



Ideas to Make Health Care Affordable Again

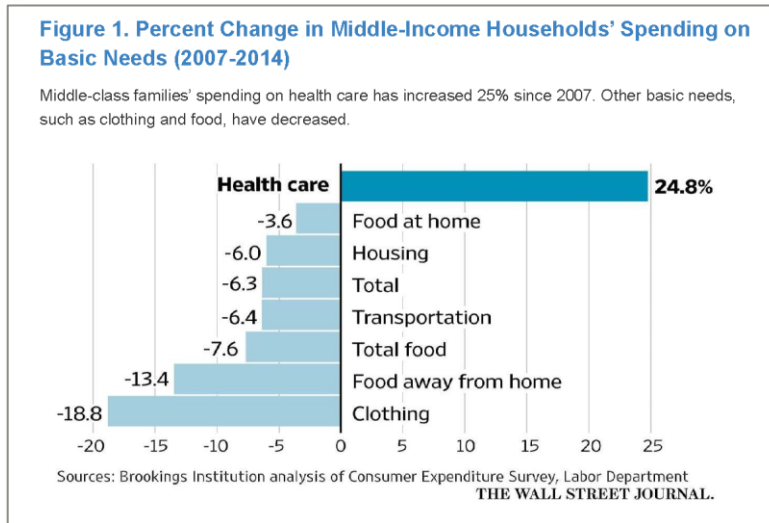
By Senator Bill Cassidy, M.D. (R-LA)

May 29, 2018

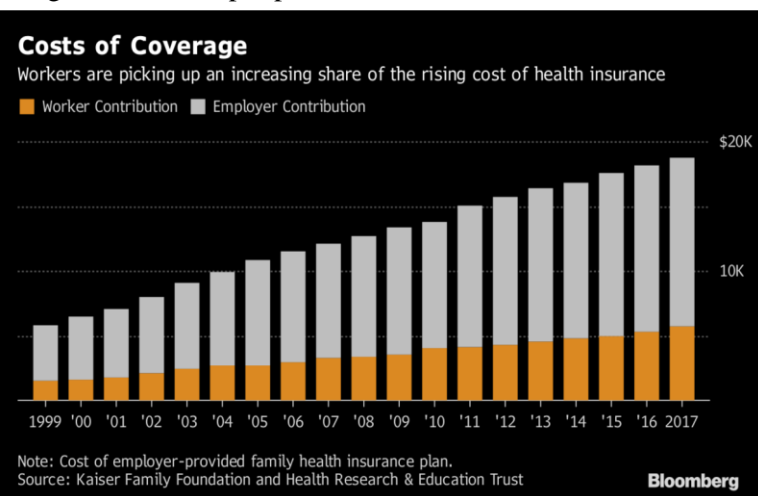
Executive Summary

More Americans are concerned about health care costs (85%) than are concerned about other common worries like retirement (73%), housing (66%), and child care (49%).¹ While Republicans, Democrats, and independents are divided over many health care issues, everyone agrees that the top health care priority should be lowering health care costs.² Americans know the status quo is unacceptable. They want solutions.

The United States spends almost twice as much on health care, as a percentage of its economy, as other developed countries — \$3.3 trillion, or 17.9 percent of gross domestic product in 2016. This is the case even though Americans use about the same amount of health care as do citizens of other wealthy countries.³ The high cost of health care more directly touches patients now than in the past, as over the last decade, patients have borne a greater share of rising costs in the form of higher premiums, higher deductibles, and higher out-of-pocket costs. From 2007 to 2014, middle-class families' spending on health care increased by nearly 25 percent, compared to decreases for other basic needs (see figure below).



Although the attention has been on premium increases in the individual market, average family premiums for employer-sponsored insurance have increased 20 percent since 2011, with deductibles increasing 49 percent over the same period.⁴ Wages have not kept up.



The individual market is worse. The average on-exchange premiums increased 105 percent in the 39 states using Healthcare.gov in 2017, compared with the average individual market premiums in 2013.⁵ This problem continues to be exacerbated by rising health care prices. In 2003, a group of influential economists published, "It's the Prices, Stupid," a paper that clearly illustrated the root problem of the U.S. health care system is high prices. Gerard Anderson of Johns Hopkins, one of the lead authors of that report, said the Affordable Care Act (ACA) "didn't reduce the actual, unit price" of health care and that "prices actually accelerated in growth post-ACA." Increased prices will continue to cause sky-rocketing premiums unless we get health care costs under control.

