Goodman Institute Quarterly
Turning Ideas Into Policy
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Did the Government Make Us Fat?

THIS QUARTER:

In this quarter the Goodman Institute published the key health policy recommendations of 81 think tanks and activist organizations. These policy changes are pro-patient, pro-family and pro-free enterprise. We also published studies on the government's failure to promote early Covid treatment, government spending as the cause of our current inflation, and the government's role in promoting bad diet advice.

A new study by Goodman Institute author Greg Rehmke makes fascinating reading.

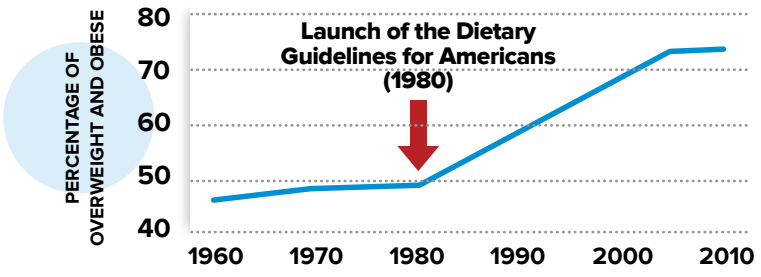
According to the Centers for Disease Control and Prevention, 70% of Americans are overweight and 40% obese. Doctors and nutritionists—following federal guidelines—have been advising overweight Americans to "eat less and exercise more." That advice fails for most overweight Americans who attempt calorie-restricted diets, leaving them frustrated, depressed, and still overweight.

Beginning around 1980, the federal government and public health agencies began demonizing meat and saturated fat as the major cause of obesity, diabetes, and cardiovascular disease in the U.S. and around the world.

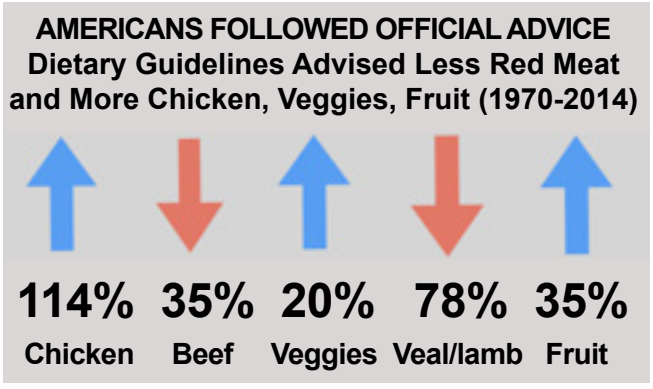
They promoted a low-fat diet, with increased consumption of carbohydrates instead. Obesity in the U.S. has been steadily increasing ever since.

Sadly, these top-down public health campaigns served up a perfect nutritional storm for higher levels of obesity, diabetes, high blood pressure, and cardiovascular disease. And this was done while mounting, high-quality, peer-reviewed nutritional research suggested the basis for their advice was completely wrong.

Furthermore, Americans did not ignore the government's advice. They got fatter while they were following the official advice.



From "US Dietary Guidelines for Americans - 101." Nutrition Coalition, https://www.nutritioncoalition.us/dietary-guidelines-for-americans-dga-introduction



US Food Consumption Data: https://ninateicholz.com/new-us-food-availability-data/, January 2017

Pro-Patient, Pro-Family Health Reform

More than 80 think tanks and research organizations have produced detailed policy recommendations in *Health Care Choices*, a project initiated by the Galen Institute with input from the Goodman Institute and the Heritage Foundation. Here are key reforms, largely based on that document, and published in a Goodman Institute Brief Analysis in February:

End Obamacare's narrow networks, which are denying patients access to the best doctors and the best care.

According to its supporters, a primary benefit of Obamacare is protecting people who enter the individual market with a pre-existing condition. Yet the Affordable Care Act triggered a race to the bottom by giving health plans perverse incentives to attract the healthy and avoid the sick. The most successful Obamacare insurers are Medicaid contractors. The plans that have survived in the exchanges look like Medicaid managed care with a high deductible.

As a result, in Dallas, Texas, no individual insurance plan includes University of Texas Southwestern Medical Center. In Texas generally, cancer patients don't have access to MD Anderson Cancer Center in Houston. This pattern is repeated all over the country.

How would the individual market be different?

In an ideal health care system, health plans would compete to attract patients with medical problems. That's because risk-adjusted premium subsidies would make it profitable to compete to enroll the chronically ill. Something like this is already being successfully done in the Medicare Advantage program.

End Obamacare's high deductibles and premiums, and let families have access to insurance that meets their medical and financial needs.

The most important reform is reinsurance – setting aside funds for the care of the sickest, most costly enrollees. Absent these catastrophic risks, insurers can afford to charge lower premiums. A second reform is "limited benefit insurance." Young families, with moderate incomes and routine health needs, will almost never willingly choose a plan with very high deductibles. They want to know that they can take a sick child to the doctor's office or to the emergency room without having to worry about whether they can afford it. That's why they will almost always choose first-dollar coverage over last-dollar coverage.

So why not allow people to have the kind of insurance that meets their needs? Let families have a partial tax credit for the kind of insurance they want and send the remainder of the credit to a safety net fund that will cover those rare and unusual circumstances when the medical bills are really high.

