrive in the patient's mail weeks or months after a procedure, all of them describing charges that were not made known at the time they were incurred.

The lack of price transparency also hurts health care providers. Hospitals, clinics, and private practices need consumer feedback to prices in order to know if they are less efficient than other providers at producing a particular service and therefore need to find ways to reduce inefficiency and waste. Similarly, providers cannot discover their comparative advantage—what they do better or at a lower cost than other providers—without a real price system in place (Azar II *et al.* 2006).

Finally, the lack of transparency does not work for taxpayers who must bear the increasingly heavy burden of paying for Medicaid and Medicare programs whose costs are skyrocketing because consumers act as if their health care were free.

Price Transparency Legislation

A July 2016 “report card” on state price transparency laws produced by the Health Care Incentives Improvement Institute and Altarum Institute said: “State laws mandating health care price transparency for consumers can help fix the mystery surrounding health care prices, unbolting the door between consumers and the information they need to shop for and buy high-quality, affordable health care” (deBrantes and Delbanco 2016).

The report card found “too many states still fall far short of requiring and implementing thorough, useable transparency resources. Dozens of states have laws that refer to price transparency, but provide little to help consumers shop for and choose care, and offer little potential to move the health care delivery system toward quality and affordability” (*Ibid.*).

While many current price transparency laws need to be improved, research shows they do work. In a 2013 “census of state health care price transparency websites” published in the *Journal of the American Medical Association*, researchers looked at the medical claims paid by employers after a price transparency tool was made available (Kullgren *et al.* 2013). The study covered 500,000 individuals in 253,000 households between 2010 and 2013 and examined three types of medical services: laboratory tests, advanced imaging services, and clinician office visits.

The results were positive: Costs for consumers using the price transparency tool were “14 percent lower for lab tests and 13 percent

lower for imaging services compared to those who did not use the tool. Costs associated with office visits declined by 1 percent.” The amount of money saved by the patients was also noteworthy. For instance, consumers using the price transparency tool for imaging services saw an average reduction of \$124.74 per service.

Tools for discovering prices and choosing lower-priced service providers are emerging, especially online (see Herrick and Goodman, 2007) but progress is slow because too few consumers benefit personally from being smart consumers. New Hampshire was one of the first states post hospital prices online, starting in 2007. According to a Government Accountability Office report, the state proves “that while providing complete cost information presents challenges, it can be done” (GAO 2011, p. 14).

In 2016, the Missouri legislature considered a health care bill that would require the state Department of Health and Senior Services to create an online web portal where hospitals and health care providers would share service costs for 100 common health care procedures. This is one way to empower consumers and creating real competition in the health care market.

Reform Agenda

Ultimately, the only way to restore prices to health care is to reduce reliance on third-party payers. Without increased consumer demand for prices, hospitals and other providers have no incentive to post prices, or even discover them for internal purposes. The reforms recommended earlier in this chapter would help reduce reliance on third-party payers, and therefore are an essential part of an agenda to increase price transparency.

Price transparency promotes competition and improves the quality of health care. When consumers are able to shop and compare prices, market pressures encourage providers to produce a more affordable, high-quality product. If they do not, they risk losing out to their competitors. State legislators should work to promote health care price transparency to help empower consumers and lower health care costs.

Recommended Readings: Alex M. Azar II *et al.*, “Transparency in Health Care: What Consumers Need to Know,” speech delivered at The Heritage Foundation, October 3, 2006; Pioneer Institute, “National Survey Finds Limited Access to Price Estimates for Routine Hospital Procedure,” February 21, 2016.

7. Expand the use of direct primary care programs.

Insurance is necessary and appropriate for expensive and unexpected care, but direct payment by patients is more appropriate for relatively routine and inexpensive treatments.

Direct primary care (DPC) programs require patients to pay a monthly membership fee, typically ranging from \$50 to \$80, to receive a more generous allocation of appointments than they would under most traditional health insurance plans. Some plans even allow for same-day appointments or house calls. Individuals enrolled in a DPC program often supplement their DPC coverage with a wraparound catastrophic insurance policy for all services not specific to primary care.

The guarantee of a set monthly fee removes the layers of regulation and bureaucracy created by the traditional insurance system and allows physicians to spend more time with patients. Routine tests and procedures are included in most DPC plans at prices considerably less than what would be charged to patients with traditional insurance (Makla and Glans 2016). Alabama recently became the 22nd state to pass legislation clarifying how DPC is regulated.

The Direct Payment Option

Insurance is necessary and appropriate for expensive and unexpected care, but nearly half of all health care spending is for relatively routine and inexpensive treatments best paid directly by patients. Recognizing this, many doctors have arranged their practices to encourage direct payment. These practices accept only cash, checks, credit cards, or debit cards for health savings accounts. Because they no longer require large staffs to process complex insurance claims or comply with price controls imposed by government programs, they are able to offer prices 25 to 50 percent less than the reimbursement paid by Medicare and other insurers.

Direct payment for health care services also reduces the need for claims reviewers and “gatekeepers” who make up the bureaucracy created by managed care programs. Under a system of direct payment, doctors and patients are once again allowed to determine appropriate care without third-party interference.

Additionally, direct payment ends the injustice present in the current system whereby households with the highest incomes, and therefore in

higher tax brackets, get the largest tax benefits for employer-provided health insurance. John Goodman estimates families in the wealthiest quintile get an annual tax subsidy of \$1,560 a year, whereas families in the poorest quintile get only \$250 (Thorpe and Goodman 2005).

Dr. Maura McLaughlin, a family physician and DPC provider in Charlottesville, Virginia, says DPC saves her patients more than 20 percent for some services. “[One] patient was due for four needed tests, which I drew for \$38 total with our discounted cash pricing,” McLaughlin told reporter Emma Vinton. “He told me those exact same four tests last year had cost him \$1,300 with insurance” (Vinton 2017).

