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# HEALTH CARE NEWS



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## The Pulse



# Congress Faces Abuses of 340B Drug Discount Program

Sens. John Thune (R-SD), pictured speaking, and Shelley Moore Capito

PHOTO COURTESY SAMUEL CORUM/STRINGER/GETTY IMAGES NEWS

**By Bonner Russell Cohen**

A bipartisan group of U.S. senators is seeking feedback on a controversial program that requires drug makers to sell drugs at a discount to hospitals and clinics serving low-income areas.

A "discussion draft" of the SUSTAIN 340B Act, unveiled on February 2, aims to clarify provisions of the drug discount program that critics say cause waste and abuse. The 340B program was established by the 1992 Health Services Act and is administered by the Health Resources and Services Administration (HRSA), an agency within the Department of Health and Human Services (HHS).

The measure's future is uncertain as the stakes for hospitals and pharmaceutical companies are high. However, at a time of deep partisan divisions on Capitol Hill, the bipartisan draft to fix 340B shows mounting concerns with the program.

**340B REFORM, p. 4**

# Michigan Requires Coverage of Expensive Cancer Therapies

**By AnneMarie Schieber**

The Michigan Department of Insurance and Financial Services (DIFS) issued a bulletin reminding health insurance companies they are bound by state law to cover all approved cancer drugs, even if treatments cost hundreds of thousands of dollars and may be ineffective.

The DIFS issued the bulletin after an article published by the activist journalism group ProPublica reported an insurance company, Priority Health, denied coverage to a Michigan cancer

**MICHIGAN REQ, p. 6**

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# Is Medical Debt Forgiveness a Good Idea?

**By Kenneth Artz**

Americans owe at least $220 billion in medical debt, according to a KFF analysis of government survey data, and there is growing support for measures to relieve patients of this financial burden.

About 14 million people, or 6 percent of the adult population of the United States, are facing medical bills of more than $1,000, and three million people (1 percent of adults) owe more than $10,000 in unpaid medical bills, according to KFF.

The Biden administration touts its efforts to reduce medical debt through increased Obamacare enrollment and regulations to eliminate unpaid medical bills as a factor in credit scoring by private bureaus. In addition, a growing number of local governments, including New York City and Cook County, Illinois, are erasing billions of dollars in medical debts by using private donors' funds, National Public Radio reports.

President Joe Biden

**"At a minimum, we should let the debt be reduced to the hospital's cash price [announced in advance to the uninsured] or to a national, free-market price charged, say, to Canadians and other medical tourists."**

**JOHN C. GOODMAN**
**PRESIDENT**
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### Two Sides of a Coin

Someone always pays, whether through cost shifting as in Obamacare, or other government fixes, such as medical debt relief, says Matt Dean, a senior fellow for health care policy outreach at The Heartland Institute, which publishes *Health Care News*.

Congress should consider free-market reforms, says Dean, such as those proposed by Rep. Pete Sessions (TX-R); John C. Goodman, president of the Goodman Institute and co-publisher of *Health Care News;* and a bipartisan bill to make health care costs more transparent.

"Pete Sessions hits the nail on the head," said Dean. "Reform that only focuses on the payment side or the delivery side misses the importance of the balance between the two. Congressman Sessions understands that you need services to pay for and a way to pay for them."

### 'Medical Debts Are Phony Numbers'

Hospital prices are not really prices but instead are simply the amounts that hospitals charge patients when they are discharged, says Goodman.

These charges are phony for three reasons, says Goodman. First, the charges are not determined by market prices. Second, there are different charges for different patients, depending on their third-party insurers. Third, patients are never told a specific amount to pay before admission.

"For those same three reasons, medical debts are phony numbers," said Goodman. "Why, then, should a patient be obligated to pay a phony number?"

The debt of patients struggling to pay medical bills should be discounted, says Goodman.

"At a minimum, we should let the debt be reduced to the hospital's cash price [announced in advance to the uninsured] or to a national, free-market price charged, say, to Canadians and other medical tourists," said Goodman. "In addition, we should adjust the debt to some reasonable percent of the patient's income to reflect the fact that hospitals receive an enormous amount of federal money to provide charity care for low-income patients."

### Push for Single-Payer

Medical debt is falsely used as an argument for a single-payer health care system, says Roger Stark, M.D., a health care policy analyst at the Washington Policy Center and policy advisor to The Heartland Institute.

"Financial debt and bankruptcy are real problems for a small percent of Americans," said Stark. "Yet, if we look at a fixed point in time, a much larger percent of Americans has debt they are paying down. The KFF article even admits that some people are essentially financially irresponsible."

Medical debt forgiveness would involve the government even more deeply in paying for health care while ignoring other solutions, says Stark. "Unfortunately, many people, including the mainstream media, believe that bureaucrats have all the answers to our health care delivery system problems," said Stark.

There are market solutions to high medical costs, says Stark, including health savings accounts, price transparency, changes to the federal tax code, insurance regulatory reform, elimination of costly mandates, and greater use of telemedicine and association health plans.

### Welfare-State Rights

Socialists continually manipulate health care to promote further increases in government power, says John Dale Dunn, M.D., J.D., a physician and policy advisor to The Heartland Institute.

"It is a government program to address a need," said Dunn. "Medical care is the place where socialists can promote their welfare programs, followed in order by other areas of need outlined by FDR in his 1944 State of the Union address.

"FDR declared the government must provide for a second bill of rights—the right to a totalitarian and autocratic welfare state," said Dunn. "Imagine that."

*Kenneth Artz* (**KApublishing@gmx.com**) *writes from Tyler, Texas.*

# Congress Faces Abuses of 340B Drug Discount Program

Sens. John Thune (R-SD), pictured speaking, and Shelley Moore Capito.

PHOTO COURTESY SAMUEL CORUM/STRINGER/GETTY IMAGES NEWS

**Continued from page 1**

**'Rebates Result in Profits'**

In a November 2022 study for the Pacific Legal Foundation, Wayne H. Winegarden pointed to one of the program's most frequently cited unintended consequences.

"The program has turned into a large profit-generator because 340B hospitals pocket the difference between their costs—based on discounted prices from drug manufacturers—and reimbursements from Medicare or insurers based on undiscounted prices," Winegarden wrote. "These rebates result in profits that can be more than 9 to 10 times those earned by non-340B providers for administering the same drugs."

The discussion draft is a critical first step in reforming the program, says Moshe Chasky, M.D., an oncologist with Alliance Cancer Specialists, which claimed in a lawsuit that 340B was a reason a large hospital system canceled the group's doctors' admitting privileges (see related article, page 5).

"It is encouraging that attention is now being paid on both sides of the aisle to the abuses of the 340B program," said Chasky. "340B was intended to be used to care for impoverished communities and has gone off the rails, now being used unabashedly by many institutions as a profit center even in well-heeled communities."

**"The program is driving up the cost of drugs and care overall. As an independent practice without 340B, we have never turned away a patient and have always treated every patient no matter their ability to pay. Our community has always depended on our group, and because of this abused program, our hospital privileges in oncology and hematology were rescinded."**

**MOSHE CHASKY, M.D.**
**ONCOLOGIST**

**Need for 'Statutory Clarity'**

While acknowledging several "concerns from stakeholders" about various aspects of the program, the "discussion draft" lacks concrete proposals. Instead, the draft identifies areas where "statutory clarity" is needed and seeks stakeholder input on ways to improve 340B. This can be seen in the discussion of "contract pharmacies" in the draft.

"Since the inception of the 340B program, covered entities [340B hospitals] have often used contract pharmacies to expand the locations and hours at which patients can access 340B drugs, particularly if they have no in-house pharmacies or cover a large service area. … Due to lack of statutory clarity, there has been ambiguity over the use of contract pharmacy arrangements which has led to litigation," the draft notes.

"Some stakeholders have expressed concern about the number of contract pharmacies used by some covered entities," states the draft. "The number of contract pharmacies used by individual covered entities ranges from 0 to 439 with the average covered entity who uses contract pharmacies using 12. We would appreciate stakeholder feedback on how to achieve the correct balance of patient access, accountability, and program integrity in the use of contract pharmacy arrangements."

Confusion also exists over what constitutes a 340B patient.

"The 340B statute does not include a definition of patient," the draft notes. In 1996, HRSA proposed a definition but later withdrew it, and Congress failed to provide a definition.

**Transparency and Integrity**

When it comes to the 340B program's transparency and integrity, the discussion draft is prescriptive.

"We believe that requiring covered entities to report detailed information regarding their program savings, policies, patient and prescription information and then enabling that information to be publicly available by the Secretary [of HHS] will help ensure all stakeholders have trust and confidence that the program is being used as intended," the draft states.

The language is equally tough in regard to 340B program integrity.

"We propose language that would require the Secretary to issue additional guidance regarding audits in the program and provide appropriate consequences if a covered entity does not meet compliance requirements," the draft states.

**'Reason to Bully' Doctors**

Ge Bai, Ph.D., CPA, a professor of accounting at Johns Hopkins Carey Business School and professor of health policy and management at Johns Hopkins Bloomberg School of Public Health, says hospitals are taking unfair advantage of the 340B program.

"This 'buy low, sell low' program for safety-net hospitals has evolved into a 'buy low, sell high' program for eligible, tax-exempt hospitals, who can generate substantial profits by providing these drugs to well-insured patients," said Bai.

"We cannot continue to have hospitals use 340B as the reason to bully out independent practices for the sole purpose of profiteering in high-cost centers," said Chasky.

"The program is driving up the cost of drugs and care overall," said Chasky. "As an independent practice without 340B, we have never turned away a patient and have always treated every patient no matter their ability to pay. Our community has always depended on our group, and because of this abused program, our hospital privileges in oncology and hematology were rescinded."

*Bonner Russell Cohen, Ph.D.* (**bcohen@nationalcenter.org**) *is a senior fellow at the National Center for Public Policy Research.*

# Did Discounted Drugs Prompt Hospital to Cancel Independent Doctors?

**By Bonner Russell Cohen**

A group of cancer doctors is considering its next legal step in a case that sheds light on a government drug program created to help the needy.

In September, Jefferson Health-Northeast (Jefferson) revoked the hospital practice privileges of physicians with Alliance Cancer Specialists (Alliance). Jefferson is one of the largest hospital systems in the Philadelphia area, and Alliance is the largest oncology and hematology practice there. Alliance sued and lost.

"We are in a transition point," said Moshe Chasky, M.D., an oncologist with Alliance. "I don't want to give up, because at the end of the day we want to be able to see our patients in consultation when they're admitted into the hospital."

**"The 340B program artificially—if not deceptively—lowers the price of medicines for certain entities. So, it should come as no surprise that these entities would do everything they can to capitalize on that advantage by expanding their practice, even at the expense of non-qualified entities—and their patients."**

**JEFF STIER**
**SENIOR FELLOW**
**CONSUMER CHOICE CENTER**

### Taking Oncology In-House

Jefferson says it entered into an exclusive agreement with its own medical group to provide inpatient and outpatient oncology and hematology services, Medscape reported on November 1.

