

# Congressional Brief: NCPA Health Reform Agenda

## Goals of Health Reform

Health reform must replace Obamacare with increased flexibility in health plan design; tax fairness regardless of where Americans get their health coverage; increased access to primary care by removing barriers to innovative medical practices and services; reform of hospital regulation to better serve patients; reduced costs through price transparency to boost competition and innovation in medical services and prescription drugs; strengthened Medicare, Medicaid and Veterans Health that better serve the needs of patients; and changes in the financing of medical care so that individuals have control over their health care dollars and the means to pay for medical care over their lifetimes.

## Reform Health Insurance Markets to Better Serve Americans

**Repeal Obamacare.** Congress should repeal the individual and employer mandates and taxes of the Patient Protection and Affordable Care Act (ACA). In addition, Congress should repeal regulations that prevent insurers and employers from designing affordable health plans, including the “essential benefits” package, and allow consumers to choose limited benefit plans and catastrophic coverage.

**Increase Health Coverage Flexibility.** Congress should repeal the ACA regulations that prevent insurers from fully adjusting individual premium rates to reflect known health risks. Instead, Congress should restore the right to renew coverage if an applicant has maintained insurance with no gaps of more than 63 days (COBRA) and insurers should be allowed to sell multiyear coverage. This would also allow individuals to keep their portable health plans regardless of employment. A national market in addition to state-regulated markets would allow insurers to sell policies across state lines, resulting in competition among states to reform overly-restrictive state mandates. Health plans should be allowed to build in cost-containment tools such as Health Savings Accounts, cost-sharing and reference pricing — which allows health plans to set the amount they will reimburse for a particular procedure. This would give providers an incentive to charge no more than the reference price or risk losing customers. Insurers and health plans should also be allowed to maintain exclusive provider networks, require competitive bidding and selectively contract in order to obtain the best prices.

**Fairness in Health Insurance Tax Breaks.** Many Americans who do not have access to coverage through work pay for health insurance with after-tax wages or pay the full cost of medical treatment out of their own pockets. Those who lack access to health coverage at work should have access to a defined tax credit that provides a comparable amount of tax relief as employer-provided health benefits for a middle-income family. The tax credit should be advanceable (so that it can be used to pay monthly premiums) and refundable (that is, a net subsidy) for those who cannot fully pay the cost of premiums because of their income or health status.

The tax credit should replace the cost-sharing subsidies and sliding-scale subsidies of the Obamacare exchanges, and could be used to purchase private health insurance or pay directly for care. The credit should be adjusted for health status, or age as a proxy for health status. Individuals who prefer should be allowed to keep their employer plans. The Cadillac Tax on insurance with little or no deductibles or copays should be replaced with a limit on the value of employer-sponsored health coverage and the amount of premium payments that are excluded from

employees' income to the equivalent value of the tax credit for a middle-income family. This can be done in a fiscally responsible manner. For instance:

- According to the Congressional Budget Office, federal spending on Medicaid and the Children's Health Insurance Plan (CHIP) will amount to \$394 billion in 2016.
- The current exclusion of employer-based health benefits from taxable income will cost \$144 billion of tax revenue this year.
- Current tax credits funding insurers in Obamacare exchanges will amount to \$56 billion.

This \$594 billion would be enough to fund a universal tax credit for 232 million people, averaging over \$2,500 per person.

### **Expand Americans' Access to Primary Care**

The shortage of primary care providers is expected to get much worse over the next 20 years. The supply of physicians is relatively inelastic — it takes time to train a doctor. But expanding the number of primary care residencies would help. In addition, there are many foreign medical graduates who would like to immigrate but find insurmountable barriers to licensure in the United States. Those who can demonstrate comparable experience should have an accelerated route to licensure (at the very least in primary care). Three-year medical degrees that allow students to begin a primary care residency in their fourth year and shorten the route to primary care would encourage more people to attend medical school and more to go into primary care. Finally, nurse practitioners and physicians' assistants can provide routine primary care, both in collaboration with doctors and in independent practice. Public policy should also encourage patient-centered medical homes where people have a routine source of care and someone to help them navigate the health care system.