McLaughlin also reported, “In Washington state, the large DPC group Qliance worked with Medicaid to provide primary care through its DPC clinics to patients with Medicaid and demonstrated a savings of 20 percent for Medicaid while improving patient satisfaction. If a similar program were implemented in Virginia, we would be able to expand Medicaid in a cost-neutral manner. Imagine how many more people could be covered with the 20 percent savings in the Medicaid budget.” (*Ibid.*)

Union County, North Carolina, expects to save \$1 million in the first year of its contract with DPC provider Paladina Health (Restrepo 2016). A pilot program enrolling 2,400 Medicaid beneficiaries in Michigan in a DPC program is expected to save millions of dollars in its first year. The hope is eventually to expand DPCs to all 2.4 million Medicaid enrollees in the state, which could generate potential savings to the state of \$3.4 billion (Glans 2016a).

More information about DPC, including directories of physicians who are part of the movement, is available on websites hosted by Docs4PatientCare, DPC Frontier, and the Association of American Physicians and Surgeons.

Reform Agenda

Direct primary care and other direct payment arrangements will expand only if policies that encourage over-reliance on third-party payers are repealed, the focus of previous principles presented in this chapter. Specific steps states and the national government can take to help promote the movement to DPC-type arrangements between patients and physicians include the following:

- Congress can pass legislation specifying DPC is an acceptable form of payment under Medicaid and Medicare and fund pilot programs testing the concept.
- Congress can pass legislation, such as the Primary Care Enhancement Act (H.R. 365), that clarifies DPC arrangements are

not health plans for the purposes of the tax code, and defines fees paid to primary care providers in periodic fee arrangements as qualified health expenses paid from HSAs.

- States should pass legislation stating DPC is not a form of insurance.
- States can integrate DPC into their Medicaid systems with or without waivers from the national government to help reduce costs and improve care.
- States can also incorporate DPC programs into health benefits for state and local employees.

Recommended Readings: Michael Hamilton, “Policy Diagnosis: Direct Primary Care Helps Patients, Doctors, and the Health Care System,” interview with Hal Scherz, M.D., founder of Docs4PatientCare, *Health Care News*, April 6, 2016, Daniel McCorry, “Direct Primary Care: An Innovative Alternative to Conventional Health Insurance,” The Heritage Foundation, August 6, 2014.

8. Expand access to prescription drugs.

Prescription drugs are too heavily regulated, restricting patient access to new drugs in a timely manner and making them more expensive than they need to be.

Prescription drugs are an essential component of the modern medical system, extending life, reducing suffering, and making surgery less necessary. New technologies for discovering and testing drugs promise to make them an ever-growing part of the health care system, leading to concerns over their cost. Drug treatments tailored to an individual’s genetic makeup are especially promising.

Thoughtful policymakers can make prescription drugs more affordable by encouraging price transparency, speeding the approval of generic drugs and new drugs by the Food and Drug Administration (FDA), and preserving the market-based provisions of Medicare Part D.

Drug Price Controls Are No Answer

While high drug prices sometimes make headlines in newspapers, drugs represent only about 9.4 percent of total U.S. health care spending. Drug therapy is often the most efficient method of caring for patients: A dollar of drug expenditure reduces hospital costs by more than \$3.50 on average (Lichtenberg 2007). Among Medicare beneficiaries, each additional prescription filled lowers hospital costs by \$104 (Stuart *et al.* 2009).

Newer drugs work even better than older ones. A reduction in the age of prescription drugs reduces other health care expenditures 7.2 times as much as it increases spending on prescription drugs (Lichtenberg 2007).

Consumers can often reduce the amount of money they spend on prescription drugs by 30 percent to 50 percent, and sometimes more, simply by comparison-shopping. Requesting a generic substitute for an expensive brand-name drug can cut prices as much as 90 percent. With a physician's permission, buying larger-dose tablets and an inexpensive pill splitter can cut drug costs in half (Herrick 2006c).

State Medicaid programs and the U.S. Veterans Benefits Administration attempt to control spending on drugs by allowing access only to those on lists of preapproved drugs, called drug formularies. In order for their drugs to appear on the lists, drug companies must offer discounts or pay rebates to the states. Formularies are used in the private sector, too, but when used to limit the cost of public entitlement programs, formularies often act as crude and ineffective price controls. Politicians rather than consumers dictate spending, resulting in pressure on plan administrators to substitute older or generic drugs for new or expensive drugs requested by doctors.

Drug Piracy and Direct Negotiation

Those who lament high drug prices often advocate lifting the ban on importing drugs from other countries. Such a policy makes drugs vulnerable to counterfeiting, contamination, and improper handling (Giuliani Partners 2005; Meier 2005b; Pitts 2006). And to what end? Countries with pharmaceutical price controls produce too few drugs to provide more than a small fraction of what the U.S. market needs (Goodman 2005a).

Pirating for sale in the United States drugs manufactured for price-controlled markets amounts to importing price controls. The availability of cheaper drugs from abroad would make it more difficult for drug companies to charge prices high enough to finance research and development, leading to less investment in new drugs in America (Turner and Meier 2004).

Another proposal for limiting spending on drugs is to allow the national government to negotiate prices with drug manufacturers under Medicare Part D, the prescription drug benefit for seniors. Part D, implemented in 2006, was designed to ensure low-income seniors and those with extremely high prescription drug costs receive coverage. To avoid the hazard of government price controls, Part D prohibits direct negotiation of drug prices between the government and drug companies, through what came to be called the “non-interference clause.”

The non-interference clause has been extremely effective. Today, Part D is one of the rare entitlement programs that target the truly needy and cost less than what was originally budgeted, and that cost does not even include an offset for expenses involving surgery and hospitalization avoided by the availability of drugs (Neuman *et al.* 2007; Medicare Board of Trustees 2013, 2007).

Unfortunately, advocacy groups have launched a campaign against Part D’s effective approach. Instead of allowing market forces to determine drug prices, these groups want the government to negotiate directly with drug companies and impose taxes (called “rebates”) on drugs made available through the program. These changes would hurt seniors and raise the risk of rationing drugs for Medicare patients.