Even so, Alliance doctors should have access to their patients, says Chasky.

"Our intent is not to take away any 'new' hospital consults," said Chasky. "Shouldn't the patient be at the epicenter of what we are talking about? This clearly leads to inferior patient care when we are not involved [with] our own patients."

Independent oncology groups nationwide are watching the case closely for fear they, too, could lose their admitting privileges, Medscape reported.

### Antitrust Violations Alleged

Alliance physicians had admitting privileges at Jefferson's hospitals for years. In its lawsuit, Alliance claims the hospital system is trying to create a monopoly in oncology and hematology services in the Philadelphia area.

In a court filing, Jefferson said its action was in "the best interest of patients, as it would ensure better integration and availability of care and help ensure that Jefferson consistently provides high-quality medical care in accordance with evidence-based standards."

In a September 18 ruling, U.S. District Judge Kai Scott rejected Alliance's argument that the revocation of admitting privileges violated federal antitrust laws and inflicted irreparable harm on the group. Scott said she would consider another motion if Alliance could present stronger arguments on Jefferson's antitrust violations and on the irreparable harm resulting from Jefferson's actions, Medscape reported.

"Jefferson did compromise on allowing us privileges as internists, but not as oncologists, which means they will not consult with us on our own patients," said Chasky. "Basically, the hospital is prohibiting us from writing a note in a patient's chart."

### Hospitals Acquire Practices

Merrill Matthews, Ph.D., a resident scholar at the Institute for Policy Innovation, says the underlying issue in this case may be the ongoing consolidation of health care imposed by hospital systems.

"Hospital systems have been buying up independent physician practices for years," said Matthews. "But the Affordable Care Act exacerbated the trend. In 2012, 29 percent of physicians worked for a hospital or in a practice partially owned by a hospital, according to the [American Medical Association]. By 2022, that number had increased to 39 percent."

Consolidation raises red flags, says Matthews.

"Hospitals always claim that relationship allows them to provide better, more integrated care, thus justifying excluding outside practices," said Matthews. "But there is a suspicion that it's just a way to cut costs by forcing physician-employees to follow hospital guidelines. Ironically, some studies indicate that the takeover of physicians' practices reduces competition and increases costs."

### Discounted Drugs

Alliance claims Section 340B of the 1992 Public Health Service Act was a factor in Jefferson's motivation to revoke its physicians' privileges.

The federal law requires pharmaceutical manufacturers participating in Medicaid to sell outpatient drugs at discounted prices to organizations that care for many uninsured and low-income patients. "The 340B program enables covered entities to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services," states the Health Resources and Services Administration (HRSA) on its website.

Oncology drugs and the newer gene and cell therapies are some of the priciest drugs on the market. "[The loss of our privileges] is really about 340B because they never did this for endocrinology or infectious disease," said Chasky. "It was directed specifically to cancer oncology."

### Law's 'Domino Effect'

Jeff Stier, a senior fellow at the Consumer Choice Center, says the drug discounts have been abused.

"The 340B program artificially—if not deceptively—lowers the price of medicines for certain entities," said Stier. "So, it should come as no surprise that these entities would do everything they can to capitalize on that advantage by expanding their practice, even at the expense of non-qualified entities—and their patients. This saga illustrates the reality that, if left unchecked, the domino effect of one market-distorting act can continue for decades."

### Program's Mission Creep

The Pharmaceutical Research and Manufacturers of America (PhRMA), a drug industry trade group, is critical of the 340B drug program.

"Since 1992, manufacturers have provided billions of dollars in steep discounts on out-patient medicines to safety-net clinics and qualifying hospitals expecting that those entities would use the savings to ensure that vulnerable patients have access to needed medicines," PhRMA states on its website. "But the 340B program has strayed from its original purpose."

"Instead, it has become less about patients and more about boosting the bottom lines of hospitals and for-profit pharmacies," states PhRMA. "How? Large hospitals buy deeply discounted 340B medicines and then turn around and charge uninsured patients and insurance companies higher prices, pocketing the difference with little or no evidence they use that money to help patients."

*Bonner Russell Cohen, Ph.D.* (**bcohen@nationalcenter.org**) *is a senior fellow at the National Center for Public Policy Research.*

# Michigan Requires Coverage of Expensive Cancer Therapies

**Continued from page 1**

patient for a gene therapy costing at least $475,000.

The patient's cancer had returned after years in remission, in an aggressive form of lymphoma. Doctors recommended a therapy known as Chimeric Antigen Receptors (CAR-T) that uses the body's immune system to attack cancer cells. CAR-T was approved by the Food and Drug Administration in 2017, and Medicare greenlighted coverage in November 2020.

Priority denied coverage, arguing CAR-T wasn't a drug but a genetic treatment. The patient filed an appeal but died several months after his diagnosis, before the case was resolved.

**Penalties Await**

The DIFS bulletin says that if a patient is improperly denied coverage, the insurer may face penalties and regulatory action. While not mentioning CAR-T specifically, DIFS stated how it interprets the 1989 law, which uses the word "drug" and was enacted before genetic therapies were available, when cancer treatments cost far less.

"As affirmed in a newly issued DIFS bulletin, Michigan law prohibits health insurers from denying coverage for cancer treatments, including genetic and immunotherapies when certain criteria are met, including that the treatment is ordered for a specific cancer and the treatment is approved by the United States Food and Drug Administration for cancer therapy, even if it is not approved for the specific cancer being treated," states the bulletin.

The Michigan Association of Health Plans (MAHP) disputes that interpretation, *Crain's Grand Rapids Business* reported on January 25.

In a letter to the DIFS, MAHP Executive Director Dominick Pallone wrote, "It is the opinion of MAHP that gene therapies could not have been intended to be included by the Legislature [in the state law] because gene therapies did not exist when the Legislature enacted its statute." The DIFS told *Crain's* it rejects that interpretation.

**Impact on Insurance Rates?**

Some genetic treatments and immunotherapies for cancer cost tens of thousands of dollars per patient, so forcing insurers to pay for them could affect insurance rates for all policyholders. Denial of coverage may not only put insurers in the crosshairs of government regulators but also make them easier targets for litigation over patients who do not recover.

"It is MAHP's understanding that our member health plans are compliant with all existing federal and state laws and are already providing coverage of expensive gene therapy procedures," said Brian Mills, MAHP's deputy director of commercial markets and communications, in an email to *Health Care News*.

"Our member health plans will continue to work with lawmakers and regulators in Michigan to find the best ways for health insurance providers to offer Michiganders affordable access to effective, evidence-based treatments and procedures," said Mills.

**Cost Increases Via Mandates**

It is no surprise that the law has come under scrutiny, says Michael Cannon, director of health policy studies at the Cato Institute.

> **"It is just dawning on policymakers what economists have always known: requiring insurance companies to cover all drugs sends drug prices through the roof. The solution is to let consumers, rather than government or employers, control the $4 trillion that goes to health care every year. They will do a better job of bringing drug prices down than government has."**
>
> **MICHAEL CANNON**
> **DIRECTOR OF HEALTH POLICY STUDIES, CATO INSTITUTE**

"It is just dawning on policymakers what economists have always known: requiring insurance companies to cover all drugs sends drug prices through the roof," said Cannon. "The solution is to let consumers, rather than government or employers, control the $4 trillion that goes to health care every year. They will do a better job of bringing drug prices down than government has."

**Less-Costly Options**

There are alternatives to mandated coverage, says John C. Goodman, co-publisher of *Health Care News* and founder of the Goodman Institute for Public Policy Research.

"In the United Kingdom, they use a cost/benefit approach for drug coverage," said Goodman. "If a drug is really expensive, and if it is expected to add only a few months of life for the average patient, it won't be covered by the British National Health Service. However, British patients can buy the drug out-of-pocket. Even better, they could buy private insurance to cover such an eventuality.

"In the United States, private insurers should adopt their own cost/benefit standard and make sure the standard is well-known and -understood," said Goodman. "Then, let people buy a second type of insurance to pay for drugs that don't meet the standard if they want to insure against that risk."

**'Restore a Competitive Drug Market'**

To deal with the breathtaking prices of new drugs, Congress and some states have imposed price controls. In 2022, President Joe Biden signed into law the so-called Inflation Reduction Act (IRA), a provision of which allows the federal government to select 10 drugs for price cuts. Drug companies that resist face a massive tax on their revenue.

A better approach is to consider why cutting-edge drugs are so costly in the first place, says Gregg Girvan, a scholar at the Foundation for Research on Equal Opportunity.

"Coverage mandates definitely give drug companies increased pricing power," said Girvan. "This is a problem not only with private insurance mandates state-to-state but also in Medicare. Medicare must cover all FDA-approved drugs within certain protected classes of drugs, including cancer drugs. This gives drug companies leverage to extract higher prices."

Girvan says state coverage mandates enacted decades ago are clearly outdated.

"Policymakers could not have contemplated drug treatments costing hundreds of thousands or even one million [dollars] or more," said Girvan.

"ProPublica and outlets like it often demonize the insurance companies that deny treatments many view as lifesaving," said Girvan. "What they fail to understand is insurance companies employ medical experts who read clinical trial data closely to determine how cost-effective a treatment is. Insurance companies don't set prices and are merely reacting to unjustified pricing by pharmaceutical companies."

*AnneMarie Schieber* (**amschieber@icloud.com**) *is the managing editor of* Health Care News.

# Legislation Aims to Protect Drug Research From Biden's Price Controls

**By Ashley Bateman**

Bipartisan legislation to reverse sanctions on small-molecule medicines is under consideration in the U.S. House of Representatives.

The Ensuring Pathways to Innovative Cures (EPIC) Act would reverse the nine-year price limit placed on small-molecule drugs under the Inflation Reduction Act (IRA), realigning negotiation timelines with those for biologic, larger-molecule drugs.

The bill was offered in early February by Reps. Greg Murphy, M.D. (R-NC) and Don Davis (D-NC) and Energy and Commerce Committee Health Subcommittee Chairman Rep. Brett Guthrie (R-KY).

**"These vouchers allow companies to explore pediatric rare diseases and to sell those vouchers upon FDA approval. This has created a significant incentive for continued investments into pediatric rare disease."**

**EVAN KOZLOW**
**DIRECTOR OF OPERATIONS AND COMMUNICATIONS**
**RARE ACCESS ACTION PROJECT**

### Innovation Inhibited

The IRA's "pill penalty" has already resulted in some investors withdrawing funding from small- molecule programs that provide hoped-for therapeutics for rare-disease patients.

"Small molecule drugs are critical therapies that Americans with cancer, neurological conditions, and other debilitating diseases rely on every day," said Murphy in a press release on February 1. "The IRA's price-fixing scheme shifts research and development away from these life-saving medications, ultimately leaving patients with fewer treatment options. … Shortsighted proposals such as the 'pill penalty' inhibit meaningful strides to lower drug costs and reduce access to life-saving treatments for those most in need."

