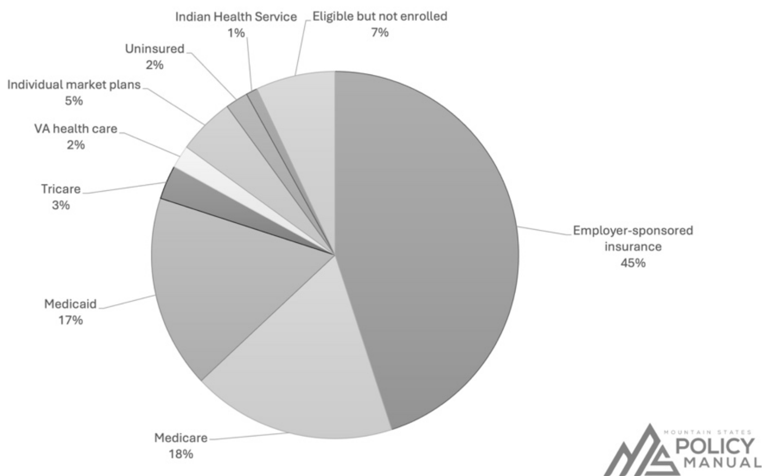
I. Require health care price transparency

America does not have a free market health care system and hasn't for the last 100 years. One needn't look further than the fact that a third party, either the government through insurance programs such as Medicare, Medicaid, and Obamacare, or employers through employee benefits pay for a very significant portion of health care in our current system.



Consequently, until recently, prices in health care have not mattered to patients. Americans have been shielded from health care costs. Yet, insurance deductibles and out-of-pocket expenses have been increasing, putting more financial pressure on patients. The quality of "health care coverage" is often determined by the amount/cost an insurance plan covers, rather than the care itself.

Let's do a simple thought experiment. Pretend that every time you go to the grocery store there are no prices posted for the food products. You have no way of knowing how much anything costs until you get to the checkout counter. And when you do get to the check out, someone else pays for over 80 percent of your groceries.

On the one hand, you really don't care what prices are because someone else is paying for much of your food. On the other hand, you are still paying for a significant portion of your groceries, so it would be handy to know prices.

This thought experiment defines the current health care system in the United States.

Patients need details on the price of medical services

At the end of the day, health care is an economic activity, just like buying groceries, or clothes, or shelter. The relationship between a provider and a patient is unquestionably the most personal activity we undertake; however, health care has costs. The one thing that all policymakers can agree on is that the rising costs of health care are unsustainable. We currently spend almost 20 percent of our economy, or gross domestic product, on health care in the U.S. Unless something changes, this number is predicted to reach over 30 percent of GDP in the next 10 to 15 years.

To change this trajectory of increasing health care spending, price transparency is mandatory. Patients must have the ability to act as true consumers of medical care and be able to compare treatment prices from multiple providers. The federal government has mandated that hospitals publish their pricing structure, yet medical facilities have been extremely slow in meeting this requirement.

Here is the current timeline of price transparency efforts according to the American Enterprise Institute:[1]

Timeline of health care price transparency efforts
American Enterprise Institute

March 2010	The Affordable Care Act is enacted. • Section 1001: Required posting of hospital charges • Section 1311(e)(3): "Transparency in Coverage"
August 2014	The Obama administration reminds hospitals of their obligation to make chargemaster rates available to interested parties.
August 2018	HHS finalizes the rule requiring hospitals to post chargemaster rates in a machine-readable format, starting in 2019.
November 2019	HHS finalizes the rule requiring hospitals to post chargemaster rates, negotiated rates, and prices for 300 shoppable services, starting in 2021.
November 2020	HHS finalizes the transparency in coverage rule for health insurers.
December 2020	The No Surprises Act is enacted. • Section 112: GFEs • Section 114: Maintenance of price comparison tool
January 2021	Hospital price transparency requirements go into effect.
July 2022	Health plan requirements for transparency in coverage go into effect (after a six-month delay).
January 2023	Health plans must post the pricing for 500 specified services and offer consumers an online tool for cost-sharing estimates. Medical services are obligated to produce GFEs for uninsured and cash-pay patients. (Enforcement is delayed for those with insurance.)
January 2024	Health plans must provide consumers with cost-sharing estimates for all services.

The first step in controlling health care costs is to give patients, as consumers of medical care, the ability to obtain quality care at the most reasonable price.

Competition in pricing is a fundamental of a free market and just as in grocery shopping, Americans should have the right to know prices for their medical care. Policymakers should work to require price details to be available to patients before services are provided.