Need for Food and Drug Administration Reform

Instead of price controls, a better way to reduce the price of new drugs is to reform the costly and time-consuming approval process used by the Food and Drug Administration (FDA). Since 1962, FDA has required new drugs to pass effectiveness and safety trials, causing the new drug approval process to take approximately eight years. Many drug developers cannot afford the substantial fees or wait that long for revenue from drug sales to begin. Further, FDA often defines “efficacy” in subjective ways—for example, “economic efficacy,” which involves its view of whether a drug is needed in the market.

A promising way to reform FDA regulation of new drugs is Free to Choose Medicine, a dual-track system whereby patients and their doctors can choose either to wait for FDA-approved drugs or use drugs that have passed Phase I safety trials but still are undergoing clinical trials for effectiveness (Madden and Conko 2010). Patients choosing early access to new drugs agree to post information about side effects to a publicly accessible Tradeoff Evaluation Database.

The Goldwater Institute has developed a similar but more limited model it calls Right To Try. The program allows access to experimental drugs by terminal patients who have exhausted other available treatments (Corieri 2014). Participating patients must provide informed consent, limiting legal exposure for the drug’s manufacturer (Glans 2014a).

Reform Agenda

Policymakers who wish to expand access to prescription drugs should:

- Support policies that increase price transparency, such as creating state websites that report the price of prescription drugs sold by different chains of drug stores and the availability of generic alternatives.
- Support efforts underway at FDA to speed up the approval of generics and new drugs and the Free to Choose Medicine plan allowing drugs to reach patients without going through FDA's time-consuming and largely obsolete series of efficacy trials.
- Oppose efforts to restrict access to new drugs by imposing restrictive formularies on public programs. While hard decisions must sometimes be made, the prevailing policy ought to be to respect the decisions of doctors and favor newer drugs.
- Continue to oppose efforts to legalize the importation of drugs from other countries. The public health hazards created by allowing drugs from countries outside the highly secure U.S. drug supply chain are simply too high to merit relaxing the current ban.

Recommended Readings: Bartley J. Madden and Gregory Conko, *Free to Choose Medicine: Better Drugs Sooner at Lower Cost* (Chicago, IL: The Heartland Institute, 2010); Christina Corieri, "Everyone Deserves the Right to Try: Empowering the Terminally Ill to Take Control of Their Treatment," Goldwater Institute, 2014.

9. Remove regulatory barriers to medical innovation.

Regulation hampers entrepreneurs and innovators seeking new ways to deliver health care that is more convenient, higher quality, and less expensive.

Entrepreneurs and innovators are developing new ways to deliver health care that are more convenient, higher quality, and less costly than currently available services. Unfortunately, public policies often stand in their way. Entrepreneurship in health care, as in other markets, requires that consumers are free to choose and producers are free to compete with one another. Policymakers should remove regulations that stifle innovation with red tape and price controls that do not allow reimbursement for new services.

Where to Find the Innovators

An excellent resource for policymakers and consumers searching for better ways to finance and deliver health care services is a website called The Wedge of Health Care Freedom at <https://jointhewedge.com>. The site, a project of the nonprofit Citizens' Council for Health Freedom, offers a directory of practices that follow eight "wedge principles": transparent, affordable pricing; freedom to choose; true patient privacy; no government reporting; no outside interference; cash-based pricing; protected patient-doctor relationship; and all patients welcome.

Twila Brase RN, PHN, president and cofounder of the Citizens' Council for Health Freedom, writes of the providers listed on her site: "All patients, insured or uninsured, are welcome. Payment is by cash, check or charge. Imagine a practice where your doctor, dentist or other health care practitioner really knows you. Imagine a practice that does not demand your insurance card and ID before the staff even say hello. Wedge Practices and their doctors are the way back to the future! A future where patients and doctors are free, prices are affordable and care is confidential—just between you and the doctor" (Brase 2017).

Another good place to find health care innovators is the website of the Free Market Medical Association at <https://fmma.org>. According to the site, the FMMA helps "identify patients willing to pay cash, doctors willing to list their prices, businesses attempting to provide affordable quality insurance, and providers/services/and patient advocates that are helping make everything work."

Three other resources reported earlier in this chapter, in Principle 7 on direct primary care, are Docs4PatientCare, DPC Frontier, and the Association of American Physicians and Surgeons. Their contact information appears in the directory at the end of this chapter.

Retail Health Clinics

Retail health clinics located in shopping malls or big-box retail outlets are increasingly popular because of their convenience, minimal waiting, low prices, and high quality of care. They typically are staffed by a nurse practitioner (NP) with a master's degree in nursing who focuses on diagnosing and treating relatively common and minor illnesses.

Prices are posted and cost per episode of care is generally less than in other health care settings (Martin 2007; Adamson 2010). In 2015, Americans visited retail clinics more than 10 million times (Japsen 2015). Global professional services company Accenture predicts retail health clinics will continue to grow rapidly, with 14 percent annual growth through 2017, a 46 percent increase over 2014 levels. In 2017, the number of retail clinics will exceed 2,800 (Accenture 2015).

Because they often are open on evenings and weekends, these clinics serve patients who might otherwise go to expensive emergency rooms (Parnell 2005a). These clinics can be hindered by legislation restricting the number of NPs a physician can supervise or limiting the scope of practice for NPs, or by preventing NPs from staffing clinics inside pharmacies (LoBuono 2006).

Specialty Hospitals

Specialty hospitals, typically owned at least in part by the doctors who practice in them, focus on a few areas of care, enabling them to increase efficiency and provide higher levels of care than general hospitals do (Parnell 2005b). Unfortunately, Obamacare prevents new physician-owned specialty hospitals from being established.

Critics of specialty hospitals, such as the American Hospital Association, cite concerns about physician self-referral and the loss by general hospitals of the most profitable medical procedures to these more efficient rivals. But specialization and competition lead to better quality and lower prices, and specialty hospitals have shown how innovations such as redesigned hospital layouts can reduce labor costs, decrease patient waiting times, and improve patient outcomes (Hogberg 2013).