### IRA Shortened Timeline

The passage of the IRA in 2022 forced changes in Medicare price negotiations for large- and small-molecule drugs.

Previously, after Food and Drug Administration approval, most small-molecule drugs faced implementation of price controls after 11 years plus two years of price negotiations. The 13 to 14 year timeline allowed companies time to recoup research and development costs and gain a profit before having to compete with generics.

Under the IRA, price controls are now implemented after seven years plus two years of price negotiations, significantly reducing market interest in research and development for these drugs.

### 'Investment Resources Fleeing'

Rare-disease programs are especially affected by stricter price controls on small-molecule drugs, says Evan Kozlow, director of operations and communications at the Rare Access Action Project (RAAP).

"Even though a limited exemption for rare therapies was included in the [IRA], the implementation is problematic because it eroded the incentives of the seminal Orphan Drug Act," said Kozlow. "Since the bill's passage, we have seen the closure of rare programs, investment resources fleeing to other therapeutic areas, and market uncertainty caused by federal policymaking."

Rare diseases affect as many as 30 million Americans and are primarily treated with small-molecule drugs.

"Congress made a clear statement on prioritizing rare-disease research when the Orphan Drug Act was passed in 1983," said Kozlow.

### Raises Expenses

Rare-disease patients are not the only group affected by the change. The IRA's controls on drug programs will raise treatment costs for other patients and taxpayers, says Joel White, president of the Council for Affordable Health Coverage (CAHC).

"The IRA creates incentives to develop more products that are infused or injected in physician offices or hospitals while reducing incentives to make more pills," said White. "This has profound implications."

While oral medications can easily be taken at home, infused and most injected products must be administered by doctors or nurses.

"Driving people to these products adds costs," said White. "For patients, this is 20 percent of the cost of the drug, which is typically much more expensive than a pill, and 20 percent of the fee charged by the doctor or hospital."

### 'Creates Barriers to Care'

In addition, the IRA provision increases disparity of care in specific populations, says White.

"Many patients in rural, low-income, and minority communities lack convenient access to doctors and hospitals, so the pill penalty also creates barriers to care," said White.

The CAHC predicts an influx of patients to hospitals and clinics instead of pharmacies, intensifying current shortages of health care workers.

### Eliminating Penalty 'Critical'

The RAAP called the proposed EPIC Act "a major step towards repairing the harm that the IRA was causing in innovation and the orphan drug pipeline," in a February 5 press release. "The IRA missed the mark entirely for the rare disease community."

"Eliminating the pill penalty is critical to reducing costs and improving access," White said. "We shouldn't pretend Congress got the law perfect. There are commonsense changes to be made, and the bipartisan EPIC Act, which would correct the pill penalty, is one of them."

### Other Plans Under Consideration

Another bipartisan bill, the ORPHAN Cures Act, introduced by Reps. John Joyce, M.D. (R-PA) and Wiley Nickel (D-NC) and Sens. John Barrasso (R-WY) and Thomas Carper (D-DE), would change the incentive structure in the IRA and encourage investment in follow-on orphan-drug development, says Kozlow.

"It is possible that there will be bipartisan support for other solutions to protect subsequent orphan indications," Kozlow said. "Reversing IRA's damaging incentives will benefit the thousands of patients currently suffering from rare diseases for which no treatments exist."

RAAP is urging Congress to return the Orphan Drug Tax Credit to its original 50 percent of qualified research and development costs through legislation to stabilize and protect innovation in rare-disease research. The group also wants to make permanent the priority review vouchers set to expire after September 30, 2024, and disappear completely in the fall of 2026.

"These vouchers allow companies to explore pediatric rare diseases and to sell those vouchers upon FDA approval," said Kozlow. "This has created a significant incentive for continued investments into pediatric rare disease."

*Ashley Bateman* (**bateman.ae@googlemail.com**) *writes from Virginia.*

# Amazon Bans COVID 'Misinformation' Books Under White House Pressure

**By Harry Painter**

U.S. Rep. Jim Jordan (R-OH) has revealed documents showing the White House pressured Amazon to censor books about the COVID-19 vaccine in early 2021.

Andrew Slavitt, a senior adviser on Biden's COVID-19 response team, led the effort to pressure Amazon to ban books the White House characterized as having "misinformation," the documents released on February 5 show.

"Who can we talk to about the high levels of propaganda and misinformation and disinformation of [sic] Amazon?" Slavitt asked in an email to an Amazon executive on March 2, 2021. The executive responded that Amazon had "taken a number of actions to not show misleading content on vaccinations, so if we're missing something, please let us know."

"If you search for 'vaccines' under books, I see what comes up," Slavitt replied, sharing an attachment. "I haven't looked beyond that but if that's what's on the surface, it's concerning."


**"I had sold millions of books in the U.S. and the U.K. I had books in 26 languages—all gone. Publishers don't even pay royalties due."**

**VERNON COLEMAN, D.SC.**

Addressing Biden administration official Robert Flaherty, the Amazon executive later assured the White House team the company's website directs users searching for vaccine books to the Centers for Disease Control and Prevention (CDC) vaccine information page.

"As you know, we very much want to help you get Americans vaccinated. That's our goal," the executive said.

### Author Singled Out

The Biden administration specifically targeted one book, *Anyone Who Tells You Vaccines Are Safe and Effective Is Lying,* by British physician, prolific author, and vaccine skeptic Vernon Coleman, D.Sc., Tyler O'Neil of *The Daily Signal* wrote in a February 6 article.

Zach Butterworth, White House director of private sector engagement in 2021, sent the Amazon executive a screenshot of Coleman's book. "Five minutes ago I searched 'vaccine' on Amazon and the attached book was one of the first in the stack," Butterworth wrote. "When I click on the product page I don't see any CDC warning." Slavitt wrote that Amazon "caters to people who are anti-vax."

Coleman's book was self-published in 2011, long before the pandemic. Coleman has singled out the COVID-19 inoculations in subsequent writings and appearances.

"I described the COVID fraud as a fraud in February-March 2020," Coleman told *Health Care News*.

### Banned from Social Media

Coleman says Amazon's censorship took a huge toll on his career.

"I had sold millions of books in the U.S. and the U.K.," said Coleman in an email to *Health Care News*. "I had books in 26 languages—all gone. Publishers don't even pay royalties due."

Coleman says he was also banned "from all social media and YouTube. My book sales have been destroyed."

Ironically, Amazon is his only remaining sales outlet.

"I wrote a book about my experiences, called *Truth Teller: The Price*," said Coleman. "I'm pleased to say it's on Amazon."

Coleman had not heard the White House had pressured Amazon to censor him until *Health Care News* reached out to him for comment, he says.

"As far as I know, my vaccine book has not yet been banned," said Coleman. "Amazon did ban other books," which are listed as "unavailable" on the results page, said Coleman.

A search of Amazon shows *Anyone Who Tells You Vaccines Are Safe and Effective Is Lying* as available in paperback.

### 'Demonization Will Get Worse'

Amazon caved to White House pressure to censor books skeptical of the COVID-19 vaccines in 2021, *The Daily Signal* reported.

Amazon told the White House via email "we did enable Do Not Promote for anti-vax books whose primary purpose is to persuade readers vaccines are unsafe or ineffective on 3/9, and will review additional handling options for these books with you, [redacted], and [redacted] on 3/19."

A month earlier, Amazon controversially removed Ryan T. Anderson's book *When Harry Became Sally*, about the transgender movement.

The end of the pandemic does not mean government censorship efforts will end, says Coleman.

"Censorship and demonization will get worse," Coleman said. "We need public support and understanding. The public is losing access to the truth."

*Harry Painter* (**harry@harrypainter.com**) *writes from Oklahoma.*

# Supreme Court Considers Arguments on Social Media Censorship Laws

**By Harry Painter**

The U.S. Supreme Court heard arguments in February over Florida and Texas laws designed to stem Big Tech bias against conservatives.

The laws, both passed in 2021, would limit the ability of social media giants such as Meta, TikTok, X, and YouTube to curate or moderate content posted by their users. The cases have implications for public health policy, and one includes health care professionals among the litigants.

Florida Gov. Ron DeSantis signed Senate Bill 7072 in 2021. The law prohibits companies from "willfully deplatforming a candidate," something that X, then known as Twitter, and Meta infamously did to then-sitting President Donald Trump after the January 6 riot at the U.S. Capitol.

The law also requires platforms to publish their criteria for banning users or content and to apply the criteria consistently. It also allows Floridians to sue the platforms for any violations of the law.

Texas Gov. Greg Abbott signed House Bill 20 the same year. The bill makes it illegal for platforms to censor content based on a user's viewpoint or location. Like the Florida law, Texas requires platforms to be open about their criteria for removing content, and it also allows residents to sue the companies for any violations.

### First Amendment Disputes

In both the Florida and Texas cases, representatives for the social media companies argue the laws infringe on their rights to choose what content they publish and promote, which they say is protected by the First Amendment.

Should the court uphold the laws, the platforms' newsfeeds could look radically different from what users are used to, say the social media titans.

In addition to the Florida and Texas cases, the Court will hear another social media censorship dispute, *Murthy v. Missouri*, in which the states of Missouri and Louisiana accuse the Biden administration of pressuring social media companies to censor conservative viewpoints.

### Companies Censoring Users

Getting private entities to do the government's bidding is the main issue in *Murthy v. Missouri*, says Jenin Younes, an attorney with the New Civil Liberties Alliance, which is representing Jay Bhattacharya, M.D., Aaron Kheriaty, M.D., Martin Kulldorff, Ph.D., and Jill Hines, who are individual plaintiffs along with the states.

"The primary allegation is that various components of the federal government, including the White House, the CDC, the FBI, and [the Cybersecurity and Infrastructure Security Agency] have been involved in social media censorship in violation of the First Amendment," said Younes. "Because government is constitutionally forbidden to use private companies to accomplish what it can't do directly, the government may not coerce, pressure, or encourage tech companies to censor users for expressing government-disfavored viewpoints, which is what it did here."

Although both the Texas and Florida cases and *Murthy v. Missouri* involve First Amendment questions, those concerned about the power of Big Tech will find themselves playing offense in the latter case and defense in the former cases, says Younes.

"The Florida and Texas cases are quite different because they're about whether states can enact laws prohibiting the companies from censoring users, not whether government can involve itself in social media censorship of individuals," said Younes.

### Newspapers or Phone Companies?

"In the Texas and Florida cases, the platforms are asserting that they have First Amendment rights to curate their sites as they choose, much like a newspaper," said Younes. "That means they can implement and enforce content moderation policies, even if that results in speech suppression, according to them. The states contend that the platforms are more like telegraph or telephone companies than newspapers, because they merely facilitate speech; they don't convey specific messages of their own."

The states argue the platforms may be regulated as common carriers and have no First Amendment right to censor users. Upon hearing oral arguments, the justices reportedly had mixed opinions on the common carrier question.

"If the platforms prevail in the Texas and Florida cases, not much will change; the sites will be able to continue to censor people as they choose, which is the situation we have now," said Younes.