¹ <https://consumers4qualitycare.org/research/>

² <https://www.kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-health-care-priorities-for-2017>

³ <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.1299>

⁴ <https://www.kff.org/health-costs/press-release/average-annual-workplace-family-health-premiums-rise-modest-3-to-18142-in-2016-more-workers-enroll-in-high-deductible-plans-with-savings-option-over-past-two-years/>

⁵ <https://aspe.hhs.gov/system/files/pdf/256751/IndividualMarketPremiumChanges.pdf>

Whether in the group or the individual market, more expensive health insurance premiums add to the financial pressure on families. In a recent survey, 20 percent of respondents said a premium increase of \$25 per month would be unaffordable, and 50 percent of respondents said a \$75 increase would make their plan unaffordable.⁶

As a doctor and a senator, I see that high health care costs make families sacrifice other basic needs, prevent companies from hiring and expanding, and strain state budgets. It is critical for leaders in Washington to work together and put the needs of the American people first.

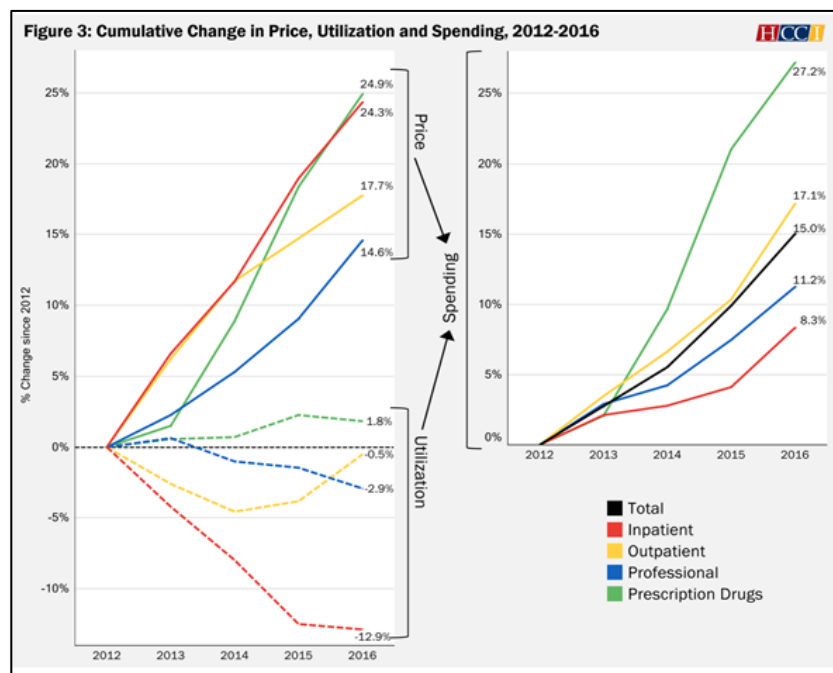
A start would be for members of Congress to take commonsense actions to lower health care costs by focusing on six policy areas:

- I. Empowering patients to reduce their health care costs
- II. Lowering health insurance premiums
- III. Ending health care monopolies by increasing competition
- IV. Decreasing drug costs for patients
- V. Eliminating administrative burdens and costs
- VI. Reducing costs through primary care, prevention, and chronic disease management

Focusing on these areas will provide relief to families, improve state and federal budgets, and give America a sustainable health care system that puts patients first.

I. Empowering Patients to Reduce Their Health Costs

Patients can and should have a larger say in how care is delivered and how much they are willing to pay. Currently, the health care system lacks tools found in a free market economy. When buying school supplies, getting an oil change, or shopping for groceries, the price and quality of the product or service is known before purchase. Not so in health care. As a result, the current system isn't open, accountable, or responsive to the needs of patients. Instead, it is expensive, bloated, and delivers mixed results. Prices for health care services have continuously risen, despite flat or decreasing demand (see figure below). A way to lower prices and return power to patients is by expanding the use and usefulness of health savings accounts (HSAs) and requiring price transparency.