Medical Tourism

Patients are increasingly traveling outside the United States for surgeries, often at prices one-fifth to one-third their cost in this country. Countries with highly advanced medical facilities specifically built or equipped for medical tourists include Belgium, Brazil, Costa Rica, Germany, India,

Malaysia, Mexico, Poland, Singapore, Spain, and Thailand (Herrick 2006b; VISA 2017).

Patients Beyond Borders, an organization founded in 2007 to connect patients with hospitals and specialty centers around the world, operates a website at <https://patientsbeyondborders.com> where visitors can search by treatment, region, country, or specialties. The choices provided on the site are vast, including specialties such as cardiology, cosmetic and reconstructive surgery, dentistry, fertility and reproductive health, oncology, ophthalmology, orthopedics, and weight loss surgery.

According to Patients Beyond Borders, spending on medical tourism in 2016, which includes people traveling to the United States from other countries for their medical care, was between \$45.5 billion and \$72 billion. Some 14 million cross-border patients worldwide generally spent between \$3,800 and \$6,000 per visit, including medically related costs, cross-border and local transport, inpatient stay, and accommodations.

Telemedicine

The internet and the spread of high-speed broadband services hold enormous potential for improving the quality and lowering the cost of health care. Patients can contact their doctors by email and get quick answers to questions, schedule meetings, and exchange test results. Doctors can monitor their patients' conditions remotely, store and access medical records more quickly, and minimize the amount of time spent on paperwork (Kleba 2007; Herrick 2006a).

Telemedicine can be held back by state laws requiring doctors be licensed in the state where the patient resides or is treated. Licensure reciprocity, discussed earlier (see Principle 3), is one way to remove that obstacle. Another obstacle is that Medicare and Medicaid may not reimburse doctors for time spent responding to emails or talking to patients by phone.

Concierge and Cash-Only

In concierge medicine, a patient pays an annual or monthly fee or retainer for all medical care provided by the physicians. Concierge physicians are often on call to patients 24/7 and are able to spend extra time with patients on matters such as preventive care. Concierge practices are growing in popularity (Parnell 2014).

Cash-only physicians refuse to take insurance and are willing to see patients who pay cash directly. Cash-only physicians are also able to spend more time with patients and often charge less than those who take insurance (Parnell 2013). Cash-only physicians do not have to spend precious time filling out insurance paperwork, and the savings result in lower prices and better quality for patients.

Health Care Sharing Ministries

Health care sharing ministries (HCSMs) are faith-based alternatives to conventional health insurance. Members pay monthly “shares” of approximately \$200 per individual or \$500 per family (Glans 2017b). As medical needs arise, members pay a portion of their expenses and forward their bills to their HCSM. The HCSM reimburses members for most of their expenses, with the “share” money contributed by other members. Approximately 625,000 people in the United States had memberships in HCSMs in 2016 (Sledge 2016).

HCSMs reimburse patients rather than pay doctors and other providers, a key difference that leads to lower spending. Members of the HCSMs are aware of how much is being spent on care by the group, and their monthly shares rise and fall based on it, further encouraging careful attention to costs. The ministries are nonprofit, which allows them to save some money on salaries and payouts to shareholders.

According to a 2015 report from the Charlotte Lozier Institute, “The savings will vary depending on the specific sharing ministry. Overall, the savings can range from 45 percent to 60 percent below the cost of health insurance sold in the individual market, depending on the ministry plan selected” (Daniels 2015).

Recommended Readings: Scott E. Daniels, *Health Care Sharing Ministries: An Uncommon Bond* (Washington, DC: Charlotte Lozier Institute, 2015); Sean Parnell, *The Self-Pay Patient* (website).

10. Reduce malpractice litigation expenses.

Malpractice insurance, litigation, and defensive medicine add to the unnecessarily high cost of health care in the United States.

Malpractice insurance, litigation, and defensive medicine add to the unnecessarily high cost of health care in the United States. Some of this expense is caused by over-reliance on third-party payers, which makes it difficult for patients to hold providers accountable for their mistakes without resorting to lawsuits.

The High Cost of Malpractice Litigation

In real terms, malpractice claims grew tenfold, and malpractice premiums tripled from the mid-1970s to 2005 (Frank and Grace 2006). Malpractice expenses grew 62.8 percent from 2005 to 2009, and although they have stabilized since 2009, the increase from 2002 to 2013 still equaled 81 percent (AMA 2013).

Even though doctors win an overwhelming majority of medical malpractice cases, these claims still impose huge costs on doctors and insurers. The average legal cost exceeds \$46,000 in cases where the doctor successfully defends against a malpractice case—an increase of almost 63 percent since 2001—and is near \$27,000 in cases where a claim is dismissed or dropped (AMA 2011).

Lawsuit abuse leads to “defensive medicine,” the practice of physicians, hospital administrators, and other providers ordering tests and filing reports solely for the sake of reducing the possibility of litigation in the event a patient does not get well. One estimate puts the cost of defensive medicine at \$480 billion annually (Oliver and Segal 2014).

Issues Regarding Award Caps

The plaintiff’s bar and even some reform advocates say caps on awards discourage attorneys from taking on risky cases, deny appropriate compensation to victims of medical malpractice, and send a signal to hospitals and doctors that life-threatening mistakes are tolerable (Hyman and Silver 2006). Others are concerned federal legislation limiting awards or legal fees would usurp traditional state authority over matters of health care and tort law (Martin 2011).

Although these concerns are legitimate, caps may be a necessary part of an overall legal reform strategy because the plaintiff’s bar opposes other reforms that would reduce their financial windfalls while ensuring victims receive fair and speedy compensation.

The Texas Experience

The experience in Texas since 2003 provides a model for state-level reform of malpractice litigation. In 2003, legislation was passed containing the following provisions (this summary is by Roger Stark, M.D. (2016)):

- Juries should hear more evidence about who may really be at fault.
- Only those individuals who cause harm should pay, and then only to the extent of their own fault.