### 'Government Has Enormous Power'

Free speech is a necessity for patients, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons, which filed an *amicus curiae* brief in *Murthy v. Missouri*.

"We believe it is extremely important that patients be able to obtain information critical for making medical decisions—unfiltered by entities with conflicts of interest, such as Big Pharma or insurers," said Orient.

"In addition, in the *Missouri* case, we felt it critical to balance the *amicus* by [the American Medical Association] and others that argues vaccines are perfectly 'safe and effective' despite all evidence of adverse effects, and [that] people should be forced to take them," said Orient. "Private entities are not covered by the First Amendment, so they should supposedly be able to say what they like, except that government has enormous power to suppress what it doesn't like."

**"The public discourse is distorted when platforms censor one side of a debate as misinformation, as they did in sharing information about COVID-19 vaccine side effects. It's astounding that the Solicitor General has taken the position that the states' regulations—which were accomplished through the democratic process and out in the open—are unlawful, while defending the federal government's backdoor, covert attempts to regulate speech by threatening and pressuring the platforms."**

**JENIN YOUNES**
**ATTORNEY**
**NEW CIVIL LIBERTIES ALLIANCE**

### 'Discourse Is Distorted'

Younes says the tech giants "control the public discourse in a way that the framers of the Constitution could never have imagined."

"The public discourse is distorted" when platforms censor one side of a debate as misinformation, as they did in sharing information about COVID-19 vaccine side effects, Younes said.

"It's astounding that the Solicitor General has taken the position that the states' regulations—which were accomplished through the democratic process and out in the open—are unlawful, while defending the federal government's backdoor, covert attempts to regulate speech by threatening and pressuring the platforms," said Younes.

*Harry Painter* (**harry@harrypainter.com**) *writes from Oklahoma.*

# Doctors Challenge AMA's Vaccine Push

The COVID-19 public health emergency, during which the government put a heavy emphasis on vaccine technology, was a pivotal moment in government overreach, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons (AAPS).

AAPS filed an amicus curiae brief in *Murthy v. Missouri*, a case challenging collusion between private companies and the Biden administration to censor unapproved medical opinions.

"Whether it was a deliberate experiment or an example of not letting a crisis go to waste, COVID showed how easy it is to manipulate people with fear and how readily they submit to tyranny based on official opinion," Orient told *Health Care News*. "It also shows how corrupt our regulatory agencies, medical organizations, media, and academic institutions are, seemingly owned by Big Pharma. Dissenting voices are essential and have saved countless lives with information about effective early treatment and vaccine adverse effects."

**'Magic' Technology**

In his State of the Union speech on March 7, President Joe Biden said, "The pandemic no longer controls our lives. The vaccines that saved us from COVID are now being used to help beat cancer, turning setback into comeback. That's what America does."

Big Pharma has high hopes for mRNA vaccine technology, says Orient.

"The technology that gave us COVID mRNA shots is touted as the magic platform for warp-speed development of vaccines for diseases X, Y, Z, et cetera, with no need for testing, and immunity from liability," said Orient.

"However, the increasing concern about severe adverse effects is cracking the barrier to questioning the huge and growing number of vaccines forced on children," said Orient. "Might these have something to do with the growing burden of autoimmune and neurodevelopment disorders? Could it be better to treat disease if it occurs, rather than try to make permanent alterations to every-

> **"The AMA and others are firmly committed to the vaccination approach, but what if they are as mistaken as they were about promoting tobacco as safe and effective?"**
>
> **JANE ORIENT, M.D.**
> **ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS**

one's immune system, which is poorly understood?"

**AMA 'Committed' to Vaccines**

AAPS's amicus also responds to an amicus bief filed in *Murthy* (see page 9) by the American Medical Association (AMA).

"The AMA and others are firmly committed to the vaccination approach, but what if they are as mistaken as they were about promoting tobacco as safe and effective?" said Orient. "Panic about this possibility might contribute to their support for censorship in their amicus—the need to quash 'vaccine hesitancy.'"

On March 18, the U.S. Supreme Court heard oral arguments in *Murthy v. Missouri*, with a decision expected within the next few months.

—*Staff reports*

## INTERNET INFO

"Brief of *Amicus Curiae* Association of American Physicians and Surgeons in Support of Respondents," February 7, 2024: **https://aapsonline.org/judicial/aaps-amicus-murthy-v-missouri-2-7-2024.pdf**

# France Criminalizes Opposition to mRNA Injections

**By Kenneth Artz**

France enacted a controversial new law in February that critics say could be used against anyone opposing injections with mRNA vaccines or other treatments recommended by the state and based upon current medical knowledge.

Although the law is aimed at preventing religious violence, one section establishes that criticism of therapeutic treatments made mandatory or recommended by the government could result in up to three years of imprisonment or a fine of 45,000 euros.

The provision, which critics quickly dubbed "Article Pfizer," represents a significant shift in the balance between public health policy and individual freedom of expression, says Robert Kogon, a pseudonymous writer for the U.K. website *The Daily Sceptic*.

"The legislation in question has prima facie nothing whatsoever to do with mRNA drugs, but is devoted rather to the fight against so-called 'sects' or 'sectarian tendencies,'" Kogon wrote. "Even if just limited to religious ones, incidentally, it is hard to see how an officially-promulgated 'fight' against sects or 'sectarian tendencies' is compatible with freedom of conscience."


**"When outside experts dissent from the recommendations, what we citizens learn is that the recommendations may not be as solid as the government experts think, and there may be some patients for whom outside experts realize the recommended treatment or vaccine may not be best. This dialogue is crucial in societal learning and needs to be preserved."**

**DANIEL SUTTER, PH.D.**
**PROFESSOR OF ECONOMICS, TROY UNIVERSITY**

### 'It's the Big Lie'

The French provision is tyrannical in addition to being unjustified by science, says John Dale Dunn, M.D., J.D., a physician and policy advisor to The Heartland Institute, which publishes *Health Care News*.

"This is totalitarian, authoritarian, autocratic government by a bunch of people who are not scientifically informed enough to make these decisions but who have decided to do what they're told by the army of experts who have designated themselves as the experts even though they have ignored the research that shows what they're claiming is not true," said Dunn.

"It's the Big Lie," said Dunn. "They're pushing the Big Lie, and the way that they get it done is they criticize, condemn, punish, or censor anyone who objects to the Big Lie."

There is a similar movement in the United States, says Dunn.

"People need to wake up to the fact that we have a totalitarian political entity running the United States at this point that's called the Uniparty," said Dunn. "So, what it comes down to is all the things you see that are going on in Europe, and why there's no big outcry by the politicians and the media in the United States, is because they want to adopt the same kind of approach here."

### 'Bad for the Soul'

It is hard to believe that such a law could be considered, much less passed, in a country claiming to be free or democratic, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons.

"It gives unbridled dictatorial power to government, with no accountability or recourse for injury or death to unwilling recipients of a medical intervention," said Orient. "Calling it the 'Pfizer amendment' is totally appropriate." Pfizer is a multinational drug company which developed an mRNA vaccine for COVID-19 in 2020. Governments and businesses punished people for not accepting the injections.

It appears government officials have been threatened or bribed to sacrifice their constituents to a massive, profit-hungry corporation that has already paid billions of dollars in criminal fines, in the process destroying the trustworthiness of scientists and medical professionals, says Orient.

"Persons of integrity, be they medical workers, journalists, or even elected officials, could be bankrupted or imprisoned, while citizens are at the mercy of brainwashed, corrupt, power-hungry apparatchiks," said Orient. "Staying in France is bad for your life, your health, and your soul."

### 'Dialogue Is Crucial'

Although the new French law may not be as draconian as some suggest, it does fit into the larger question of health policy and freedom and exposes those in the public health profession who seek to go beyond the limits of experts in a free society, says Daniel Sutter, Ph.D., the Charles G. Koch Professor of Economics with the Manuel H. Johnson Center for Political Economy at Troy University.

"Experts should not make decisions for citizens," said Sutter. "Rather, they should help inform citizens of the advantages and disadvantages of proposed courses of action, clearly letting the citizen ultimately decide what is best for himself or herself," said Sutter.

Shutting down or criminalizing differences of opinion impairs our ability to learn as a society, says Sutter.

"We need to let dissenting experts, in particular, criticize the rules recommended by government agencies," said Sutter. "We know politics, and not science, can influence all government health recommendations. And government experts might share similar biases and are failing to recognize some costs.

"When outside experts dissent from the recommendations, what we citizens learn is that the recommendations may not be as solid as the government experts think, and there may be some patients for whom outside experts realize the recommended treatment or vaccine may not be best," said Sutter. "This dialogue is crucial in societal learning and needs to be preserved."

### Voluntary Choice Better Than Force

"I think pharmaceutical companies should rethink their long-term position relative to getting government to mandate their treatments or vaccines," said Sutter.

"Markets are based on voluntary choices, and Big Pharma would be better served by trying to truly market their products instead of forcing them on people," said Sutter. "It's easy to boost sales short-term through government mandates, but longer term, consumers no longer view your companies as truly part of the market, as products meant to make consumers' lives better."

*Kenneth Artz* (**KApublishing@gmx.com**) *writes from Tyler, Texas.*

# New Regulations Hamper Medicare Advantage

**By Bonner Russell Cohen**

The Centers for Medicare and Medicaid Services (CMS) is planning to change the method it uses to calculate payments to Medicare Advantage (MA) plans, potentially compounding the effects of coverage reductions in discouraging seniors from enrollment.

In 2023, CMS eliminated 2,000 diagnostic codes for MA, "which meant less coverage for seniors in Medicare Advantage plans than conventional Medicare fee-for-service," Drew Johnson, a senior fellow with the National Center for Public Policy Research, wrote in an opinion piece on the Fox News website on January 24. "CMS also instituted an absurd 48-hour waiting period for seniors hoping to chat with agents or brokers to discuss insurance plans."

Diagnostic codes are used in MA to adjust for risk. CMS pays providers based on the risk level of the enrollee. Fewer codes mean less coverage for seniors.

The comment period on the notice issued on January 31 ended on March 1. Rate changes will be announced on or before April 1.

**"The Biden administration has been looking for ways to make [Medicare Advantage (MA)] plans less attractive by imposing new costs and restrictions, even as MA plans seek to make them more attractive. For example, Humana, which has one of the most popular MA plans, recently announced a $540 million quarterly loss amidst 'navigating significant regulatory changes while absorbing unprecedented increases in medical cost trends.'"**

**MERRILL MATHEWS, PH.D.**
**RESIDENT SCHOLAR, INSTITUTE FOR POLICY INNOVATION**

### Bundled Coverage Popular

MA (also known as Part C) is a "Medicare-approved plan from a private company that offers an alternative to Original Medicare for your health and drug coverage," states an article on the Medicare website. "These 'bundled' plans include Part A, Part B, and usually Part D. In many cases, you can only use doctors who are in the plan's network."

KFF, formerly the Kaiser Family Foundation, reports MA enrollment surpassed 50 percent of total Medicare enrollment in 2023.

