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Bipartisan Rx for America's Health Care

A PRACTICAL PATH TO REFORM

February 2020

Bipartisan Policy Center

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As a member of the Future of Health Care initiative, Alice was a passionate health care policy leader who advocated for moving America's health care delivery system toward high-quality, more cost-effective delivery of care. She strongly supported BPC's belief that nothing can be accomplished without negotiation and compromise—between both houses of Congress, across party lines, and with the president. BPC is very grateful for her contributions to this report before her death.

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HEALTH PROJECT

Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, M.D., BPC's Health Project develops bipartisan policy recommendations that will improve health care quality, lower costs, and enhance coverage and delivery. The project focuses on coverage and access to care, delivery system reform, cost containment, chronic and long-term care, and rural and behavioral health.

ACKNOWLEDGMENTS

BPC would like to thank the Robert Wood Johnson Foundation for its generous support.

DISCLAIMER

The findings and recommendations expressed herein do not necessarily represent the views or opinions of BPC's founders or its board of directors.



Letter from the Future of Health Care Leaders

Republicans and Democrats agree that reforms are needed to improve upon today's health care system and make coverage more sustainable and affordable. Despite the acrimony of recent debates, we believe there are common elements in the approaches of both parties from which to develop a politically viable plan. The best bipartisan solutions to our health care challenges will improve on what the private and public sectors do today.

As health care analysts with differing political perspectives, our recommendations are based on the following principles:

1. All individuals should have meaningful and affordable public or private health insurance.

We acknowledge a continuing role for both private and publicly-financed insurance. Regardless of the source of coverage, benefits should be evidence-based, and sufficient to ensure access to needed care, while avoiding poorly designed financial incentives that lead to either over- or under-use of care. Low- and moderate-income households need to be adequately subsidized so that they can enroll in insurance plans that provide them with ready access to quality, affordable care when they need it.

2. Health reform should be designed to avoid major disruption because many patients rely on today's long-standing arrangements to get needed care.

Reform should provide incentives for existing systems (employer-sponsored, individual markets, Medicare, Medicaid) to better align, become more efficient, and improve quality and care relationships. Reform should expand, rather than reduce, the options individuals have to improve upon their existing coverage.

3. Insurance markets should be stable, not endangered by premium increases due to adverse selection or insufficient pooling of risks.

This will require coping with extraordinarily expensive outlier health conditions through options such as adequately-financed and administered reinsurance, alternative tax credit structures and adequately-financed and structured high-risk pools. Reform proposals should ensure broad-based participation in private insurance markets to ensure pre-existing condition protections and market affordability and stability.

4. Health reform should reduce excessive and unnecessary health care cost growth.

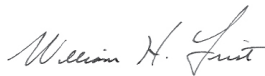
This will require policies that are designed to achieve more effective competition among insurers and providers of medical services; promote more and clearer choices for consumers; encourage payment reforms that promote improvements in care; achieve more efficient delivery of care in all settings; and encourage preventive interventions that improve health status and outcomes.

5. Reform policies must be politically and financially sustainable over the long-term.

Bipartisan solutions are more likely than approaches supported primarily by one party to produce policies that can be sustained over many years and election cycles. The hard work of developing and securing bipartisan agreements in these areas will pay dividends in terms of greater stability and certainty for patients and their families, employers, providers, plans, governments and taxpayers.



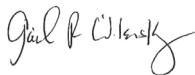
Tom Daschle



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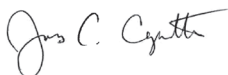
Gail Wilensky, Ph.D.



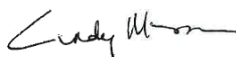
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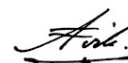
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Executive Summary