First, Congress should make HSAs more useful and more used. These tax-preferred accounts allow patients to save money for future health expenditures. A Rand study found that individuals using HSAs generally spend less on health care and

⁶ https://news.ehealthinsurance.com/_ir/68/20183/eHealth%20Survey%20-%20Costs%20and%20Consequences%20-%20April%202018.pdf

use fewer medical services. Rand also found that the majority of patients do not forgo needed primary and preventative care.⁷ These accounts have worked so well that many employers looking to reduce health care expenses have moved their employees into these arrangements. But, as only individuals enrolled in high-deductible health plans (HDHPs) are eligible to have an HSA, Congress should allow Medicare and Medicaid beneficiaries to have the same options as individuals with private HDHP. Also, by expanding the type of plan that can be linked with an HSA to traditional policies with an actuarial value of 70 percent or less, more individuals will be able to save for future medical expenses. By expanding what an HSA can be used for, insurers can develop more innovative plan designs that fit the needs of patients, including the chronically ill.

Second, Congress should require price transparency for elective medical services. The same Rand study found that a majority of people using HSAs lacked adequate information to make informed choices about medical care. A Kaiser study found that two-thirds of Americans say it is too difficult to find out what medical services cost.⁸ Price transparency is about giving patients the price and quality information for elective services in advance so that they can make the decision that is best for their health and their pocketbook. Patients do make different choices and save money when they are able to compare prices and quality for health care services.⁹ This must be accompanied by an education campaign to ensure consumers are aware that they can figure out the price and quality of their care ahead of time. Encouraging price transparency will lower costs, reduce pricing variation between providers, improve quality, and return power to the patient.

II. Lowering Health Insurance Premiums

Congress can provide immediate relief to those in the individual exchange by enacting the Bipartisan Stabilization Act, authored by U.S. Senators Lamar Alexander, Patty Murray, Susan Collins, and Bill Nelson. This bill was the product of an inclusive and deliberative process in which the Senate Committee on Health, Education, Labor, and Pensions held four hearings and four roundtables with leading experts. Specifically, the proposal would fund cost-sharing reduction subsidies, give states greater flexibility to innovate through the 1332 waiver process, ensure plans can be sold across state lines, provide federal funding for reinsurance or invisible high-risk pools, and make more affordable, copper plans available to patients in the individual market. All together, these actions could lower premiums by as much as 40 percent in the coming years compared to current projected levels.¹⁰ It is unfortunate that Washington Democrats, including the bill's Democratic authors, recently voted against it. This raises the legitimate question of whether those on the other side are more interested in playing politics and blaming Republicans than lowering premiums in the individual exchange.

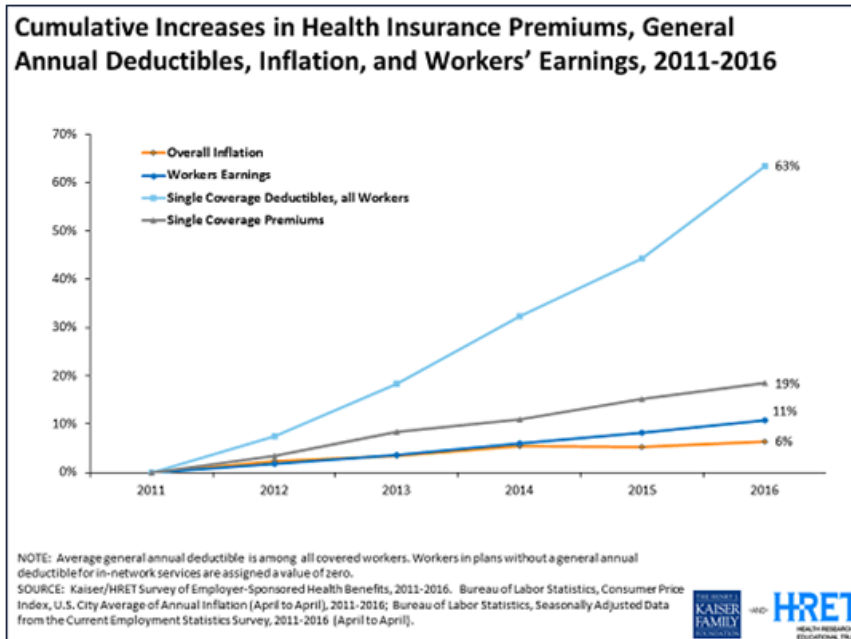
There are three more things Congress can do to make health insurance more affordable over the long-term. The first is to give states the option to combine the Medicaid expansion and the individual marketplace risk pools. States that did so would receive the money otherwise allocated to these patients and use it only for health insurance and risk-mitigation techniques such as reinsurance and high-risk pools. A state could find a state-specific innovation to provide affordable health insurance. For example, the Maine High Risk Pool worked well before the ACA closed it down. This is now a model for other reinsurance programs. Alaska has an individual market enrollment of 21,000 with two insurers that have a combined market share of 99 percent. Providing long-term stability to Alaska's individual market requires different solutions than the individual market in California, which has 2.45 million enrollees and 11 participating insurers. On the other hand, California has significant premium differences between Northern and Southern California, which the state could address. The distribution of funding should equalize the treatment of expansion and non-expansion states over a period of time but avoid harming expansion states with dramatic funding cuts. Flexibility to states would not jeopardize protections for individuals with pre-existing conditions.