KFF says that "in 2021, more than 3 million people with traditional Medicare, mostly low to modest-income beneficiaries, had no supplemental coverage, placing them at risk of facing high out-of-pocket spending, or going without needed medical care due to costs. As more beneficiaries have shifted to Medicare Advantage plans, the number and share of traditional Medicare beneficiaries with no additional coverage has declined from 5.6 million (10% of total Medicare population) in 2018 to 3.2 million (6% of total Medicare population) in 2021."

### Medicare Spending

A new policy brief by Joe Albanese, a senior fellow at the Paragon Health Institute, indicates the arguments CMS could use to justify lower payments to MA plans.

"In its January 12, 2024, public meeting, Medicare Payment Advisory Commission (MedPAC) staff estimated that 2024 MA spending is 23 percent higher than FFS ($88 billion) due to coding intensity (14 percent of $54 billion) and favorable selection (9 percent or $36 billion)...," Albanese wrote. "Ensuring efficient Medicare spending is an important goal, but policymakers should understand the full context of this analysis."

"Coding intensity" and "favorable selection" are technical terms used by MedPAC to conclude MA spending is higher than in FFS Medicare, says Albanese.

### Risk-Adjusted Plan Payments

Payments to MA plans are risk-adjusted, writes Albanese, "which means that plans receive higher payments for enrollees with higher expected costs and lower payments for enrollees with lower expected costs. This is intended to counteract the incentive that would otherwise exist for plans to avoid expensive enrollees."

After calculating risk-adjustment factors based on age, sex, disability, Medicaid eligibility, and patient health, CMS estimates enrollees' expected costs.

"Because plans receive more payment for patients with more risk factors, they have an incentive to report more diagnoses more thoroughly than FFS does," wrote Albanese. "'Coding intensity' refers to higher MA risk scores—and score growth—relative to FFS."

### 'Overestimates MA's Excess Payments'

"Because FFS payments are largely not risk-adjusted, there is less incentive to thoroughly record diagnoses for FFS patients," wrote Albanese. "Similar efforts to systematically increase coding accuracy in FFS would likely increase its risk scores and reduce coding intensity."

MA payments are based on average FFS costs, an arrangement rooted in the assumption that risk-adjusted health care spending in MA is equal to FFS, says Albanese.

"'Favorable selection' occurs if MA consistently attracts enrollees with lower spending than expected by their risk scores," wrote Albanese. In its January 2024 finding, MedPAC said MA benchmarks "do not accurately reflect the costs of MA enrollees, leading to overpayments that are additive to those from coding intensity," according to Albanese.

"Policymakers should keep in mind structural and policy differences between MA and FFS," wrote Albanese. "While coding intensity and favorable selection are important issues, MedPAC likely overestimates MA's excess payments from these factors."

### 'Imposing New Costs'

"Policymakers are facing a lot of pressure to enact new regulations on Medicare Advantage," Albanese told *Health Care News*. "But its rapid growth shows it offers significant value to seniors through lower out-of-pocket costs and more benefits. Adding too much red tape could make it harder to preserve these strengths."

MA has long been seen as the biggest free-market threat to those pushing for a government-run health care system, says Merrill Mathews, Ph.D., a resident scholar at the Institute for Policy Innovation.

"The Biden administration has been looking for ways to make MA plans less attractive by imposing new costs and restrictions, even as MA plans seek to make them more attractive," Matthews said. "For example, Humana, which has one of the most popular MA plans, recently announced a $540 million quarterly loss amidst 'navigating significant regulatory changes while absorbing unprecedented increases in medical cost trends.'"

### 'Hits Hardest' Lower-Income Seniors

Ratcheting down payments to MA plans harms the constituents of progressive politicians, says Matthews.

"Ironically, a disproportionately larger percentage of lower-income and inner-city seniors choose MA plans, since there is no need to spend money on a Medicare supplemental plan," said Matthews. "Thus, Democrats' efforts to undermine MA plans hit hardest the very population Democrats say they want to protect."

*Bonner Russell Cohen, Ph.D.* (**bcohen@nationalcenter.org**) *is a senior fellow at the National Center for Public Policy Research.*

COMMENTARY

# Medical Advantage Should Get Respect, Not Hostility From Biden Administration

By John C. Goodman

When does the failure to answer a phone call in eight seconds cost the company receiving the call $190 million?

When the caller is a spy working for the agency that runs Medicare and the receiving entity is a private insurance company.


**"Studies have shown health care spending, hospitalizations, and trips to the emergency room are 20 to 25 percent lower in [Medicare Advantage (MA)] plans, and MA produces better outcomes for things like knee and hip replacements, strokes, and heart failure."**

**JOHN C. GOODMAN**
**FOUNDER, GOODMAN INSTITUTE FOR PUBLIC POLICY RESEARCH**

### One Missed Call—Maybe

According to documents filed in a recent lawsuit, rules established by the Centers for Medicare and Medicaid Services (CMS) require Medicare Advantage (MA) plans to answer phone calls from elderly patients with hearing problems who use a computer device within eight seconds.

To ensure compliance, CMS hires "secret shoppers" to place artificial calls. On 63 straight calls, the insurer Elevance Health (formerly Anthem) passed inspection. But the 64th call was not answered at all.

That last call is a matter of dispute. Elevance Health claims it never received the call. Nonetheless, the incident caused the company to be given a lower "star" rating—a quality measure that affects how much MA plans get paid.

That one missed call cost Elevance Health $190 million.

### Government's Double Standard

If this doesn't strike you as a bit over the top, you need to know that the Social Security Administration takes an average of 35 minutes to answer calls. The IRS doesn't answer the phone at all most of the time, picking up only 29 percent of its calls. What penalty do public employees suffer when they do not respond to customer queries? None that we know of.

What makes all this especially strange is that MA comes closer to meeting government standards than any other program in the health care system. Only in MA can a doctor who discovers a change in a patient's health status send that information to an insurer (in this case Medicare) and receive a higher premium payment reflecting the new expected cost of care.

Accordingly, MA plans have financial incentives to discover patient problems early and solve them. Since MA premiums are fixed, the plan makes money by catching problems early, getting patients the care they need and keeping them away from the emergency room and out of the hospital.

### Medical Advantage Is Innovative

Unlike traditional health insurance, MA plans can specialize in chronic conditions such as diabetes, heart disease, and cancer. These MA plans seek to enroll patients other plans would like to avoid.

Nowhere else in our health care system will you find a health plan that wants to attract an enrollee with expensive medical problems. No employer. No commercial insurer. No Obamacare exchange plan. Numerous studies have found MA plans provide higher-quality care at a lower cost.

Studies have shown health care spending, hospitalizations, and trips to the emergency room are 20 to 25 percent lower in MA plans, and MA produces better outcomes for things like knee and hip replacements, strokes, and heart failure.

### Financial Incentives Matter

An obvious reason for these results is financial. In traditional fee-for-service Medicare, there are 10,000 tasks doctors are paid to do. If a task is on the list, doctors get paid. If it is not on the list, they don't get paid.

For example, until the COVID pandemic, the phone was not on the list for most purposes. Nor was email, or Zoom, or Skype. So those types of interactions rarely occurred.

Most important, Medicare's list of 10,000 does not give doctors any reward for keeping patients healthy. The reward for keeping a diabetic out of the emergency room? Zero. How about keeping a patient out of the hospital? Zilch. What about avoiding an amputation for a diabetic? Nada.

### Hostile Biden Administration

So, what has been the Biden administration's response to MA's successes? Nothing short of outright hostility. It seems that every day there is a new attack on some aspect of MA from some part of the government's health care bureaucracy.

MA plans are accused of overbilling Medicare, of "upcoding" to represent enrollees as sicker than they are to get higher risk-adjusted premium payments, and of unreasonably requiring prior authorization for medical procedures.

In response, the Biden administration plans to eliminate 2,000 billing codes from the MA risk-adjustment formulas (see opposite page). This will compress the coding so plans get the same risk-adjusted payments regardless of the severity of the case.

MA plans get more money if they find more medical problems, and they make money by catching problems early and curing them. By contrast, a garden variety, fee-for-service Medicare doctor gets no extra payment for getting the coding right and gets no financial reward for keeping patients healthy.

### MA Must Get It Right

Health conditions can go very wrong, and when they do, the treatment costs can be expensive. An amputation, for example, costs more than $100,000.

Former Kaiser Permanente CEO George Halvorson notes, "Diabetes is the number one cause of amputations in America. In fee-for-service Medicare, 20 percent of diabetic patients will develop foot ulcers, and 20 percent of those ulcers turn into amputations. In contrast, even the less successful [MA] programs end up with half as many ulcers and less than a third of the amputations compared to fee-for-service. Some best-care settings get the amputation rate down to 2 percent."

Payments to MA are capitated, so MA must get it right out of the gate. If the Biden administration wants to fix MA, it should reduce regulatory micromanagement, like requiring insurers to answer a phone call in eight seconds.

*John C. Goodman, Ph.D.* (**johngoodman@goodmaninstitute.org**) *is co-publisher of* Health Care News *and president and founder of the Goodman Institute for Public Policy Research.* *An earlier version of this article appeared in* Forbes. *Reprinted with permission.*

# Researchers Study Repurposing Drugs to Treat Cancer

**By Bonner Russell Cohen**

A team of U.S. clinicians has launched a first-of-its-kind observational study on how repurposed drugs with expired patents, such as ivermectin, might help in treating cancer.

The study, led by the Frontline COVID-19 Critical Care Alliance (FLCCC), began in February and is examining five-year survival rates for several types of cancers. Five hundred patients nationwide will be part of the study.

Conventional cancer treatments such as chemotherapy and radiation have succeeded in preventing more than four million deaths from cancer since 1991. FLCCC and its partners say emerging research demonstrates more can be done using treatment regimens that include well-studied, repurposed drugs previously approved by the U.S. Food and Drug Administration (FDA) for other illnesses.

"We hope that our research will bring attention to often overlooked methods for treating cancer as well as managing the symptoms of conventional treatment," said Paul E. Marik, M.D., lead author of the study and chief scientific officer at the FLCCC, in a press release on February 2. "Our research is intended to advance a better understanding of how cancer can be treated more efficiently, with fewer side effects, using well-studied approaches that include readily available medications ... known to have minimal side effects."

**'Having Remarkable Results'**

Joining FLCCC in the study is Kathleen Ruddy, M.D., a retired cancer surgeon and founder of the New Jersey-based practice Breast Health and Healing.

"For over a year I have been observing and advising 50 patients using a variety of repurposed treatments in the regimen, with some having remarkable results," said Ruddy in the FLCCC press release. "More is to be learned, so I am excited to partner with the FLCCC on this new research."

Clinicians participating in the study acknowledge that by focusing on off-the-shelf drugs, they will run afoul of a medical establishment wed to traditional, very expensive cancer treatments.

Ruddy told *Rescue with Michael Capuzzo* on Substack that the study will be performed "methodically, impartially, and according to the highest standards of medical research."