- Damages should be limited to the amount the injured patient paid or incurred or what someone, like an insurance company, paid or incurred on their behalf, thereby eliminating “phantom damages.”
- A medical report written by a physician in the same or similar field as the physician being sued should be submitted within 120 days of the filing of a lawsuit, clearly identifying the appropriate standard of care, how the standard of care was violated, and the damages that resulted from the violation of the standard of care.
- Non-economic damages should be capped at \$250,000 for any and all doctors sued with an additional cap of \$250,000 for each of up to two medical care institutions.
- Other procedural and substantive devices, such as forum shopping, used to tilt the scales of justice should be eliminated.

Malpractice insurance premiums in Texas dropped about 60 percent in the 10 years following passage of the legislation, and the number of licensed physicians in the state nearly doubled (Nixon and Texas Public Policy Foundation 2013). More recently, in 2016, Texas saw a malpractice insurance premium decrease of 0.5 percent (*Insurance Journal* 2016).

Dr. Stark concludes, “The experience of Texas shows that reasonable medical malpractice reform works. A meaningful legal cap on non-economic damages is the most effective element of successful lawsuit reform legislation. To a lesser extent, a statute of limitations on lawsuits and pre-trial screening are often effective in reducing the cost of specific medical malpractice lawsuits.”

Other states that have passed legislation to reduce the cost of malpractice litigation include Alaska, California, Colorado, Florida, Maine, Michigan, Oklahoma, and Utah.

Reform Agenda

We recommend states follow the lead of Texas by adopting the policies summarized above.

Recommended Readings: Joseph Nixon and Texas Public Policy Foundation, “Ten Years of Tort Reform in Texas: A Review,” *Background* No. 32830, The Heritage Foundation, 2013; Roger Stark, “The Cost of Medical Malpractice Lawsuits in Washington State—Lessons from Texas Reform,” Washington Policy Center, April 2016.

References

- AAPS (Association of American Physicians and Surgeons). 2017. *White Paper on Repeal/Replacement of the Affordable Care Act*. January 6.
- Accenture. 2015. *US Retail Health Clinics Expected to Nearly Double by 2017 According to Accenture Analysis*.
- Adamson, David M. 2010. "Health Care on Aisle 7: The Growing Phenomenon of Retail Clinics." *Research Highlights*. Rand Corporation.
- Agrawal, Vishal, Tilman Ehrbeck, Kimberly O'Neill Packard, and Paul Mango. 2005. *Consumer-Directed Health Plan Report—Early Evidence Is Promising*. Pittsburgh, PA: McKinsey & Company.
- AHIP (America's Health Insurance Plans). 2017. "2016 Census of Health Savings Account – High Deductible Health Plans." February.
- Alonso-Zaldivar, Ricardo. 2016. "Obama Administration Announces Double-Digit Premium Hikes for Affordable Care Act." Associated Press. October 24.
- AMA (American Medical Association). 2011. "New AMA Studies Show Cost Burden of the Medical Liability System." December 21.
- . 2013. *Advocacy Update*. Chicago, IL: American Medical Association.
- American Funds. 2017. "Health Savings Accounts Are Growing at a Healthy Pace." March 20.
- Asch, Steven M., Eve A. Kerr, Joan Keeseey, John L. Adams, Claude M. Setodji, Shaista Malik, and Elizabeth A. McGlynn. 2006. "Who Is at Greatest Risk for Receiving Poor-Quality Health Care?" *New England Journal of Medicine* **354** (11): 1147–56. doi:10.1056/NEJMsa044464.
- Associated Press. 2013. "Policy Notifications and Current Status, By State." *Yahoo! Finance* (website). December 26.
- Azar, Alex M. II, *et al.* 2006. "Transparency in Health Care: What Consumers Need to Know." Speech delivered at The Heritage Foundation. October 3.
- Baicker, Katherine, Sarah L. Taubman, Heidi L. Allen, Mira Bernstein, Jonathan H. Gruber, Joseph P. Newhouse, Eric C. Schneider, Bill J. Wright, Alan M. Zaslavsky, and Amy N. Finkelstein. 2013. "The Oregon Experiment—Effects of Medicaid on Clinical Outcomes." *New England Journal of Medicine* **368** (May): 1713–22. doi:10.1056/NEJMsa1212321.
- Barnes, John. 2006. "Failure of Government Central Planning: Washington's Medical Certificate of Need Program." *Policy Brief*. Washington Policy Center.
- Bast, Diane Carol. 2005. "Bill Would Allow Consumers to Purchase Health Insurance across State Lines." *Health Care News*. June.
- Bast, Joseph L. 2004. "Destroying Insurance Markets: How Community Rating and Guaranteed Issue Have Destroyed the Individual Insurance Market in Eight States." *Health Care News*. February.
- Bast, Joseph, Richard Rue, and Stuart Wesbury. 1993. *Why We Spend Too Much on Health Care*. Chicago, IL: The Heartland Institute.