### **Reform Hospital Care to Better Serve Patients**

Nearly one-third of health care spending is on hospital care. It is more costly than need be because hospitals do not compete on price to attract patients. Hospitals charge more for almost every service, whether it is only performed in hospitals or can be done in other care settings. Hospitals should not be paid more

for performing the same service as other providers. Moreover, physician-owned specialty hospitals should be allowed to compete and undercut the prices of community hospitals. Certificate of need laws (CON) requiring approval to build or expand hospitals or buy new equipment should be repealed; so also should federal and state Stark Laws that limit referrals. The former reduces competition while the later inhibits beneficial collaboration by physicians and facilities, such as a physician both supervising a retail clinic and receiving referrals from the clinic.

Finally, hospitals purchase medical supplies through group purchasing organizations (GPOs). Although well-intended, the antitrust exemption that allows suppliers to provide legal kickbacks to GPOs (and rebates from GPOs to hospitals) creates cartels of large manufacturers. GPOs earn more and pay higher rebates not from sourcing the cheapest suppliers, but by working with the largest, richest suppliers whose high prices provide for high rebates (that is, kickbacks).

### **Expand Price Transparency**

Market prices set by buyers (demand) and sellers (suppliers) provide essential information for the allocation of resources (capital and labor). When prices are set by a Soviet-style bureaucracy — as with Medicare price controls — markets become inefficient. As a result, it is difficult to ascertain the price of medical care in advance of treatment because there are multiple prices for any given treatment that depend on the payer and the provider's network affiliation. Many health plans treat their negotiated prices as proprietary information. Providers often contractually require price secrecy from their payers. It is especially frustrating for patients when they discover a doctor who treated them is out-of-network even though the patient made sure the hospital was affiliated with their network. Undisclosed out-of-network bills for the balance often result in higher fees and higher out-of-pocket costs.

Public policy should seek to encourage price transparency, where providers disclose fees and declare their network status. Hospital admissions generally require patients to sign a financial responsibility form that is used to enforce all fees charged by affiliated providers inside the hospital regardless of whether those providers are hospital employees or in the patient's network. Payments should be obtained through informed consent rather than consent under duress.

Public policy should encourage a meeting of the minds — the standard for an enforceable contract — and create a safe harbor for a provider to collect fees if he or she is transparent about costs.

### **Reform Health Care to Better Care for High-Cost Patients**

One-fifth of patients generate 80 percent of medical costs. The extent of medical spending on a small number of patients is actually much worse than those figures suggest. About half of all medical spending is on only 5 percent of patients, and 20 percent of expenditures are for the sickest 1 percent of patients. Some Medicaid Advantage plans employ a patient-centered medical home that coordinates care for high-cost patients. Another technique is a high-risk pool that requires a higher level of patient responsibility for sticking with treatment programs and following the advice of their care coordinator.

### **Reform Medicaid to Serve Low-Income Families**

Medicaid is an inflexible program where the federal government sets the rules and states have little ability to tailor their programs to their unique needs. And states have little reason to boost the efficiency of Medicaid programs since the federal government matches state spending — paying 50 percent to about 80 percent in some cases. The federal government should convert Medicaid into a block grant, where states and the federal government negotiate their respective contributions in addition to program design. States should be able to experiment with different program designs for different populations, and should be responsible for cost overruns.

For able-bodied adults on Medicaid, the program could be designed to transition them to private plans as their incomes rise, including requiring enrollees to pay small premiums; to work, seek work or participate in job training programs; and requiring enrollees to pay nontrivial copays and cost sharing.

### **Reduce the Burden on Seniors' Health Care**

Medicare is unsustainable in its present form. Currently, pilot projects such as Accountable Care Organizations are having mixed success, largely due to poorly designed regulations and incentives that

aren't aligned with the needs of seniors, taxpayers and insurers. As a result of Medicare price controls, some providers are over-compensated while others are under-compensated. The program needs to experiment with cost-containment measures, such as reference pricing to encourage price competition among providers, competitive bidding among providers and selective contracting with low-cost providers.

Cumbersome regulations and procedures make the Medicare program bureaucratic. The adoption of electronic health records has reduced productivity and is not designed with physicians' or patients' needs in mind. The requirement that physicians adopt nearly 70,000 ICD-10 billing codes has also reduced productivity.

Medicare Advantage plans have been shown to improve care and have a record of care coordination. These programs are hampered by rules that reduce their effectiveness. MA plans that are joining ACOs find they do not know their members in advance. Thus, they cannot care for their members effectively.