**'Registry Is a Terrific Idea'**

The study could be a gamechanger, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons.

"Chemotherapy is enormously expensive and highly toxic," said Orient. "We really don't know how much it prolongs life. If a drug [treatment] started early, the patient may live longer than expected, but one can't be sure it is longer than the natural course.

"There are many common drugs that seem to discourage cancers, at least in the laboratory—for example, digoxin, cimetidine, and doxycycline—and some impressive case reports with ivermectin," said Orient. "But there are so many variables! The FLCCC idea of a registry is a terrific idea if a lot of honest data can be collected."

**'Effective Drugs at Lower Prices'**

Finding new uses for established drugs could lower the cost of treating cancer, says Gregg Girvan, a resident fellow at the Foundation for Research on Equal Opportunity.

"I support efforts to repurpose drugs that are proven to be effective in treating other diseases when such drugs are available as generics," said Girvan. "We spend far too much for prescription drugs in the United States despite the fact that 90 percent of drugs dispensed here are generic, and any way to provide patients effective drugs at lower prices should be encouraged."

Girvan says he is generally skeptical of observational studies.

"You need randomized controlled trials (RCT) to truly know whether these repurposed drugs are effective for conditions like cancer," said Girvan. "They may very well be effective, and if so, this would be a huge victory not only because the treatments are effective but because they are inexpensive generics. But without RCTs, pronouncements on the effectiveness of repurposed drugs are simply conjecture."

**"You need randomized controlled trials (RCT) to truly know whether these repurposed drugs are effective for conditions like cancer. They may very well be effective, and if so, this would be a huge victory not only because the treatments are effective but because they are inexpensive generics. But without RCTs, pronouncements on the effectiveness of repurposed drugs are simply conjecture."**

**GREGG GIRVAN**
**RESIDENT FELLOW**
**FOUNDATION FOR RESEARCH ON EQUAL OPPORTUNITY**

**'Patient Zero'**

The prospect that affordable, readily available drugs could enable patients to survive even the deadliest of cancers was boosted by an experience Ruddy had with a Missouri man thought to be in the final stages of terminal cancer.

Fifty-five-year-old Paul Mann underwent 10 rounds of radiation and six of chemotherapy, after which his doctors told him his only options were hospice and a minister. What had begun as prostate cancer quickly spread to other parts of his body. However, a call from Ruddy in October 2022—four months after the cancer diagnosis—advising Mann to add ivermectin to his regimen, set forces in motion that have so far kept death at bay.

Mann still suffers from stage-4 cancer. But he has lived far longer than his doctors originally thought possible. Whether this is attributable to ivermectin or ivermectin in combination with other treatments is unclear.

**Patient Choice, Board Oversight**

Patients in the FLCCC study will choose which FDA-approved drugs they want to use to treat their cancers, either along with or in place of traditional therapies.

Their progress will be monitored by the five clinics participating in the study, with anonymous patient information shared to see which treatments work. An ethics board will oversee the study to ensure patient safety, scientific rigor, independent statistical analysis, and peer review.

Among the conditions included in the study are breast, prostate, lung, and colorectal cancer.

*Bonner Russell Cohen, Ph.D.* (**bcohen@nationalcenter.org**) *is a senior fellow at the National Center for Public Policy Research.*

# Texas Collects More than $700 Million in Medicaid Fraud, Overpayments

**By Kenneth Artz**

Texas Attorney General Ken Paxton announced his office has recovered more than $200 million in improper or fraudulent payments to medical providers, suppliers, and drug companies by the state's Medicaid system in fiscal year 2023.

The findings of the AG's Medicaid Fraud Control Unit (MFCU), its Civil Medicaid Fraud Division, and the Texas Health and Human Services Office of the Inspector General (OIG) were released in a joint annual report.

More than $203 million in remedies, penalties, and fines were returned to the state as a result of the AG's investigations and settlements in 2023. In addition, the OIG recovered $532 million in overpayments to health care providers.


**"When government gets big and hands out lots of money, what's the surprise that there would be people taking some? As Willie Sutton explained, he robbed banks because that's where the money was. Well, federal programs with big budgets are certainly a place where the money is, and the money is not well-managed and secured from theft."**

**JOHN DALE DUNN, M.D., J.D.**
**PHYSICIAN**

### Criminal Prosecutions, Too

According to the report, the MFCU obtained 79 indictments and 61 convictions averaging 4.6 years on various Medicaid fraud charges.

For example, a pharmacy owner was sentenced to more than 17 years in federal prison for participating in a fraudulent opioid pill mill scheme involving diverted narcotics and fake prescriptions billed to government health care programs.

Paxton says his office is continuing to pursue major cases involving Medicaid fraud, including a lawsuit against Pfizer and Tris Pharma for providing adulterated drugs to children and making related misrepresentations to the Texas Medicaid program. In another case, Texas filed a lawsuit against Gilead Sciences, alleging the company engaged in unlawful marketing ploys to incentivize medical providers to prescribe its drugs over competing medications.

### 'Rife with Fraud and Abuse'

The amount Paxton recovered is probably just a drop in the bucket compared to the actual losses, says Devon Herrick, a health economist who writes for the Health Blog of the Goodman Institute, which co-publishes *Health Care News*.

"Medicaid tends to be rife with fraud, and abuse that doesn't rise to the level of fraud but is still inappropriate," said Herrick.

These programs invite such abuses, says Herrick.

"Here's an example: dental fraud in the Texas program," said Herrick. "Years ago, Texas got in trouble for not having a robust enough dental benefit for kids. So the state began offering more benefits, and the dentists began doing all kinds of fraudulent things. … [A]bout 20 years ago, someone I knew had a kid who qualified for benefits and took them in for routine dental work—it was baby teeth, and the dentist put crowns on all of them!

"The teeth weren't bad, but why would you put crowns on a baby tooth?" said Herrick. "Those teeth will be gone in two years, so they didn't need all that work done. They probably needed to check for cavities and that kind of stuff, so that wouldn't be fraud. It would be abuse and torturous for the kid to go through all that unnecessary dental work."

### Gaming Government Health Care

In any public program, all the providers, including the scrupulous ones, are going to game the system and look for ways they can take advantage of it, says Herrick.

"What happens is the providers are not paid well for visits and services, so they try to make it up on volume," said Herrick. "If you were the person paying the bill, you would scrutinize it and ask, 'Does my kid really need eight crowns and to be tortured like that?'"

When people are not paying the bills, as in Medicaid, and they have lower family incomes, they might think it's a great deal and subject their children to unnecessary procedures under the mistaken belief they are getting something for nothing because it's free at the point of sale, says Herrick.

"In the free market, prices are used to ration goods, but in Medicaid and Medicare prices aren't used for rationing goods, so they have to find other mechanisms," said Herrick. "However, when you use mechanisms other than pricing, you also have stakeholders or advocates for kids, and so forth, trying to block that rationing system, and that's when you have overutilization and waste. But the waste is probably far worse than the fraud, … and some of the waste, they don't even call it fraud because it's legal."

### 'What's the Surprise?'

While Medicaid and Medicare fraud are longstanding problems, the government response to COVID created additional opportunities for fraud and abuse, says John Dale Dunn, M.D., J.D., a physician and policy advisor to The Heartland Institute, which publishes *Health Care News*.

"I would say that the Texas Medicaid scam is small-time compared to the scam that stole billions from the Feds on COVID relief projects," said Dunn.

A look at earmark projects in budget bills makes the Medicaid scam a penny-ante theft compared to other examples of fraud in government programs, says Dunn.

"The magnitude of fraud in the matter of COVID funds is a much, much bigger rip-off of the taxpayers," said Dunn. "When government gets big and hands out lots of money, what's the surprise that there would be people taking some?

"As Willie Sutton explained, he robbed banks because that's where the money was," Dunn said. "Well, federal programs with big budgets are certainly a place where the money is, and the money is not well-managed and secured from theft."

*Kenneth Artz* (**KApublishing@gmx.com**) *writes from Tyler, Texas.*

# Health Care Providers Use Telemed to Dodge State Abortion Bans

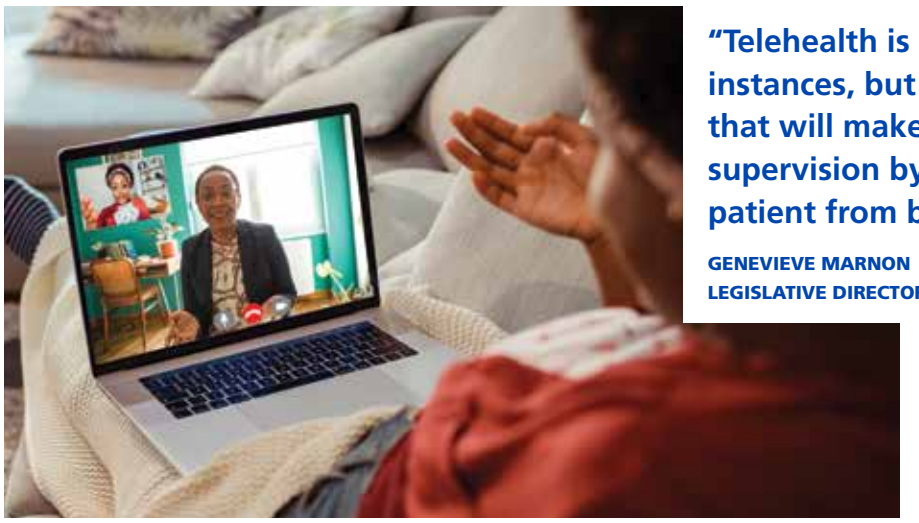
**By Harry Painter**

Health care professionals are not waiting for the U.S. Supreme Court to decide whether it is constitutional to send abortion pills through the mail.

Since the summer of 2023, blue-state doctors have used a backdoor method to provide abortions to women in red states that have banned or heavily restricted abortion procedures and abortion-inducing drugs.

Doctors and other licensed health professionals have mailed abortion pills to tens of thousands of women. So-called telemedicine shield laws in six blue states—California, Colorado, Massachusetts, New York, Vermont, and Washington—prevent out-of-state prosecutors from pursuing these doctors. These states refuse to extradite the doctors, turn over records, or aid in any investigation, in sharp contrast to the usual practice of cooperation in arresting criminals across state lines.

Abortion providers and their allies have set up mobile clinics outside their states' borders and have funded abortion tourism to make it easier for women to travel to states where abortion is legal. Some women have stocked up on abortion pills, even if they are not pregnant, in case they want them later.



**"Telehealth is appropriate in many instances, but not for a procedure that will make a person bleed without supervision by a person who can stop the patient from bleeding to death."**

**GENEVIEVE MARNON**
**LEGISLATIVE DIRECTOR, RIGHT TO LIFE MICHIGAN**

### Enhanced Dangers

"The danger of telemedicine shield laws is really because they compound the threats of telemedicine abortions in general," said Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons. "Telemedicine abortions provide no medical exam, no ruling out of ectopic pregnancies, no ultrasound dating of gestational age, and no access to a medical provider in the event of a complication."