- Bisu, Rituparna. 2013. *The Broken State of American Health Insurance Prior to the Affordable Care Act: A Market Rife with Government Distortions*. Irvine, CA: Ayn Rand Institute.
- Blue Cross and Blue Shield Association. 2005. "Blue Cross and Blue Shield Association Consumer Survey Shows High Rate of Satisfaction with HSAs, Cites Increased Reliance on Decision-Support Tools." September 29.
- Brase, Twila. 2017. "About." *The Wedge of Health Freedom* (website).
- Bryan, Darcy N., Jared Rhoads, and Robert Graboyes. 2016. "Occupational Regulation." Mercatus Center Healthcare Openness and Access Project. December 1.
- Bunce, Victoria Craig. 2002. "Dirty Little Secrets about Clean Claims Laws." *Issues & Answers*. Council for Affordable Health Insurance. November.
- . 2013. *Health Insurance Mandates in the States, 2012*. Washington, DC: Council for Affordable Health Insurance.
- CBO (Congressional Budget Office). 2014. "Labor Market Effects of the Affordable Care Act: Updated Estimated." Appendix C in *The Budget and Economic Outlook: 2014 to 2024*. Washington, DC: Congressional Budget Office.
- CBS News. 2017. "What Happens When the Only Health Insurer Exits?" March 6.
- Chen, Caroline. 2014. "Obamacare Insurer Wellpoint Sees Double-Digit Rate Rise." *Bloomberg News* (website). March 25.
- Cigna. 2013. *Cigna Choice Fund Experience Study: Summary of Key Findings*. Bloomfield, CT: Cigna Health and Life Insurance Company.
- Claxton, Gary, Matthew Rae, Nirmita Panchal, Anthony Damico, Nathan Bostick, Kevin Kenward, and Heidi Whitmore. 2013. *Employer Health Benefits: 2013 Annual Survey*. Menlo Park, CA: Henry J. Kaiser Family Foundation; Chicago, IL: Health Research & Educational Trust.
- Clements, Nick. 2016. "Obamacare Premiums Increase 25%: Is the 'Death Spiral' Here?" *Forbes* (website). October 25.
- CMS (Centers for Medicare and Medicaid Services). 2012. *National Health Expenditures; Aggregate and Per Capita Amounts, Annual Percent Change and Percent Distribution: Selected Calendar Years 1960–2012*.
- Conover, Christopher. 2013. "No, David Axelrod, the 'Vast Majority of People in This Country' Are Not Keeping Their Plan." *Forbes* (website). October 30.
- Conover, Christopher J., and Frank A. Sloan. 1998. "Does Removing Certificate-of-Need Regulations Lead to a Surge in Healthcare Spending?" *Journal of Health Politics, Policy and Law* **23** (3): 455–81.
- Cordato, Roy. 2005. "Certificate-of-Need Laws: It's Time for Repeal." *Nathaniel Macon Research Series* No. 1. John Locke Foundation.
- Corieri, Christina. 2014. "Everyone Deserves the Right to Try: Empowering the Terminally Ill to Take Control of their Treatment." Goldwater Institute.
- Council for Affordable Health Insurance. 2007. *HSA State Implementation Report*.
- Daniels, Scott E. 2015. *Health Care Sharing Ministries: An Uncommon Bond*. Washington, DC: Charlotte Lozier Institute.

- deBrantes, Francois, and Suzanne Delbanco. 2016. *Report Card on State Price Transparency Laws*. Health Care Incentives Improvement Institute. July.
- DeNavas-Walt, Carmen, Bernadette D. Proctor, and Jessica C. Smith. 2013. *Income, Poverty, and Health Insurance Coverage in the United States: 2012*. Washington, DC: U.S. Government Printing Office.
- Dubay, Curtis. 2013. "After Repeal of Obamacare: Moving to Patient-Centered, Market-Based Health Care." The Heritage Foundation. October 31.
- Emanuel, Jeff. 2008. "Health Savings Accounts." *Research & Commentary*. The Heartland Institute. May 15.
- Employee Benefits Research Institute. 2015. "Satisfaction with Health Coverage and Care: Findings from the 2014 EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey." *Notes* 36 (7).
- Ferrara, Peter. 2010. *The Obamacare Disaster*. Chicago, IL: The Heartland Institute.
- . 2015. *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*. Arlington Heights, IL: The Heartland Institute.
- Finkelstein, Amy. 2007. "The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare." *Quarterly Journal of Economics* 122 (3): 1–37. doi:10.3386/w11619.
- Flowers, Aricka T. 2007. "National Market Could Cure America's Health Care Crisis: Policy Analysts." *Health Care News*. January.
- Frank, Ted, and Martin F. Grace. 2006. "Faulty Studies from Center for Justice & Democracy Are Stunting the Medical-Malpractice Debate." *Liability Outlook* No. 2. American Enterprise Institute.
- Friedman, Milton. 2004. *Interview with Fox News*. May.
- Gabel, Jon R., Ryan Lore, Roland D. McDevitt, Jeremy D. Pickreign, Heidi Whitmore, Michael Stover, and Ethan Levy-Forsythe. 2012. "More Than Half of Individual Health Plans Offer Coverage That Falls Short of What Can Be Sold through Exchanges as of 2014." *Health Affairs* 31 (6): 1339–48. doi:10.1377/hlthaff.2011.1082.
- GAO (Government Accountability Office). 2011. *Health Care Price Transparency: Meaningful Price Information Is Difficult for Consumers to Obtain Prior to Receiving Care*. GAO–11–791. September.
- . 2017. "Progress on Many High-Risk Areas, While Substantial Efforts Needed on Others."
- Garfield, Rachel, Anthony Damico, Cynthia Cox, Gary Claxton, and Larry Levitt. 2016. "Estimates of Eligibility for ACA Coverage among the Uninsured in 2016." Kaiser Family Foundation. October 18.
- Giuliani Partners. 2005. *Examination and Assessment of Prescription Drug Importation from Foreign Sources to the United States*. Washington, DC: Pharmaceutical Research and Manufacturers of America.
- Glans, Matthew. 2014a. "Experimental Drugs and the Right to Try." *Research & Commentary*. The Heartland Institute.
- . 2014b. "Certificate of Need Reform." *Research & Commentary*. The Heartland Institute. November 13.