⁷ https://www.rand.org/pubs/research_briefs/RB9234/index1.html

⁸ <https://www.kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-health-care-priorities-for-2017>

⁹ <https://www.publicagenda.org/pages/how-much-will-it-cost>

¹⁰ http://health.oliverwyman.com/transform-care/2018/03/a_proposal_to_lower.html



The second thing Congress can do to make health insurance more affordable over the long-term is create policies patients need as opposed to making them pay for that which they do not. Congress should codify the Trump Administration’s regulations allowing the sale of short-term limited duration plans that are available for up to 364 days and have guaranteed renewability. States would still be allowed to regulate these plans as they see fit. This would allow more affordable insurance options to be available for individuals and families currently priced out of the individual market. These plans aren’t the solution for everyone, but affordability correlates with purchasing insurance, so these plans will allow some uninsured individuals to enroll in a plan they can afford and provide them the protection they need in the event of an accident. Furthermore, there should be proper notification requirements to inform consumers about the differences between short-term plans and qualified health plans offered in the individual market. This notification process, along with current safeguards under the Public Health Services Act and the risk-mitigation dollars under the new streamlined grant to states, will ensure that individuals with pre-existing conditions are properly protected and have access to comprehensive and affordable health insurance.

Third, Congress should provide funding to states to encourage younger Americans to enroll in the individual market. Insurance experts agree that we can lower premiums in the individual market by improving the risk pool and increasing enrollment. Currently, young, healthy Americans are avoiding the individual market because it is too expensive. By incentivizing these presently uninsured individuals to enroll in the marketplace through additional premium assistance, we can increase coverage and reduce health care costs for all Americans in the individual market. States should also be given additional flexibility to experiment with other techniques and incentives to help individuals enroll in coverage.

III. Ending Health Care Monopolies by Increasing Competition

Our free market system allows companies to make a profit and pay their employees, but it should not allow monopolies to drive up costs and take advantage of patients. According to a 2015 JAMA study, annual health care expenditures increased by nearly a trillion dollars between 1996 and 2013, largely due to rising health care prices.¹¹ One way to lower prices is by increasing competition among providers and plans and ending the monopolies that are driving up prices. A new study found that:

"prices at monopoly hospitals are 12 percent higher than those in markets with four or more rivals... In concentrated insurer markets the opposite occurs – hospitals have lower prices and bear more financial risk... Examining the 366 merger and acquisitions that occurred between 2007 and 2011, we find that prices increased by over 6 percent when the

¹¹ <https://jamanetwork.com/journals/jama/article-abstract/2661579?redirect=true>

*merging hospitals were geographically close (e.g. 5 miles or less apart), but not when the hospitals were geographically distant.*¹²