II. Make telemedicine permanent

The COVID-19 pandemic forced many health care providers to move their services online, and many Americans have enjoyed the benefit ever since.

[1] "Price Transparency 2.0: Helping Patients Identify and Select Providers of High-Value Medical Services," AEI, January 2023, available at https://www.aei.org/wp-content/uploads/2023/01/Price-Transparency-2.0.pdf?x85095

Unfortunately, Medicare beneficiaries and some privately insured patients could lose access to telemedicine by the end of 2024. This is because restrictions on telehealth were only temporarily waved by the federal government. Those waivers are set to expire unless Congress acts.

A 2021 survey found more than 23% of Americans have used telemedicine at least once over the past four weeks.[2] Studies have shown offering telehealth services can also dramatically lower the cost of care.

Several pieces of legislation are pending to make telemedicine permanent.[3] Policymakers should make sure to end this unnecessary restriction that can lower cost and improve access.

III. Don't expand the Hospital 340B program without reforms first

As a safety net for the poor, Congress started a drug rebate program in Medicaid in 1990 to provide pharmaceuticals to the most vulnerable enrollees. Section 340B of the Public Health Service Act requires drug companies that participate in the Medicaid entitlement to sell outpatient pharmaceuticals to various medical facilities that provide care to low-income patients. The program began in 1992 and was essentially an extension of the original drug rebate plan.

Drug companies give outpatient medicines at a discounted price to facilities called "covered entities" that serve the poor or uninsured. However, covered entities can sell the drugs to anyone, not just the poor, regardless of their insurance or ability to pay.

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[2] Congress should take action to make telemedicine permanent, by Sally Pipes, May 20, 2024, available at https://www.sun-sentinel.com/2024/05/20/congress-should-take-action-to-make-telemedicine-permanent-opinion/

[3] Warner, colleagues push to preserve access to telehealth for seniors on Medicare, office of U.S. Senator Mark Warner, Virginia, January 23, 2024, available at https://www.warner.senate.gov/public/index.cfm/2024/1/warner-colleagues-push-to-preserve-access-to-telehealth-for-seniors-on-medicare

In other words, these facilities obtain drugs at a mandated discount price through the 340B program, sell them at higher prices to insured and paying patients, and then collect the profits between the full retail price and their discounted price. The bottom line, the program has changed from assistance to the poor into a money-maker for these facilities and an additional cost, or tax, for the drug manufacturers.

The definition of a covered entity has expanded several times since 1992, but Congress and newly passed laws, such as the Affordable Care Act, increased the number of qualified facilities dramatically. Obamacare added outpatient cancer clinics, rural clinics, sole community hospitals, and critical access hospitals to the list. Plus, the ACA increased Medicaid significantly.

340B program expanding but not serving the original goal

As of 2021, the 340B program accounted for 7.2 percent (approximately $44 billion) of all prescription drugs sold in the U.S. By 2022, the amount increased to $54 billion.[4] A total of 53,000 medical facilities participated in the 340B plan, which is almost double the number of facilities in the program in 2014.[5] The average profit margin on the sale of prescription drugs not obtained in the 340B program for medical facilities is 23 percent, compared to profits of 72 percent for drugs obtained in the 340B program.[6]

Over 40 percent of all insured patients in the United States are in the government programs of Medicare and

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[4] "The 340B Drug Pricing Program," PHRMA, accessed on May 22, 2024, available at https://phrma.org/policy-issues/340b

[5] "Overview of the 340B Drug Discount Program," Congressional Research Services, October 14, 2022, available at https://crsreports.congress.gov/product/pdf/IF/IF12232

[6] "For-Profit Pharmacy Participation in the 340B Program," BRG, October 2020, available at https://media.thinkbrg.com/wp-content/uploads/2020/10/06150726/BRG-ForProfitPharmacyParticipation340B_2020.pdf

Medicaid, both of which began in 1965. Since the 1980s, provider payments have gradually, but relentlessly, gone down. This has caused doctor and hospital consolidation so that medical providers could survive financially.

Unfortunately, medical facilities use the 340B program as another income source. Elected officials argue that the money comes from drug manufacturers and not taxpayers, so why not expand the program?

Although it began with the goal of helping the poor, the 340B program has morphed into a supplemental income plan for the participating medical facilities. The poor are not being helped as originally intended. The other untoward consequence of the program is the financial burden placed on the pharmaceutical manufacturers. Instead of more money for the research and development of life-extending and life-saving drugs, the companies are subsidizing medical facilities that the government can't financially support.