- . 2016a. “Michigan Direct Primary Care Pilot Could Save Medicaid Millions.” *Research & Commentary*. The Heartland Institute. May 31.
- . 2016b. “Are Maintenance of Certification Programs a Money Grab?” *Research & Commentary*. The Heartland Institute. April 22.
- . 2017a. “State High-Risk Pools for Health Insurance.” *Research & Commentary*. The Heartland Institute. May 25.
- . 2017b. “Health Care Sharing Ministries a Good Alternative to ACA.” *Research & Commentary*. The Heartland Institute. January 27.
- . 2017c. “Missouri Should Avoid Overregulating Dental Service Organizations.” *Research & Commentary*. The Heartland Institute. June 21.
- Gohmann, Stephan F., and Myra J. McCrickard. 2009. “The Effect of State Mandates on Health Insurance Premiums.” *Journal of Private Enterprise* 24 (2): 59–73.
- Goodman, John C. 2005a. “Drug Reimportation: The Free Trade Solution.” *Brief Analyses* No. 503. National Center for Policy Analysis.
- . 2005b. “Making HSAs Better.” *Brief Analyses* No. 518. National Center for Policy Analysis.
- . 2009. “Does Lack of Insurance Cause Premature Death?” *Health Affairs Blog*. September 21.
- . 2012. *Priceless: Curing the Health Care Crisis*. Oakland, CA: Independent Institute.
- Goodman, John C., and Dorman E. Cordell. 1998. “The Nightmare in Our Future: Elderly Entitlements.” *Policy Report* No. 212. National Center for Policy Analysis.
- Goodman, John C., and Gerald L. Musgrave. 1992. *Patient Power: Solving America's Health Care Crisis*. Washington, DC: Cato Institute.
- Gorman, Linda. 2008. “Dying for (Media) Coverage.” *Health Policy Blog*. May 2.
- Gottlieb, Scott. 2011. “Medicaid Is Worse Than No Coverage at All.” *The Wall Street Journal*. March 10.
- Graham, John R. 2008. *From Heart Transplants to Hairpieces: The Questionable Benefits of State Benefit Mandates for Health Insurance*. San Francisco, CA: Pacific Research Institute.
- Hamilton, Michael. 2016a. “More States Consider Outlawing Forced Maintenance of Certification.” June 7.
- Hamilton, Michael. 2016b. “Policy Diagnosis: Direct Primary Care Helps Patients, Doctors, and the Health Care System.” Interview with Hal Scherz, M.D., founder of Docs4PatientCare. *Health Care News*. April 6.
- Hamilton, Michael, Bette Grande, and John Davidson. 2016. “The Case for Licensing Dental Therapists in North Dakota.” *Policy Brief*. The Heartland Institute.
- Herrick, Devon M. 2006a. “Telemedicine Provides Benefits, but Security and Privacy Risks Abound.” *Health Care News*. June.
- . 2006b. “Medical Tourism Prompts Price Discussions.” *Health Care News*. October.
- . 2006c. “Shopping for Drugs: 2007.” *Policy Report* No. 293. National Center for Policy Analysis.

- Herrick, Devon M. and John C. Goodman. 2007. "The Market for Medical Care: Why You Don't Know the Price; Why You Don't Know about Quality; And What Can Be Done about It." *Policy Report* No. 296. National Center for Policy Analysis. March 12.
- HHS (Department of Health and Human Services). 2017. "HHS Report: Average Health Insurance Premiums Doubled Since 2013."
- Hogberg, David. 2013. "Congress Should Repeal Limits on New Doctor-Owned Hospitals." *Washington Examiner*. March 6.
- . 2014a. "Obamacare's Little Noticed Victims." *American Spectator*. February 20.
- HSA for America. 2017. "States Following Federal HSA Tax Treatment."
- Hyman, D.A. and Silver, C. 2006. "Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid." *Vanderbilt Law Review* **59** (4): 1085.
- Insurance Journal. 2016. "Medical Malpractice Liability Premiums Remain Flat: Survey." October 10.
- Jacobs, Chris. 2017. "Summary of Repeal and Replace Amendments." *Chris Jacobs on Health Care*. May 4.
- Japsen, Bruce. 2015. "Retail Clinics Hit 10 Million Annual Visits But Just 2% Of Primary Care Market." *Forbes* (website). April 23.
- KFF (Kaiser Family Foundation). 2015. "Distribution of the Nonelderly Uninsured by Federal Poverty Level (FPL)."
- Kleba, Heather. 2007. "A Health Link Hits Home." *Governing*. March.
- Kullgren, Jeffrey T., Katia A. Duey, and Rachel M. Werner. 2013. "A Census of State Health Care Price Transparency Websites." *Journal of the American Medical Association*. June 19.
- Levy, Helen, and David Meltzer. 2008. "The Impact of Health Insurance on Health." *Annual Review of Public Health* **29**: 399–409.
- Lichtenberg, Frank R. 2007. "Benefits and Costs of Newer Drugs: An Update." *Managerial and Decision Economics* **28** (4–5): 485–90. doi:10.1002/mde.1355.
- LoBuono, Charlotte. 2006. "Cost Comparison Web Sites Enhance Choice for Prescription Drug Buyers." *Health Care News*. November.
- Madden, Bartley J., and Gregory Conko. 2010. *Free to Choose Medicine: Better Drugs Sooner at Lower Cost*. Chicago, IL: The Heartland Institute.
- Makla, Nathan, and Matthew Glans. 2016. "Direct Primary Care Saves Union County, North Carolina \$1 Million." *Research & Commentary*. The Heartland Institute. March 21.
- Martin, Maureen. 2011. "Heartland Institute Legal Expert Can Talk About New HEALTH Act, Tort Reform." May 12.
- Martin, Trevor. 2007. "Retail Health Clinics." *Research & Commentary*. The Heartland Institute.
- McCorry, Daniel. 2014. "Direct Primary Care: An Innovative Alternative to Conventional Health Insurance." August 6. The Heritage Foundation.
- McKeown, Karen D. 2011. "Empowering Patients as Key Decision Makers in the Face of Rising Health Care Costs." *Backgrounders* No. 2635. The Heritage Foundation. December.

Medicare Board of Trustees. 2007. *2007 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. Washington, DC: Centers for Medicare and Medicaid Services.

———. 2013. *2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. Washington, DC: Centers for Medicare and Medicaid Services.

Meier, Conrad F. 1999. "Extending Affordable Health Insurance to the Uninsurable." *Policy Study*. The Heartland Institute. August 27.

Meier, Conrad F. 2005a. *Destroying Insurance Markets: How Guaranteed Issue and Community Rating Destroyed the Individual Health Insurance Market in Eight States*. Washington, DC: Council for Affordable Health Insurance and Chicago, IL: The Heartland Institute.

———. 2005b. "Campaign for Drug Importation Falters." *Health Care News*. February.

Moses, Stephen A. 2017. "How to Fix Long-Term Care Financing." Center for Long-Term Care Reform and the Foundation for Government Accountability. July 26.

NAHU (National Association of Health Underwriters). 2005. "Analysis of State-Level Health Insurance Market Reforms."