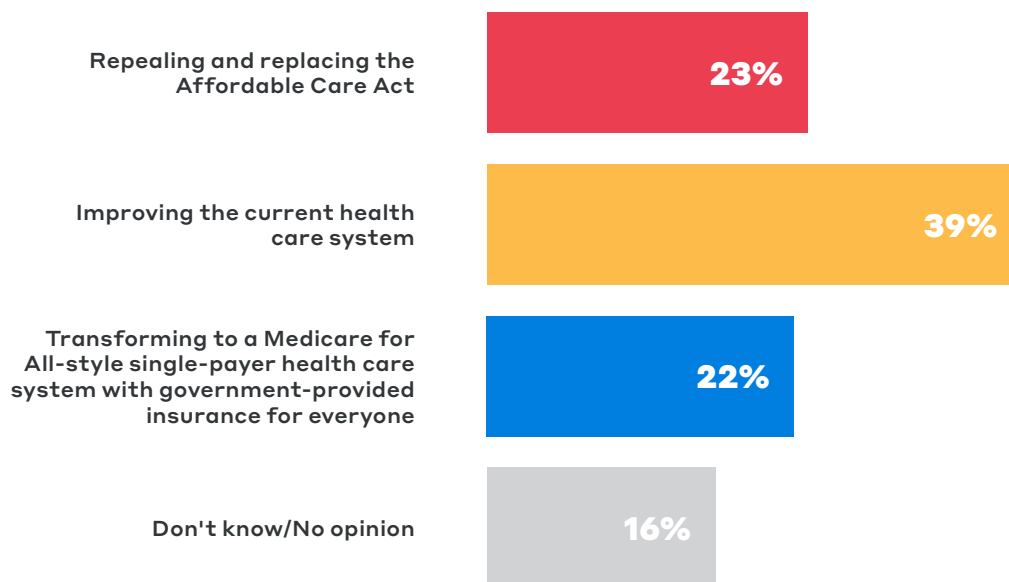
The Bipartisan Policy Center launched the Future of Health Care initiative in 2017 with a bipartisan group of leading national policy experts to create a consensus approach to improving our nation's health care system. Since then, members have met with actuaries, leaders across the health care industry, state officials, consumer organizations, policy experts, and providers to develop policies aimed at increasing access to affordable insurance coverage, improving quality of care delivered to patients, lowering costs for all Americans, and creating competition throughout the health care sector.

BPC's group of health care leaders has diligently worked together under the shared belief that the nation's health care system requires ongoing reform. Recognizing today's polarized political environment, the approach has been to build upon the current public-private system and offer policymakers a fiscally responsible alternative to repealing and replacing the Affordable Care Act on the one hand and "Medicare for All" on the other.

Importantly, in a recent [BPC poll](#), nearly 40% of voters listed improving the current health care system as their top health care reform approach. That reform approach received the most bipartisan support with a plurality of Democrats (46 percent) and Independents (38 percent), and a third of Republicans (32 percent). Among all voters, it was the most popular reform choice.

In December 2019, the BPC conducted a poll, asking voters the following question about their preferred health reform approach.

Currently, the presidential candidates are debating many plans to reform the U.S. health care system. Of the following options, which health care plan do you support the most?



Today, most national polls—including BPC’s survey—show a majority of Americans believe individuals and families pay too much for their health care and health care is a top concern in the 2020 presidential election.

This report is a multifaceted policy prescription for reforming America’s current health care system. It includes recommendations for congressional action that target excessive costs in the private insurance market, Medicare, and Medicaid, and anti-competitive behavior by some pharmaceutical manufacturers and health systems, which is occurring as a result of increasing hospital consolidations.

RECOMMENDATIONS

1. TO STABILIZE INSURANCE PREMIUMS IN THE INDIVIDUAL HEALTH INSURANCE MARKETPLACES, CONGRESS SHOULD (PAGE 15):

- Establish a federally-funded and state-administered reinsurance program.
- Auto-enroll subsidy-eligible individuals in Marketplace plans.
- Restore cost-sharing reduction payments.
- Expand federal outreach and enrollment activities.
- Expand the availability of premium tax credits to middle-income individuals.

2. TO PROVIDE RELIEF AND FLEXIBILITY TO EMPLOYERS, CONGRESS SHOULD (PAGE 22):

- Repeal the employer penalty for not providing workers with insurance.
- Rationalize subsidization of employer-sponsored insurance.
- Monitor impact and codify Health Reimbursement Account regulations.

3. TO REDUCE SYSTEM-WIDE HEALTH CARE COSTS ACROSS PAYERS, CONGRESS SHOULD (PAGE 26):

- Lower hospital costs in non-competitive markets.
- Promote all-payer claims databases.
- End surprise medical bills.
- Promote Health Savings Accounts (HSAs).
- Eliminate barriers to prescription drug competition.

4. TO IMPROVE MEDICARE, CONGRESS OR THE SECRETARY OF HHS SHOULD (PAGE 34):

- Streamline annual enrollment.
- Accelerate value-based payment models in Medicare.
- Modernize the Stark Law and Anti-Kickback Statute.
- Reform payments for post-acute services.
- Modify the Medicare prescription drug (Part D) benefit.
 - ◇ Decrease federal reinsurance payments.
 - ◇ Cap out-of-pocket beneficiary spending.
 - ◇ Lower cost-sharing to encourage the selection of generic and low-cost brand drugs.
 - ◇ Require an option in Part D plans that bases beneficiary cost sharing on actual cost.
- Address increasing costs for prescription drugs in Medicare Part B.
 - ◇ Institute a flat-rate add-on for Medicare Part B reimbursement.
 - ◇ Lower drug reimbursement based on wholesale acquisition cost.
 - ◇ Require manufacturer price data reporting.
 - ◇ Consolidate billing codes for biologics and biosimilars.
 - ◇ Establish a voluntary Part B Drug Value Program.