The inability to rule out ectopic pregnancies is especially dangerous for women, says Orient, because "ectopic pregnancies occur in 1 to 2 percent of all pregnancies and the abortion pill is contraindicated."

"A ruptured ectopic pregnancy is deadly, yet has symptoms similar to the expected effects of the abortion pill, thereby masking it," said Orient.

Other dangers include taking the pill beyond the approved gestational limit, which "can lead to serious complications for the woman, including hemorrhage," said Orient.

### Absent Doctors

Receiving the abortion pill via telemedicine means the woman might not have a relationship with the prescribing doctor, says Orient. A woman can simply search online, fill out a form, and then wait for the pills to arrive in the mail.

"By shipping abortion pills to states where abortion is prohibited, women who have a complication may be hundreds of miles away from the doctor who prescribed the abortion pill, and will be forced to seek care at an emergency room," said Orient. "In abortion-free states, the emergency room physician may not suspect an abortion complication. This could lead to misdiagnosis and inadequate treatment."

### 'Privileged Form of Care'

"The root of the abortion problem is defining it as medical care, and a particularly privileged form of care, being exempt from regulations that apply to most care," said Genevieve Marnon, the legislative director of Right to Life Michigan. "It certainly is unique in that its intended purpose is to cause death. Mifepristone is a poison that causes death to a fetus."

Mifepristone is the most common abortion drug and usually the first in a two-drug series doctors prescribe to women seeking abortions.

"Do we permit murderers to beat the rap if they send poison through the mail to a different state?" asks Marnon. "The one actually administering the poison is the mother. But I don't know of any states that define the mother as the lawbreaker."

### 'Too Dangerous'

Marnon says telehealth is not right for the abortion pill.

"Telehealth is appropriate in many instances, but not for a procedure that will make a person bleed without supervision by a person who can stop the patient from bleeding to death," said Marnon. "Abortion is a serious procedure that requires informed consent, which is almost always lacking; evaluation for ectopic pregnancy; counseling; and awareness that the patient may be a victim of sex trafficking."

Marnon says states should criminalize mail-order abortions if the government will not reverse its approval of mifepristone. "Mifepristone should, arguably, have never been approved for causing abortion," said Marnon. It is "too dangerous," Marnon says, noting that chemical abortions have more complications than surgical abortions.

"Mail-order abortions should be illegal everywhere," said Marnon. "I suspect that they are at least as bad as back-alley abortions."

As of press time, the Supreme Court was scheduled to hear arguments on whether the 2002 approval of mifepristone by the U.S. Food and Drug Administration (FDA) should be invalidated, on March 26.

*Harry Painter* (**harry@harrypainter.com**) *writes from Oklahoma.*

# Teens Home Alone, Misusing Drugs

**By Ashley Bateman**

More than half of adolescents misusing prescription drugs are doing so in isolation, increasing the risk of overdose deaths, according to a new study by the U.S. Centers for Disease Control and Prevention (CDC).

The CDC reviewed data from 15,963 self-assessments of 13- to 18-year-olds who were screened for drug abuse treatment during the period from 2014 to 2022.

Among the reasons for drug use cited by the teens, 73 percent reported using substances to relax, 40 percent to cope with anxiety and depression, and 50 percent "to have fun or experiment."

While most of the teens reported using alcohol and nonprescription drugs recreationally, 50 percent said they used such substances alone. Fifty-one percent of the teens misused prescription drugs in private, with 19 percent reporting misuse in the previous month. This solitary use contributed to the rise in overdose deaths among teens over the past decade.

### 'Massive Overuse'

Americans' use of prescription drugs has reached record highs in recent years, with 6.3 billion prescriptions filled in 2020.

Public schools miseducate children about drugs, while providing places to buy and sell them, which is inexcusable, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons.

"Teens are immersed in a drug culture, including massive overuse of prescription drugs," said Orient. "Children are not adequately taught about the perils of drugs, compared with constant tobacco education. Yet tobacco generally takes decades to kill you and doesn't harm your intellect."

### 'Mental Health Crisis'

The CDC study highlights a long-term trend, says Michelle Cretella, M.D., cochair of the American College of Pediatrics Adolescent Sexuality Council. "The U.S. has been in a longstanding and now burgeoning mental health crisis among its youth. Drug abuse is an expected, prominent response."

In 2020, the Substance Abuse and Mental Health Services Administration's Hotline, a free referral and information service, received 833,598 calls, a 27 percent increase since 2019.

### 'Recipe for Disaster'

Years after the COVID-19 lockdowns kept Americans at home at the expense of livelihoods, education, and community engagement, the toll on mental and emotional health is still accumulating.

A 36-study review of the impact of the pandemic on pediatrics found "school closures and social lockdowns during the first COVID-19 wave were associated with adverse mental health symptoms … and health behaviors."

Untreated mental health disorders lead to a much higher risk of drug abuse. Nearly 93 percent of households with children in school engaged in online learning during the pandemic, spending months less mobile, indoors, in front of screens.

"Coupled with the nihilistic, valueless environment traditional public schools offer, this was a recipe for disaster," said Orient.

### 'Treatment More Challenging'

Exacerbating the problem, treatment for substance abuse is costly and often inaccessible. A *Health Affairs* study found the average cost for in-patient care is $28,731 and there are no treatment facilities for teens in 10 states, requiring expensive travel for therapy.

While opioid use disorder has been effectively treated with methadone or buprenorphine, treating teens is more complicated.

"Young people have psychological comorbidities and may also have problems in their home environments that drive them to self-medicate with illicit drugs," said Jeffrey Singer, M.D., a surgeon and a senior fellow at the Cato Institute. "This makes treatment more challenging. They often require psychotherapy, family counseling or therapy, family involvement, and sometimes psychiatric pharmacotherapy, in addition to the approaches used for adults."

For teens, "most treatment programs are overpriced and ineffective," Orient said.

### 'I Urge Families to Homeschool'

The number one cause of drug abuse has long been recognized as the breakdown of the traditional family, and with teens spending an average of eight and a half hours looking at screens each day, human interaction is significantly reduced even within intact homes, says Cretella.

"Digital devices—which are addictive in and of themselves—are a significant cause of the modern-day surge in anxiety, depression, ADHD, OCD, pornography addiction, and gender incongruence, especially among youth," said Cretella.

The current surge in homeschooling may be an attempt to reclaim childhood. A study found homeschoolers use fewer substances and strongly disapprove of illicit drug use.

"Due to the ubiquitous teaching of Critical Race Theory and gender ideology in public schools, I urge families to homeschool," said Cretella. "Available curricula are academically superior to and have more uplifting content than [those used in] government-funded schools. Socialization through co-ops and sports is very doable and successful."

**"Young people have psychological comorbidities and may also have problems in their home environments that drive them to self-medicate with illicit drugs. This makes treatment more challenging."**

**JEFFREY SINGER, M.D.**
**SENIOR FELLOW**
**CATO INSTITUTE**

*Ashley Bateman* (**bateman.ae@googlemail.com**) *writes from Virginia.*

COMMENTARY

# Does Medicare Underpay Physicians?

**By Devon Herrick**

There is a shortage of physicians in the United States.

There is an especially severe shortage of primary care physicians willing to treat Medicare enrollees. People nearing the age of Medicare eligibility are often advised to begin searching for a primary care physician who accepts Medicare a year in advance.

Based on data published in 2020, the Association of American Medical Colleges estimates that the United States could have a shortage of 54,100 to 139,000 physicians by 2033. That shortfall is expected to span both primary- and specialty-care fields.

U.S. physicians are compensated by a mix of various payers. These include government programs such as Medicare and Medicaid, private insurers, and cash. Doctors often complain that government programs underpay them compared to their market value. Medicare and Medicaid are often singled out as unprofitable. Medicare patients (and certainly Medicaid patients) are less desirable than commercially insured patients because of the lower fees and other factors.

> **"Medicare provides health insurance coverage to 65 million adults, nearly 20 percent of the U.S. population, and is a major source of revenue for providers, including physicians and other clinicians."**
>
> **DEVON HERRICK**
> **HEALTH ECONOMIST**

### Participation Rates Offer Clues

Physician income varies by specialty, with some specialties earning twice the pay of others. The same is true for Medicare fees. There are about 10,000 different tasks doctors can bill under Medicare. Some tasks are underpaid, while others are overcompensated.

Labor economics provides an easy way to gauge whether someone is underpaid. If Medicare is substantially underpaying physicians, one would expect few physicians would be willing to treat seniors, but that is not the case. Nearly 99 percent of licensed physicians participate in the Medicare program. Less than 2 percent have opted out.

Some of those opting out have very specialized practices for services not generally covered by Medicare. Nearly 8 percent of psychiatrists are not Medicare providers, the highest of any specialty. Plastic surgeons are also less likely to participate in Medicare. Insurance rarely covers cosmetic surgery, so it is hardly surprising that 4.2 percent of cosmetic surgeons opt out. The third-highest specialty opting out of Medicare is neurology, at 2.8 percent.

Less than 2 percent of all other specialties decline to participate in the Medicare program. What is more common than opting out of Medicare is limiting new Medicare patients to maintain a ratio of privately insured and cash-paying patients.

### Hard to Avoid Medicare

Why do so few physicians opt out of Medicare? Because it's a big program. Reimbursements may not be as high as those for commercially insured patients, but very few doctors can afford to turn away all Medicare patients.

Medicare provides health insurance coverage to 65 million adults, nearly 20 percent of the U.S. population, and is a major source of revenue for providers, including physicians and other clinicians. In 2022, Medicare spending on Part B services (including physician services, outpatient services, and physician-administered drugs) accounted for nearly half (48 percent) of total Medicare benefit spending. This share is expected to grow to more than half (52 percent) by 2032. Physicians are not required to participate in Medicare, though the vast majority choose to do so.

Physicians who choose to opt out of Medicare cannot pick and choose which seniors they will see through Medicare and which ones they will charge cash. A physician doesn't have to accept every Medicare patient who asks for an appointment, but doctors cannot make some seniors pay cash for services, so some physician offices began to require a membership or concierge fee of, say, $100 a month for a senior to be a member of their practice.

These fees are for services Medicare supposedly does not cover. Neither can a Medicare-participating physician balance-bill seniors for more than Medicare pays.

### Payment Rates Affect Efficiency

Congress periodically adjusts physician reimbursements in Medicare. Certainly, higher pay would boost access to care for seniors, but it's not clear how much that should be.

A program as large as Medicare has significant monopsony power as the single payer for seniors' medical care. Another viewpoint is that doctors and prescription drugs are relatively cheap compared to use of hospitals. Seniors who end up in the hospital because they couldn't get in to see an office-based physician are more costly to treat.

Thus, getting physician reimbursement right should be an important goal.

*Devin Herrick, Ph.D.* (**devonherrick@sbcglobal.net**) *is a health care economist. An earlier version of this article was published on the Goodman Institute Health Blog. Reprinted with permission.*

Washington Examiner

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*WASHINGTON EXAMINER*

# To Save Medicare, Build on What Works

**By Joe Albanese**

Politicians usually avoid proposing changes to Medicare in an election year, but the program's rising costs and expected insolvency within the next five to 10 years will demand attention in the next presidential term.