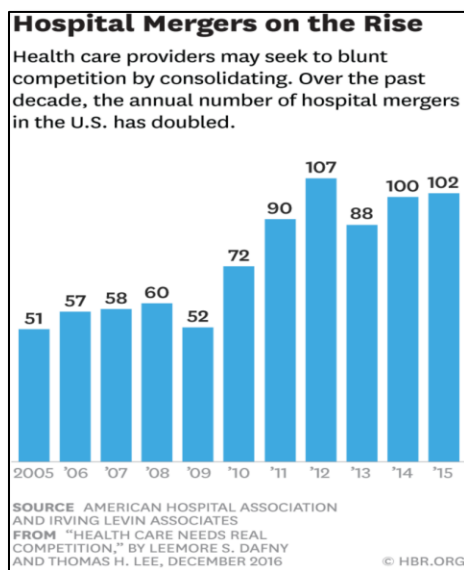
HHS should commission a comprehensive study of monopolies within the health care system. It should be broken down by geographic area and type of service. This will help governors, Congress, and regulators identify problem areas within the system and realign incentives to encourage greater competition and lower provider prices.

Monopolies by large health systems have been particularly devastating to patients in rural areas. Part of this is due to misaligned incentives in the Medicare program that favor urban providers. Under current law, hospitals are paid in part based on the cost of wages in their geographic area. The cost of wages should be considered when reimbursing providers, however, current policy does not have a floor or ceiling in place for this adjustment. As a result, urban hospitals continue to raise wages and get higher reimbursement rates from the federal government. Conversely, rural providers, which already have workforce challenges, get lower reimbursement because they can't raise wages at the same rate as urban providers. Congress should update the Medicare Wage Index to adopt a floor and a ceiling so that rural providers can be more competitive, and so that large, expensive, urban health systems can't keep artificially driving up prices. We can balance the fact that certain areas are required to pay more for wages with the fact that some urban hospitals are abusing an uncapped adjustment to further encourage consolidation and drive up costs to patients and taxpayers.

Current payment policies are exacerbating monopolies by incentivizing physicians to sell their practices to hospitals and discouraging lower cost settings of care from expanding or entering into the market. As we continue to move forward with delivery system reform that rightly encourages value over volume, it is important that Congress identify the hurdles to this evolution. The Medicare Payment Advisory Commission and the Medicaid and CHIP Payment Advisory Commission should conduct a comprehensive study to identify barriers to delivery system reform and make recommendations to Congress. This should include information on the impact payment differences for similar services provided by physicians, ambulatory surgery centers, and hospitals are adding unnecessary costs to the system and increasing the amount patients are paying.

Congress should also look at ways to promote lower-cost settings of care, freeing hospitals to specialize in the most complex diseases and conditions. These lower cost settings of care could include allowing greater use of ambulatory surgery centers, free-standing emergency rooms, rural emergency centers, and physician-owned hospitals. This should be done in a manner that ensures patients are receiving high-quality care and are not subjected to large, surprise medical bills. In addition, Congress should allow greater use of telemedicine and remove regulations that reduce competition.

Finally, the individual market has shown the consequences of insurance monopolies. Several states have experienced "bare counties" in which no insurance plan is available for that county on the individual market. This dynamic has led to insurers asking for a blank check to enter back into the market. Complicating matters is the fact that under current federal law, insurers that leave the individual market are barred from re-entering for five years. This rule had the admirable goal of trying to maintain stability in the market and keeping insurers from gaming the system by re-entering only when it is most profitable. Unfortunately, it leaves no discretion to states struggling with bare counties and unique market conditions. Congress should give states greater authority to respond to insurer monopolies and bare counties by giving authority to the states to decide when and how an insurer is banned from reentering the market. This will remove the rules currently hamstringing states' ability to negotiate and help them more proactively and creatively respond to insurer monopolies.



¹²http://www.healthcarepricingproject.org/sites/default/files/20180507_variationmanuscript_0.pdf?utm_source=newsletter&utm_medium=email&utm_campaign=newsletter_axiosvitals&stream=top-stories

IV. Decreasing Drugs Costs for Patients

Americans across the political spectrum agree the costs of prescription medications are too high. There is not a silver bullet for high drug costs, but any set of solutions must include the following:

1. Empowering patients through transparency
2. Realigning incentives towards innovation and better outcomes and away from ‘me-too’ drugs
3. Blunting tools of regulatory arbitrage and gaming the system
4. Bringing what the U.S pays for innovative drugs in line with other countries