Neuman, Patricia, Michelle Kitchman Stollo, Stuart Guterman, William H. Rogers, Angela Li, Angie Mae C. Rodday, and Dana Gelb Safran. 2007. "Medicare Prescription Drug Benefit Progress Report: Findings from a 2006 National Survey of Seniors." *Health Affairs* 26 (5): w630–43. doi:10.1377/hlthaff.26.5.w630.

Nixon, Joseph, and Texas Public Policy Foundation. 2013. "Ten Years of Tort Reform in Texas: A Review." *Backgrounder* No. 32830. The Heritage Foundation.

OFR (Office of the Federal Register). 2010. "Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act." *Federal Register* 75 (116).

Oliver, Wayne, and Jeffrey Segal. 2014. "Do not Reform The Malpractice System To Reduce Healthcare Cost—Eliminate It." *Forbes* (website). November 5.

Ollove, Michael. 2017. "ACA Repeal Could Mean Return to 'High-Risk Pools.'" Pew Charitable Trust. February 16.

Palmieri Heck, Mia. 2017. "Overregulation Threatens Market-Driven Solutions in Dentistry." *The State Factor*. American Legislative Exchange Council.

Parnell, Sean. 2005a. "Nurse Practitioners Offer Effective, Low-Cost Care." *Health Care News*. October.

———. 2005b. "Specialty Hospitals Offer Savings, Improved Care in Future." *Health Care News*. January.

———. 2013. "Direct Primary Care Practices—Why Are They So Much Less Expensive?" *The Self-Pay Patient* (website). December 17.

———. 2014. "Wisconsin Direct Primary Care Practice Closing, But More Opening Nationally." *The Self-Pay Patient* (website). January 2.

Pioneer Institute, 2016. "National Survey Finds Limited Access To Price Estimates For Routine Hospital Procedure." February 21.

Pitts, Peter J. 2006. "Pharmaceutical Fakery is Health Care Terrorism." *Baltimore Sun*. August 15.

- Restrepo, Katherine. 2016. "Union County Saves Big With Direct Primary Care." *Carolina Journal*. March 15.
- Shatto, John D., and Kent Clemens. 2010. *Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers*. Office of the Actuary, Centers for Medicare and Medicaid Services. August 5.
- Sledge, Hayley. 2016. "Despite Increases, Health Care Ministry 'Shares' Stay Cheaper Than Insurance Premiums." *Health Care News*. November 29.
- Stark, Roger. 2016. "The Cost of Medical Malpractice Lawsuits in Washington State—Lessons from Texas Reform." Washington Policy Center. April 11.
- Stuart, Bruce C., Jalpa A. Doshi, and Joseph V. Terza. 2009. "Assessing the Impact of Drug Use on Hospital Costs." *Health Services Research* **44** (1): 128–44. doi:10.1111/j.14756773.2008.00897.x.
- Thorpe, Kenneth E., and John C. Goodman. 2005. *Reforming the Health Care System*. Muncie, IN: Ball State University and Chicago, IL: The Heartland Institute.
- Turner, Grace-Marie, and Conrad F. Meier. 2004. "Prescription Drug Importation: Just the Facts." *Health Care News*. June 1.
- Ungar, Rick. 2013. "The Great American Hospital Pricing Scam Exposed—We Now Know Why Healthcare Costs Are So Artificially High." *Forbes* (website). May 8.
- Vinton, Emma. 2017. "Virginia Lawmakers Approve Direct Primary Care Bills—Again." *Health Care News*. February 28.
- VISA. 2017. "Mapping the Future of Global Travel and Tourism."
- Wieske, J.P. 2007. *State Legislators' Guide to Health Insurance Solutions*. Washington, DC: Council for Affordable Health Insurance.
- Wieske, J.P., and Merrill Matthews. 2007. *Understanding the Uninsured and What to Do About Them*. Washington, DC: Council for Affordable Health Insurance.

Additional Resources

Additional information about health care policy is available from The Heartland Institute:

- PolicyBot, The Heartland Institute's free online clearinghouse for the work of other free-market think tanks, contains thousands of documents on health policy issues. It is on Heartland's website at <https://www.heartland.org/policybot/>.
- <https://www.heartland.org/Center-Health-Care/> is the website of Consumers for Health Care Choices, devoted to the latest research, news, and commentary about health care policy issues. Read headlines, watch videos, or browse the thousands of documents on health care policy issues available from PolicyBot.

- From July 2001 until September 2017, Heartland produced *Health Care News*, a monthly newspaper devoted to health policy issues. It also produced *Consumer Power Report*, a weekly e-newsletter devoted to health policy, between August 2009 and September 2017. Back issues of both publications are available online at <https://www.heartland.org/publications-resources/newsletters>, and new issues will be posted there if the publications resume.

Directory

The following national organizations provide valuable information about health care financing and policy.

Alliance of Health Care Sharing Ministries,
<http://www.healthcaresharing.org/>

Association of American Physicians and Surgeons, <http://aapsonline.org/>

Cato Institute, <https://www.cato.org/>

Center for Long-Term Care Reform, <http://www.centerltc.com/>

Charlotte Lozier Institute, <https://lozierinstitute.org/>

Citizens Council for Health Freedom, <http://www.cchfreedom.org/>

Docs4Patient Care Foundation, <https://d4pcfoundation.org/>

DPC Frontier, <http://www.dpcfrontier.com/>

Employee Benefit Research Institute, <https://www.ebri.org/>

Free to Choose Medicine, <http://www.freetochoosemedicine.com/>

Galen Institute, <http://galen.org/>

Goldwater Institute, <http://goldwaterinstitute.org/en/>

Goodman Institute for Public Policy Research,
<http://www.goodmaninstitute.org/>

Heartland Institute, <https://www.heartland.org/>

Heritage Foundation, <http://www.heritage.org/>

HSA for America, <http://www.hsaforamerica.com/>

Kaiser Family Foundation, <http://www.kff.org/>

The Self-Pay Patient, <http://theselfpaypatient.com/>

The Wedge of Health Freedom, <https://jointhewedge.com/about/>