The question will be how to reduce spending while preserving benefits for seniors. The best approach is to build on the success of Medicare Advantage (MA).

**"If supporters of [Medicare Advantage (MA)] do not address the program's shortcomings, its opponents will. Many researchers and regulators are staunchly opposed to private plans in Medicare and have recently ramped up attacks on MA."**

**JOE ALBANESE, SENIOR POLICY ANALYST, PARAGON HEALTH INSTITUTE**

In traditional Medicare, the government decides what services it will cover and the price it will pay. In MA, seniors choose private coverage options where plans make more of those decisions in a competitive market. Most seniors who choose MA do so because it offers them better value.

### Advantage of Patient Choice

MA enrollees tend to have more preventive care visits, fewer hospital admissions and shorter stays, and lower health care spending. Since MA plans deliver better health outcomes and more coordinated care, their average cost of covering core Medicare benefits is much lower—about 17 percent below traditional Medicare.

Plans pass part of these savings to taxpayers and the rest to enrollees in the form of lower expenses or extra benefits that are not covered by traditional Medicare, such as dental, vision, and hearing coverage. While MA plans cap out-of-pocket spending, many traditional Medicare enrollees must purchase expensive Medigap plans to receive comparable benefits.

MA's growth means more seniors have access to its advantages. Patient choice is transforming the entire Medicare program in a way that bureaucrats have been unable to do.

There are opportunities to improve MA that will allow it to drive even more innovation for more people. To do that, it is necessary to address concerns that overall MA spending is higher than traditional Medicare despite MA's success in lowering health-care expenses. This will require refinements to MA's structure and overdue reforms to traditional Medicare.

### Building on Success

A recent paper by Paragon Health Institute offers a package of recommendations that would strengthen MA while saving taxpayers an estimated $250 billion over a decade. There are four key policies.

First, where MA options are strongest, reduce the government's base payment rate to plans so it does not exceed traditional Medicare costs, as currently happens in half of the country. Other technical fixes should make these payments even more accurate.

Second, eliminate MA quality bonuses. Researchers have found that government performance metrics do not predict quality well, and instead cause plans and doctors to focus more on box-checking exercises than improving health care.

Third, improve risk coding. Plans currently receive higher reimbursement for sicker enrollees, a necessary feature so plans do not avoid costlier patients. However, plans identify diagnosis codes with greater intensity than traditional Medicare. Congress should address this with more targeted payment adjustments and increased monitoring of diagnostic documentation.

Finally, Congress should increase parity between MA and traditional Medicare. The lack of cost controls in traditional Medicare and counterproductive MA regulations make it impossible for the two programs to compete on equal footing. For example, Congress should address problems with Medigap to control spending and ease switching between MA and Medigap. Additionally, it should direct seniors to choose coverage rather than receive traditional Medicare by default.

### Fixing What's Wrong

If supporters of MA do not address the program's shortcomings, its opponents will. Many researchers and regulators are staunchly opposed to private plans in Medicare and have recently ramped up attacks on MA.

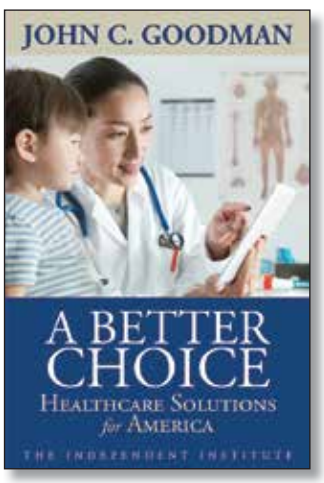
This same story played out with Medicare Part D. By allowing seniors to access prescription drug benefits through private plans, Part D kept overall drug costs lower than expected. But rising prices for certain treatments and patient exposure to catastrophic expenses were problems that became a rallying cry.

When Democrats won the presidency and both houses of Congress, they significantly expanded regulations on the program through the Inflation Reduction Act. These policies will likely raise seniors' Part D premiums, limit their coverage options, and suffocate drug development over time.

Policymakers can avoid this fate for MA. The right changes can save money, improve quality, and give seniors more choices in Medicare. On the other hand, failing to offer positive solutions could erase these gains for millions of seniors and return them to the same government-driven approach that has failed time and time again.

*Joe Albanese* (**jalbanese@paragoninstitute.org**) *is a senior policy analyst for the Paragon Health Institute. An earlier version of this article appeared in the* Washington Examiner. *Reprinted with permission.*

# Prescription for Better Healthcare Choices




## A Better Choice
### Healthcare Solutions for America
**John C. Goodman**

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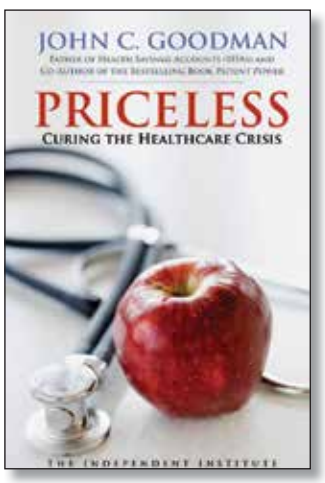
—**Bill Cassidy**, M.D., U.S. Senator

Polls show that by a large margin Americans remain opposed to Obamacare and seek to "repeal and replace" it. However, the question is: Replace it with what? In ***A Better Choice***, John C. Goodman clearly and concisely provides the compelling answer. For anyone who wants to learn about some of the boldest prescriptions designed to remedy our healthcare system, Goodman's book is a must-read.

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# Proposals Will Expand Access to HSAs

**By AnneMarie Schieber**

Lower-income Americans who get a cost-sharing reduction (CSR) from their Obamacare health insurance could soon set aside part of that money to spend on health care as they choose.

H.R. 5608, known as the ACCESS Act, would allow individuals and families to put some of their CSR subsidy into a tax-free health savings account (HSA) they would own and control. CSR lowers the amount patients pay for deductibles, copayments, and coinsurance under health insurance policies sold in the Affordable Care Act (ACA) marketplace. The bill was introduced last September by Reps. Greg Steube (R-FL) and Kat Cammack (R-FL).

"The ACCESS Act is a needed relief for millions of lower-income families who are stuck in costly, one-size-fits-all ACA plans and could use more options to pick from," said Dean Clancy, a senior health policy fellow at the lobbying group Americans for Prosperity (AFP), in a news release.

"Being able to select a prefunded health savings account would empower Americans with new choices that will allow them to upgrade from substandard government health care to more-personalized solutions that better meet their needs," said Clancy. "We applaud Congressman Steube and Congresswoman Cammack for sponsoring this innovative legislation that funds people and families—not the system. We urge Congress to pass the ACCESS Act as soon as possible."

### 'Access, Choice, and Control'

AFP says the HSA option would be open to about five million Americans enrolled in subsidized Obamacare plans. Policyholders could use the accounts to purchase medical items and services not covered by their insurance.

In addition, the bill would set aside funds for the HSA accounts, something which Congress has failed to do for the CSR program. The Congressional Budget Office estimates the provision would save taxpayers $29 billion over the next 10 years.

HSAs have proven to be a powerful financial tool for millions of Americans, but they are limited to about 10 to 20 percent of the population. "These less-advantaged Americans will enjoy the same kind of access, choice, and control that affluent families have always enjoyed," states AFP.

### AFP Ad Blitz

AFP has launched a six-month digital ad campaign in support of the ACCESS Act, targeting the Washington, D.C., metropolitan area and dozens of key congressional districts.

"We're off to a strong start," said Lauren Stewart, AFP's senior federal affairs liaison. "Our ads have already reached millions of people and increased awareness on Capitol Hill, and we're just getting started. We've had incredibly productive conversations with members of Congress, and going forward we expect to see more and more congressional support for the ACCESS Act. And we know the bill is popular, with our latest poll showing that 82 percent of Americans support it."

Feedback on the bill has been positive and bipartisan, says Stewart.

"Lawmakers love that the bill saves taxpayers billions of dollars and increases access to affordable health care for low-income Americans," said Stewart. "Democrats, who have historically been lukewarm on HSA expansion, … are seemingly open to exploring the idea of decoupling HSA eligibility from high-deductible health plans. Republicans support expanding HSAs for several reasons: more competition, empowering customers to shop for care, increasing choices, and lower costs."

### Winning Issue for Candidates

Stewart says Americans continue to feel the weight of health care costs, making it an issue of concern to legislators.

"Our grassroots teams continuously tell us that health care is a top-three issue for voters they speak with," said Stewart. "The ACCESS Act is a solution for lawmakers and candidates who want to help lower-income Americans get the affordable care they need in a more fiscally responsible way for taxpayers. And with President Biden's inflationary ACA subsidies set to expire next year, the bill represents a sensible alternative to continuing to funnel billions in taxpayer dollars to insurance companies."

Congressional interest in expanding HSA access goes beyond the ACCESS Act, says Stewart.

"We've seen bipartisan support on HSA expansion in the House, so there's momentum," said Stewart. "A good example is the bipartisan HSA Improvement Act, led by Reps. Lloyd Smucker (R-PA) and Earl Blumenauer (D-OR), which the House Ways and Means Committee approved. We definitely expect the ACCESS Act to have similar bipartisan support."

### Veterans' Accounts, Too

Another HSA bill that has garnered support is the Veterans HSA Access Act, introduced by Rep. Mike Carey (R-OH), says Daniel Perrin, founder of the HSA Coalition, a nonprofit advocacy group.

**"Congressman Mike Carey has drafted a bill that will be on its way through the Ways and Means Committee to correct a grossly unfair situation for our veterans, some of whom are disabled.**
**Rep. Carey's bill will bring our veterans one step closer to having tax-free funds to spend on their health care from their health savings account, which veterans under the care of the VA will no longer be prohibited from having after Rep. Carey's bill's provisions are signed into law."**

**DANIEL PERRIN**
**FOUNDER**
**HSA COALITION**

"Congressman Mike Carey has drafted a bill that will be on its way through the Ways and Means Committee to correct a grossly unfair situation for our veterans, some of whom are disabled," said Perrin. "Rep. Carey's bill will bring our veterans one step closer to having tax-free funds to spend on their health care from their health savings account, which veterans under the care of the VA will no longer be prohibited from having after Rep. Carey's bill's provisions are signed into law."

Carey's bill would allow nonservice-connected disabled veterans to contribute to their HSAs after they receive VA health services, without interruption, says Perrin.

"Current law requires nonservice-connected disabled veterans to wait three months before they're able to contribute to their HSAs," said Perrin.

Perrin says House floor votes on the Bipartisan Improvement Act and the HSA Modernization Act could occur as early as April.

*AnneMarie Schieber* (**amschieber@icloud.com**) *is the managing editor of* Health Care News.

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REPRESENTATIVE ISAAC LATTERELL
SOUTH DAKOTA



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