### **Reform Prescription Drug Pricing**

Reforming the U.S. Food and Drug Administration and its outdated, incessantly slow approval process could unleash greater competition in drug discovery. New advances in information systems and data analysis allows drug makers to track health metrics in ways not possible when clinical trials were enshrined in regulations. A proposal under consideration in the U.S. House of Representatives, *21st Century Cures*, aims to bring the process into the information age.

In addition, beefing up the resources the FDA uses to review and process abbreviated new drug applications would boost competition among generic drugs. Finally, some drug makers are increasingly using so-called “captured pharmacies” to prevent generic substitution and keep prices artificially high. A captured pharmacy is one that is either owned or has a contractual arrangement not to substitute generic drugs when they are available, and not to collect cost-sharing that would otherwise encourage patients to ask about lower cost generic drugs. Drug plans and payers should have the right to use all the tools at their disposal to keep prices paid by consumers low.

### **Expand Health Savings Accounts**

Americans are increasingly paying out of pocket for their day-to-day medical needs. Health insurance

deductibles have about doubled in the past decade. Moreover, high-deductible plans are the most common in the health insurance exchange. Individuals need more avenues to save for medical bills. Flexible Spending Account (FSA) holders should be allowed to rollover their unused funds into Health Savings Accounts (HSAs). HSAs should be expanded to allow for larger contributions. The ACA law prohibiting the use of such accounts for over-the-counter drugs should be repealed. Workers should be able to use some of their HSA contributions to reimburse for wages lost to sick days. HSAs should be allowed to wrap around any health plans — including Medicare — and individuals should be allowed to use their funds to pay health insurance premiums.

### **Reform the Practice of Medicine to Better Serve Patients**

The practice of medicine has hardly changed in the past century. Yet, there are many technological advancements that could increase efficiency, reduce costs and boost convenience for patients and doctors alike. Many states have paved the way for more physicians to use the telephone to consult with their patients. However, some states make it difficult to treat patients who have not had an in-person visit prior to the telephone consultation. Patients should be the judge of how they want to interact with their physicians.

States have different regulations governing the scope of practice of so-called physician extenders — other health professionals supervised by a physician. Some of these require supervision, while others require collaboration with a physician. Allowing independent practice in areas experiencing a physician shortage would increase the number of nurse practitioners and physicians assistants.

### **Regulatory and Legal Reform of the Practice of Medicine**

**Tort Reform and the Reform of the Malpractice System.** Patients should be encouraged to negotiate and contract the level of liability compensation by a medical provider and methods of binding arbitration or mediation in the event of an adverse event.

**Regulatory Reform and the Practice of Medicine.** The telephone has existed for more than a century. Almost every physician owns a cellular telephone and every physician's office has a phone to talk with payers,

pharmacies and to schedule appointments and convey the test results. However, it is relatively rare for doctors to consult with their patients via the telephone.

Some states have erected protectionist barriers to doctors who want to communicate with patients they have not seen in person. States should allow doctors to practice in the manner they and their patients prefer. States should also move to allow patients to choose the level of provider they believe suits their needs — including physician extenders like nurse practitioners and physicians' assistants.

### **Expand Care Coordination Using Patient-Centered Medical Homes**

**Accountable Care Organizations.** ACOs are voluntary partnerships of doctors, hospitals, health plans and other stakeholders that aim to better manage patient care. A complaint often voiced by ACO administrators is that the Centers for Medicare and Medicaid Services (CMS) assigns members retrospectively at year-end. This makes it difficult to develop outreach programs to identify at-risk members with chronic diseases. Moreover, retrospective assignment also means costs are borne by one ACO while the benefits may ultimately accrue to another ACO.

**Patient-Centered Medical Homes.** Coordinating Medicare patients' care is invaluable after the critical care transition between a hospital and follow up care. A coordinator could advise seniors on lower cost health care settings, evaluate the need for home care and ensure seniors receive post-hospital follow up care and comply with drug therapy. An ACO providing a medical home could also advise seniors on where to find cost-effective services and whether they need a specialist and which specialist to see. Medicare could save billions of dollars if all seniors were given an annual risk assessment and assigned a medical home to coordinate their care. The ultimate goal is to achieve behavioral change among providers and patients. A primary care provider must have the incentive to keep seniors healthy and out of the hospital. Specialists must have an incentive to communicate with patients care coordinators. Seniors must change the way they interact with the health care system.

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