Let workers have access to personal, portable health insurance.

In an ideal world, most people would own their own health insurance and take it with them as they travel from job to job and in and out of the labor market. Because of a Trump administration executive order, we are closer to the ideal. Employers can now give tax-free funds to employees to buy health insurance that they will own. Congress needs to codify this change.

Expand virtual medicine, so that patients can get more care in their own homes.

As we entered the year 2020, it was illegal (by act of Congress) for doctors to charge Medicare for a patient consultation by means of phone, email or Skype. Even non-Medicare patients and their doctors were prohibited from using Zoom or Facebook or similar devices – because of privacy regulations.

Two things made radical change possible: Covid-19 and the Trump administration's commitment to deregulation. Unfortunately, the administration's executive orders can easily be reversed by a future president. And, in almost

every case, when the Covid emergency goes away, the newly acquired freedoms also go away. Congress needs to codify these changes to ensure their permanence.

Give families access to 24/7 care.

Atlas MD in Wichita offers around-the-clock care by means of phone, email, Skype, Zoom and Facebook if needed. The cost: $50 a month for mother and $10 for a child. This model, called "direct primary care," not only offers patients the entire range of primary care services, it helps patients make appointments with specialists and helps them get discount prices on MRI scans and other medical tests. It even provides generic drugs for less than Medicaid pays in some instances.

This type of care needs to be an option throughout the health care system – in individual plans, in the Obamacare exchanges, in employer plans, and in Medicare.

Let patients manage more of their own health care dollars.

There is mounting evidence that patients suffering from diabetes, heart disease, and other chronic illnesses can (with training) manage a lot of their own care as well as – or better than – traditional doctor therapy. If they are going to manage their own care, they should also have the opportunity to manage the money that pays for that care.

Unfortunately, the Health Savings Account (HSA) law does not allow employers and insurers to pay for drugs and other services that should be made available to chronic patients at no cost (to encourage their use) and to put additional funds into the HSA account for patients to manage other expenses (to encourage economical choices).

Guidance issued by the Trump administration was a major step in the right direction. People who use HSAs are now exempt from the high-deductible requirement for the purchase of drugs for 13 chronic conditions. This means that the employer or insurer can now provide first-dollar coverage for drug therapy without running afoul of HSA regulations. These changes need to be codified and expanded.

Give seniors the same opportunities young people have, including access to Health Savings Accounts.

Once seniors become eligible for Medicare, they are no longer able to make deposits to HSAs. This restriction should be replaced with the opportunity to have a Roth-style savings account, with after-tax deposits and tax-free withdrawals for any purpose.

Give patients with chronic diseases access to health plans that specialize in their condition.

Outside of Medicare, insurance plans are not allowed to specialize. They are required to offer a full range of services to all enrollees. Yet if health plans are not allowed to focus and get good at meeting some patient needs, they are likely to be mediocre when they try to meet all patient needs.

John Goodman and former Heritage Foundation Vice President Marie Fishpaw worked on marketing health reform ideas.

Health Care News *(co-published by the Goodman Institute and the Heartland Institute) covers stories ignored by the mainstream media.*

Covid: Could We Have Saved More Lives?

According to a Goodman Institute study by David Henderson and Charles Hooper, studies suggest that there are at least 11 drugs that can substantially reduce mortality in patients who contract Covid-19. These drugs are widely used, safe, and convenient. Because they are generic, most of them cost $1. A few of them cost $5.

However, the FDA actively dissuades doctors and patients from using these older drugs for unapproved, "off-label" uses by saying that such usage could be dangerous. Why would they be dangerous? Because while the FDA approved them as safe for other conditions, it hasn't yet approved them as safe for Covid-19. Never mind that these drugs are legally marketed and have been used safely billions or even trillions of times. By what logic does a safe drug become dangerous when it's used for a new purpose? By the FDA's bureaucratic logic.

David R. Henderson is a Research Fellow with the Hoover Institution.

Charles L. Hooper is President of the health care consultancy Objective Insights.

What's Wrong with the Economy?

Writing in the *Wall Street Journal*, former Sen. Phil Gramm and Michael Solon say, "It is hard to recall a greater disconnect between economic reality and public policy in American history."

Inflation has been driven by an explosion of federal spending, which was set to average 20% of gross domestic product in 2020 and 2021. Instead, it doubled to 40% of GDP in a 12-month period as pandemic spending exploded. The multiple stimulus bills did more than fill the gap in aggregate demand. Spending surged as the pandemic shutdown reduced employment and production during that period by an average of 7%. In this textbook case of inflation, $1.20 of income began chasing $0.93 of goods and services – a process greased by expansive monetary policy. That mismatch sent inflation to a 40-year high.

Phil Gramm is a visiting scholar at American Enterprise Institute.

Michael Solon is a Senior Partner of US Policy Metrics.

Coming Next Quarter: Health Policy Blog

John Goodman's health policy blog was the only pro-free-enterprise health care blog for more than a decade. It was put to rest after five years, and no other blog emerged to fill the void.

So, Dr. Goodman and Dr. Devon Herrick are resurrecting it. More about this next time.

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