Transparency means that a Pharmacy Benefit Manager cannot include gag clauses in which pharmacists cannot tell an insured patient that they could save money by paying cash instead of the insurance co-pay. It also requires giving the patient a “point of sale rebate,” which is the same price that the insurance company pays for a drug instead of the full list price charged by the pharmaceutical company. Lack of transparency means pharmacies can charge a lot more. Consumer Reports had secret shoppers call for the cash price of a month’s supply of five commonly used medicines at an online pharmacy, 25 different independent pharmacies and the major national chain pharmacies. For a month’s supply of the same five drugs, the cost ranged from \$69 to \$1,351.¹³

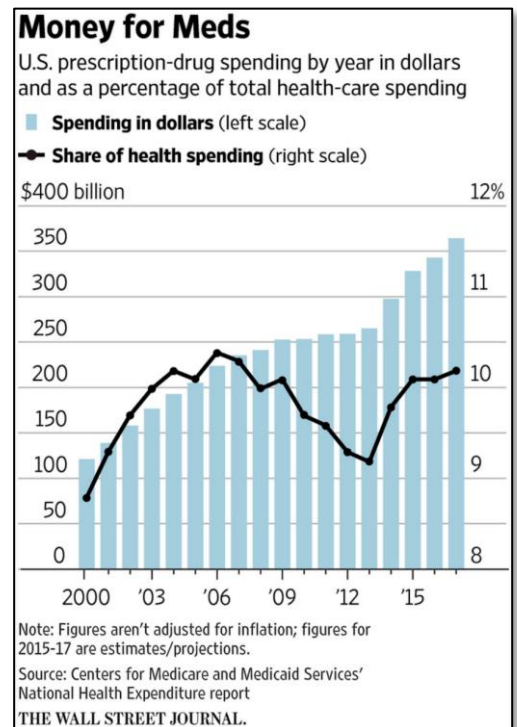
Perhaps the best example of a “me-too” drug is Duexis, a combination of the generic, over-the-counter (OTC) drugs ibuprofen (Motrin) and famotidine (Pepcid). Duexis costs \$2,600 per month.¹⁴ Ibuprofen and famotidine OTC costs \$20 per month. Unsuspecting and unknowing patients, directly or indirectly through higher insurance premiums, pay \$2,600 a month for \$20 worth of generic OTC medicine.

To realign incentives towards innovation and better outcomes and away from ‘me-too’ drugs, pharmaceutical companies should receive greater returns for truly innovative drugs that treat costly and deadly or disabling conditions than for “me-too” copycat drugs or drugs that treat a nuisance like toenail fungus. This could be accomplished by expediting reviews for innovative, high-priority drugs and providing longer protection for truly innovative cures. In turn, states and insurers need the ability to enter into value-based contracting to both afford expensive drugs and ensure there truly are better health outcomes.

Where possible, regulatory arbitrage should be addressed by market forces. To illustrate, Martin Shkreli-led Turing Pharmaceuticals purchased Daraprim, and was the only supplier of this generic drug. Turing used monopoly power to raise the price from \$13.50 to \$750 per pill.¹⁵ Shkreli relied on regulatory hurdles to prevent competition.

To end this practice, when there is only one generic manufacturer, U.S. purchasers should be able to buy at will drugs off the international market, provided that the purchased medicine is manufactured at a facility certified by the FDA or certain, equivalent international agencies such as the European Medicines Agency (EMA) that is producing an approved drug distributed using guidelines and logistics as safe and secure as mandated by U.S. law. Unlike reimportation, this proposal ensures the safety of the drug supply chain and uses market forces to drive competition and lower costs.

Regulatory arbitrage can also be addressed by aggressively preventing companies from limiting generic competition through “pay to delay,” or by buying competing product lines and shutting them down. Other issues include “evergreening,” in which minor, insignificant changes to a product are used to keep a competing product from entering the market, and misusing the Risk Evaluation and Mitigation Strategy (REMS) process, in which manufacturers limit



¹³ <https://www.consumerreports.org/drug-prices/shop-around-for-better-drug-prices/>

¹⁴ <https://www.drugs.com/compare/duexis>

¹⁵ <https://www.nytimes.com/2015/09/21/business/a-huge-overnight-increase-in-a-drugs-price-raises-protests.html>