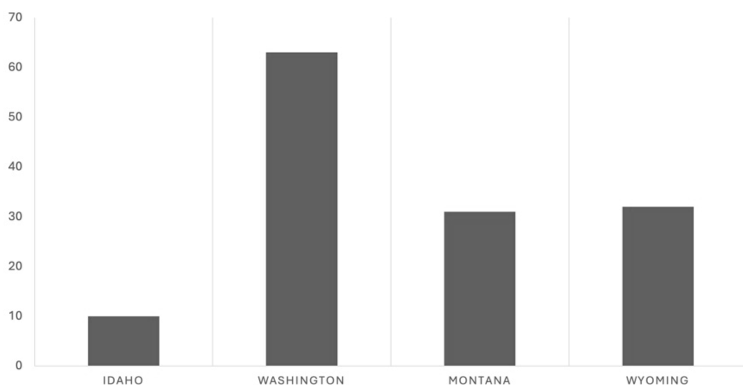
The 340B program either needs serious reform to actually support the most vulnerable patients or it should be closed. It definitely should not be expanded by policymakers in its present form.

IV. Reduce health insurance mandates to offer more insurance options

Americans view health insurance much differently than other types of insurance. When a person says that they have great health insurance, what they really mean is that their insurance covers a whole host of medical problems – eye wear, dental, preventive care, and routine check-ups. Other forms of insurance, for example homeowners, cover major problems, but routine issues, like mowing the lawn and cleaning the gutters are covered by out-of-pocket expenditures.

Compounding this difference between health insurance and other types of insurance are state and federal mandates that require policies to cover various medical problems. The Affordable Care Act, or Obamacare, requires every health insurance policy to contain ten specific mandates. Each state has its own mandates that in many cases overlap the federal mandates. As of several years ago, Wyoming had 32 health benefit and provider mandates, Montana had 31, and Idaho had 10.

Health care insurance benefit mandates by state



Instead of government-mandated "insurance" and entitlement programs that attempt to cover every possible health-related activity, health coverage needs to work like other forms of indemnity insurance used to mitigate risk, such as car, homeowners, and life insurance. Just as it makes little sense to use insurance to pay for gas or to mow the lawn, state and federal governments need to get away from the idea that health insurance should cover all our health-related events. True indemnity insurance should be there for catastrophes and emergencies. Routine day-

to-day health services should be paid for out-of-pocket as needed.

Health mandates unnecessarily add cost

Each health care mandate increases the overall cost of health insurance. The reality is that not everyone needs all of the required mandates. For example, a healthy, unmarried thirty-year-old man does not need obstetrical coverage, yet he is paying for it in his health insurance plan. Women do not need tests to screen for prostate cancer.

Mandates are a classic example of politically powerful interest groups lobbying elected officials to include payment for their services in every insurance policy. Mandates restrict competition, drive up prices, and greatly restrict choices for patients.

Supporters of mandates say no one can predict a patient's future needs, so the government should require people by law to buy expensive coverage. It is true that the future is unknown, but a catastrophic, high-deductible insurance plan can be designed to cover any future major medical problem. Affordable auto and homeowner insurance policies, except in very unusual circumstances, cover any and all major problems and provide individuals and families with millions of dollars of coverage should the need arise.

As mentioned above, states vary in the number of mandates required. Unlike other forms of insurance, health insurance is sold on a state-by-state basis. A reasonable first step would be to allow the interstate purchase of health insurance. Patients would have a huge increase in their choices and the market would become much more competitive. The health coverage that some state governments mandate would still be available, but consumers would make their own decision about whether to buy it.

Americans across the political spectrum agree that the fundamental problem with health care in the United States is the ever-increasing cost. Reducing or eliminating government health insurance mandates altogether would be a definite move to lowering these costs.

V. Abolish certificate of need (CON) requirements

Limiting options is not a way to reduce cost or improve care.

Certificate of need (CON) laws are a state regulatory tool that seeks to limit the number of health care resources in a specific area under the theory that excess facilities will lead to excess cost. In fact, the opposite is true.