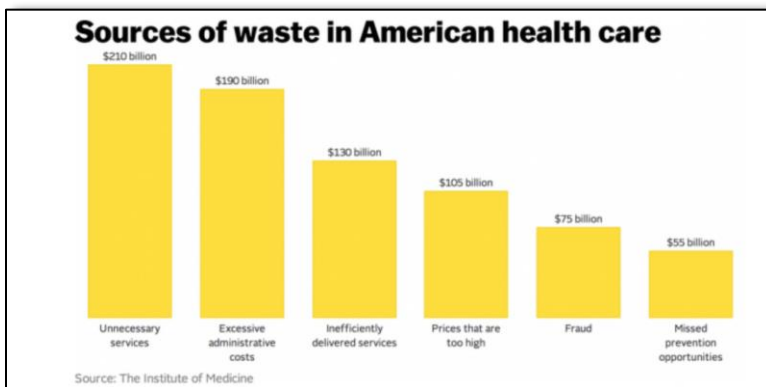
access to drug samples so that a potential generic competitor cannot test their version against the original manufacturer. An egregious example of gaming is when the Orphan Drug Act was used to increase the price of a drug costing \$50 a vial to \$40,000.¹⁶¹⁷

For these and other reasons, Americans pay more for drugs than other countries. According to a study published in JAMA, Americans spend \$1,443 per person on pharmaceuticals a year, compared to the average of \$749 in other developed countries.¹⁸ There are several ways to decrease what the U.S. pays for new drugs.

A third party can be contracted with to make sure a new drug is truly innovative (see above regarding Duexis). If there are multiple drugs in a class, a taxpayer-funded program such as Medicare should not pay more than the lowest-priced drug in that class, and the classes should not be defined so narrowly that similarly acting drugs are in different classes. To ensure that Americans pay comparable prices to other countries, what U.S. taxpayers pay for a new medicine should be pegged to a market-basket of what other larger, advanced economies pay. For drugs first introduced in the U.S. and/or quite novel products (e.g. gene therapy), alternative payment models should be developed and approved. These models could include paying for the therapy over many years, value-based purchasing where the manufacturer rebates the cost of the medicine if therapy fails, and licensing the unlimited use of a medicine for a set payment in defined populations.

These are some ideas to lower drug costs that will preserving incentives to find cures for disabling and deadly diseases.

V. Eliminating Administrative Burdens and Costs



A 2017 report by the Organization for Economic Cooperation and Development (OECD) shows that U.S. health care administration costs (the planning, regulating, and managing of health systems and services) account for more than eight percent of U.S. health care spending. This is by far the highest in the developed world, with other developed countries averaging only three percent spent on administration. Reducing burdensome regulations on providers and stakeholders would aid significantly in lowering unnecessary health care costs. Congress should start by repealing the

employer mandate and its reporting requirements, which add significant costs to employers and discourage them from hiring more workers. More must also be done to provide regulatory relief to providers and health systems trying to advance delivery system reform. The U.S. Department of Health and Human Services (HHS) should conduct a comprehensive study of current regulations and pursue a goal of reducing costs associated with these regulations by at least 10 percent. This should include reforming the meaningful use program that is turning highly educated and compensated health professionals into data entry clerks. Additionally, more must be done to consolidate existing quality measures and reorient the system toward outcomes measures that are designed by and tailored to specific types of providers. Finally, Congress should address medical liability reform. Defensive medicine and frivolous lawsuits have contributed to unnecessary health care spending and ultimately led to costs spiraling out of control.¹⁹

VI. Reducing Costs through Primary Care, Prevention, and Chronic Disease Management

To lower health care costs over the long-term, we must realign the system to focus on prevention, primary care, and the social determinants of health that lead to bad outcomes and expensive chronic conditions. Enacting change on this front will take a long time, but Congress and the administration can take steps now to put the country on the right path.