The United States Department of Health and Human Services has concluded that CON laws can restrict investments that would benefit consumers and lower costs in the long term and are likely to increase, rather than constrain, healthcare costs.[7]

Idaho and Wyoming do not have a CON law. Montana's CON requirement is limited to nursing homes. Washington state's CON requirement, which has been in place since 1971, is much more restrictive.[8]

As of January of 2020, health care services in Washington that needed a Certificate of Need included[9]:

- Ambulatory Surgical Centers (ASCs)
- Assisted Living & Residential Care Facilities

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[7] Reforming America's Healthcare System through Choice and Competition, U.S. Department of Health and Human Services, 2017, available at https://ij.org/wp-content/uploads/2023/07/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf

[8] National Conference of State Legislatures, Certificate of Need State Laws, Updated February 26, 2024, available at https://www.ncsl.org/health/certificate-of-need-state-laws

[9] Washington and Certificate of Need Programs, Mercatus Center, George Mason University, March 22, 2021, available at https://www.mercatus.org/publication/washington-and-certificate-need-programs-2020

- Burn Care
- Cardiac Catheterization
- Home Health
- Hospice
- Hospital Beds (Acute, General Licensed, Med-Surg, etc.)
- Neonatal Intensive Care
- New Hospitals or Hospital-Sized Investments
- Nursing Home Beds / Long-Term Care Beds
- Obstetrics Services
- Open-Heart Surgery
- Organ Transplants
- Psychiatric Services
- Rehabilitation
- Renal Failure/Dialysis
- Substance/Drug Abuse
- Swing Beds

Analysts at the Mercatus Center at George Mason University have found that there would be more health care services, as well as savings in the cost of healthcare spending in Washington state, if there were no Certificate of Need requirement.[10]

VI. Reject further Medicaid expansion

The passage of the Affordable Care Act, and the new, enticing dollars made available from the federal government convinced most states to expand their Medicaid coverage. In fact, all but nine states decided to take the plunge. Wyoming, wisely, decided against.

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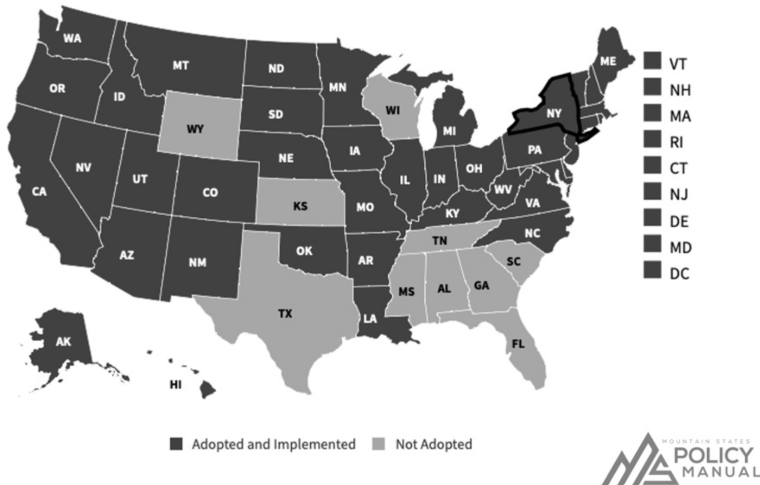
[10] Ibid

Medicaid expansion by state



Medicaid coverage can be extremely limiting, not only for patients but for health care facilities. Providers consistently run into billing problems, and reimbursement rates are so low that health care facilities will either limit the number of Medicaid patients or try to make up the cost elsewhere.

Medicare vs. Medicaid vs. private insurance reimbursements

Specialty	Medicaid Reimbursement	Medicare Reimbursement	Private Insurance Reimbursement
Total	74.3%	87.8%	96.1%
BROAD CATEGORIES			
Primary care	75.8	80.6	96.8
Surgical/medical care	72.9	93.8	95.5
SPECIFIC CATEGORIES			
Dermatology	46.2	97.7	98.0
General/family practice	76.0	93.6	94.0
General surgery	87.5	95.9	99.6
Internal medicine	62.9	95.2	98.8
Obstetrics and gynecology	81.7	88.7	98.9
Ophthalmology	77.4	-	-
Orthopedic surgery	85.8	99.1	99.2
Other specialties	70.0	92.8	96.0

In Montana, where Medicaid expansion happened in January of 2016, there has been a dramatic difference between hospital payments from Medicaid, and the cost of providing services to enrollees, according to the Foundation for Government Accountability.[11]

Hospital shortfalls before Medicaid expansion in the Treasure State totaled roughly $55 million. Post-expansion, hospital shortfalls are double at $110 million.[12] The data shows charity care has also fallen by nearly a third.

When Idaho voters passed Medicaid expansion in 2018, a lot of promises were made. Few, however, have panned out.

There were promises of limited enrollment – 60,000. But the latest numbers show more than double the projection and more than 1 in 4 Idahoans now enrolled.

There were promises it would be a good financial deal and lower health care costs. That hasn't happened either.