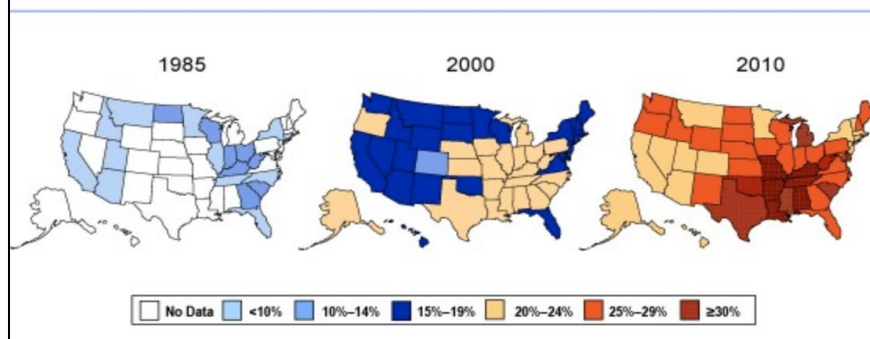
¹⁶ <https://www.nytimes.com/2012/12/30/business/questcor-finds-profit-for-acthar-drug-at-28000-a-vial.html>

¹⁷ <https://www.cbsnews.com/news/the-problem-with-prescription-drug-prices/>

¹⁸ <http://www.commonwealthfund.org/publications/in-the-literature/2018/mar/health-care-spending-united-states-other-high-income-countries>

¹⁹ <http://money.cnn.com/2017/01/11/news/economy/healthcare-administrative-costs-us-obamacare/index.html>

Obesity Trends in the US: 1985 - 2010



Patients do better when they have a relationship with a doctor or affiliated practitioner. Costs decrease when the providers and/or the patients have a financial incentive to control costs.²⁰ Physicians are best positioned to control cost and improve outcomes. Practice models that capitalize on this must be enabled. More must also be done to provide mental health and substance abuse treatment for patients on Medicaid. Congress should alter or remove the Medicaid Institutions for Mental Diseases (IMD) exclusion and give states greater flexibility to connect patients with the mental health and substance abuse services they need.

Obesity is a major public health crisis. According to the Centers for Disease Control and Prevention, more than 36 percent of U.S. adults have obesity.²¹ The percentage of Americans with obesity is set to exceed 50 percent by 2030 unless we take immediate action to change the situation.²² Obesity is the root cause of many chronic diseases plaguing seniors and driving up health care costs. According to Dr. Lee Kaplan, obesity medicine specialist at Massachusetts General Hospital, obesity is linked with more than 60 other chronic conditions.²³ In total, obesity accounts for more than 20 percent of annual health care costs.²⁴ Clearly, if we want to lower health care costs, we need to tackle the obesity epidemic. This will take an all-of-society approach. There isn't a single solution but addressing this must be a singular objective.

HHS should commission a comprehensive study on the social determinants of health and disparities that exist within the current system. The current disparities that exist between Americans of different races and socioeconomic status are frightening and a travesty. For example, according to a recent New York Times article regarding maternal and infant health disparities between races, "black infants in America are now more than twice as likely to die as white infants — 11.3 per 1,000 black babies, compared with 4.9 per 1,000 white babies, according to the most recent government data — a racial disparity that is actually wider than in 1850, 15 years before the end of slavery."²⁵ At the conclusion of this study, HHS should submit a list of recommendations to Congress on how to bend the cost curve and improve health outcomes by addressing these disparities.

Conclusion

Health care costs continue to weigh down American families. For too long, Washington has failed to take action that adequately addresses these concerns. Time and again, our elected officials have prioritized partisan finger-pointing rather than the needs of the American people. We can and must do better.

As a doctor, I want what's best for patients. It's time for Congress to challenge those who are protecting a broken system that imposes higher costs on families without delivering better value. The American people want action on policies that solve these problems and lower health care costs. I'm willing to work with the administration and anyone in Congress to enact legislation that addresses the six key policy issues laid out in this paper. No one has cornered the market on good ideas. With smart policy we can lower health care costs for American families.

²⁰ <http://www.commonwealthfund.org/publications/in-the-literature/2015/jun/effects-medical-home-intervention-on-quality>

²¹ <https://www.cdc.gov/obesity/data/adult.html>

²² <http://healthyamericans.org/assets/files/A.pdf>

²³ Campaign to End Obesity: Dr. Lee Kaplan at Preventing and Treating Obesity in the Primary Care Setting 2013 Workshop - http://www.obesitycampaign.org/obesity_facts.asp

²⁴ <http://campaigntoendobesity.org/documents/FinalLong-TermReturnsofObesityPreventionPolicies.pdf>

²⁵ <https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html>