The 2023 Idaho state budget increased Medicaid state spending to $856.3 million - a 25% increase from just four years ago. If the trend holds, Idaho will hit one billion dollars in Medicaid spending in the next few years.

As a Foundation for Government Accountability report indicates[13]:

> "In Idaho, there were at least 83,000 ineligible enrollees reported in January 2021. These enrollees do not meet traditional eligibility

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[11] Medicaid expansion deceives states and harms the truly needy, Foundation for Government Accountability, May 2024, available at https://thefga.org/research/medicaid-expansion-deceives-states/
[12] Ibid
[13] Shattered projections and broken promises, Foundation for Government Accountability, December 1, 2022, available at https://thefga.org/paper/able-bodied-adults-ineligible-enrollees-fueling-idahos-medicaid-surge/?fbclid=IwAR18PcGkOLp3nHgKc29vVm62ejcA4mi-qcU-oQkH6lYQBdhaAYL3VtzGXZo

> standards, but state officials are unable to remove them from the program because of the congressional handcuffs. If the trend continues, there could be hundreds of thousands of additional ineligible Medicaid enrollees. These ineligible enrollees would come with a monthly price tag of tens of millions of dollars—a figure that will only continue to grow as the public health emergency is prolonged."

Meantime, data from the Centers for Medicare and Medicaid Services shows the number of individuals enrolled on private insurance via the exchange has increased in the states that did *not* expand Medicaid. If they were to take the expansion plunge, at least 6,339 individuals in Wyoming would be forced on to the Medicaid rolls.[14]

How can lawmakers in Idaho, Montana and beyond begin to rectify the situation with Medicaid? By opting out of additional federal funding.

By removing the Medicaid handcuffs, policymakers can take control of their programs and focus on serving the most vulnerable populations, rather than being restricted by federal regulations. This would allow a state to tailor its Medicaid program to the unique needs of its residents and make more effective decisions about how to allocate resources. By prioritizing the truly needy, lawmakers can ensure that a Medicaid program is truly serving its intended purpose.

VII. Expand the use and availability of Health Savings Accounts

[14] 2024 open enrollment period state-level public use file, U.S. Department of Health and Human Services, available at https://www.cms.gov/files/zip/2024-oep-state-level-public-use-file.zip

Policymakers at the state and federal levels should be doing whatever they can to expand and promote the use of Health Savings Accounts (HSA's).

An HSA is an account that allows a user to set aside money on a pre-tax basis to pay for health care expenses. Often, employers will match an employee's contributions to an HSA. And, depending on how the HSA is setup, employees can earn interest in the account.

An HSA puts the power of everyday health care spending in the hands of the consumer. Instead of forcing citizens to abide by all the rules of their health insurance company, they can shop around and, in doing so, help put pressure on the market to lower costs and improve care. Current HSA account balances exceed $100 billion nationally roughly $3,000 per account, on average.[15]

Unfortunately, 90% of Americans lack access to health savings accounts. Why? Because, under current law, it is illegal to have an HSA unless you have a high-deductible health care plan. This means even those who are uninsured cannot legally save for their health care in an HSA. Most federal health care programs like Medicaid and Medicare don't meet the definition of high deductible, so Americans are shut out there as well.

This makes no sense. Lawmakers can change the system by either decoupling HSA's from insurance altogether, or it could allow most insurance plans to be HSA-qualified.

One proposal recently introduced would even allow citizens to accept federal contributions to an HSA in lieu of reduced

[15] Why 90% of Americans lack access to health savings accounts, by Dean Clancey, Americans for Prosperity, October 2022, available at https://americansforprosperity.org/blog/how-to-fix-the-hsa-ceiling/

cost-sharing of insurance purchased through an exchange.[16]

For example, if a citizen buys health coverage through an exchange, cost-sharing by the federal government reduces the cost. Citizens would be able to choose whether they wanted a lower insurance premium, or a higher premium with the option to have an HSA partially funded by the government.

Researchers with the Paragon Health Institute contend doing so would result in approximately $1,400 a year being placed in a citizen's new health care savings account. For a younger adult who has few health care costs, the account could grow and be worth as much as $119,000 in 30 years.[17]

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[16] The Access Act, introduced by Congressman Greg Steube and Congresswoman Kat Cammack, September 21, 2023, available at https://steube.house.gov/uncategorized/steube-cammack-introduce-the-access-act/
[17] Follow the Money: How Tax Policy Shapes Health Care, Paragon Health Institute, available at https://paragoninstitute.org/private-health/follow-the-money-how-tax-policy-shapes-health-care/