5. TO IMPROVE MEDICAID, CONGRESS SHOULD (PAGE 44):

- Create a state option for 12-month continuous eligibility for adults.
- Provide flexibility in Medicaid Section 1115A (Section 1332 of the ACA) coverage expansions.
- Promote fiscal responsibility in 1115 waivers.
- Redirect supplemental payments to Medicaid providers – promoting integrity and access.
- Require Medicaid outcomes measures and shared savings initiatives.
- Address Medicaid coverage of prescription drugs.

The latest national health care spending data underscores the need for these changes. According to the Centers for Medicare and Medicaid Services, national health care spending grew 4.6% to \$3.6 trillion, or \$11,712 per person in 2018, mainly driven by a faster growth in private health insurance and Medicare. Annual spending is expected to grow 5.5% between 2018 and 2027, reaching \$6 trillion by 2027. Additionally, the total number of uninsured people in the United States in 2018 increased by 1 million for the second year in a row, reaching 30.7 million.

By bringing together the nation's leading, yet politically diverse health care experts, BPC has demonstrated that it is possible to break the health care reform stalemate and create real reforms that both parties can embrace. Unfortunately, progress on reforming the nation's health care system has been stymied by a drastic movement towards ideological extremes. BPC's effort serves as an example for what can be done when policymakers put politics aside and put the health of people first.

The group's internal deliberations, not unlike those in Congress, have been intense and challenging with each member having divergent views on policies and differing opinions on the appropriate role for federal and state governments, private industry, and individuals.

These recommendations encompass changes that would increase federal spending in some cases and reduce it in others. Overall, it is the intent and expectation of the experts participating that the plan should modestly improve the government's fiscal outlook. If necessary, the policies recommended here could be adjusted to achieve this goal.

While no member of the group would necessarily support each individual recommendation on its own, collectively, they represent a comprehensive plan on how to balance sound policy and political viability that can break the status quo and strengthen America's health care system.

Our public-private health care system is complex. There are no simple solutions to the challenges faced in reforming the system. Today, there are vast differences between Democrats and Republicans about how to reform the system, as is evident in the unfolding debates ahead of the 2020 presidential election. Sustainable solutions must address consumers' concerns about the high cost of health care in a way that doesn't needlessly disrupt their coverage choices or the way they receive services today. BPC's health care leaders appreciate the efforts of Congress and the administration in seeking workable solutions and respectfully offer these recommendations as a path forward to controlling health care costs and strengthening the nation's public-private insurance system.

**"WE BELIEVE WE HAVE ADVANCED GOOD
RECOMMENDATIONS THAT ARE ACHIEVABLE IN
TODAY'S CHARGED ENVIRONMENT. WE ARE HUMBLE
TO ADMIT THAT WE MAY NOT HAVE ALL THE
ANSWERS TO REFORMING OUR NATION'S CURRENT
HEALTH CARE SYSTEM, BUT THINK OUR BIPARTISAN
POLICY PROPOSALS CAN BE EMBRACED BY BOTH
PARTIES FOR MEANINGFUL CHANGE."**

- FUTURE OF HEALTH CARE LEADERS



Introduction

Most national polls, including [one recently conducted by BPC](#),¹ show a majority of Americans believe individuals and families pay too much for their health care, and health care is a top concern in the 2020 presidential election. However, there is insufficient support for either a solely government-run or strictly market-based health care system, once consumers consider the necessary trade-offs of increased taxes, limited choices, or reduced benefits for the elderly, infirmed, or low-income populations.

BPC's [Future of Health Care](#)² initiative was established in 2017 to develop realistic, actionable policies that would provide a fiscally-responsible alternative to repealing and replacing the Affordable Care Act (ACA) on the one hand and Medicare for All on the other.

The initiative was led by a group of bipartisan national health care leaders who met with actuaries, health system and insurance industry leaders, state officials, consumers, and providers to develop a comprehensive package of proposals aimed at improving the coverage, quality, and costs of health care for all Americans.

The group strongly believes the current health care system requires ongoing reform. They approached this work with a shared belief that fundamental structural changes to the current system can only occur if Congress works across party lines to address anti-competitive behavior by some health systems and the pharmaceutical industry, and excessive costs in the private insurance market, Medicare, and Medicaid.

The recommendations in this report were developed through difficult negotiation reflecting the discomfort that is inherent in reconciling substantive and political differences. The Future of Health Care leaders believe the recommendations offer the most potential for meaningful impact in today's polarized political environment.

BPC's health care leaders hope that consensus from Congress on these policies can engender a level of mutual investment and trust among both Democrats and Republicans. Such an investment is a precondition for constructive and productive bipartisan collaboration on the reforms that are necessary to improve and sustain the nation's complex health care system.



Recommendations and Policy Rationale

1. LOWER CONSUMER HEALTH CARE COSTS

TO STABILIZE INSURANCE PREMIUMS IN THE INDIVIDUAL HEALTH INSURANCE MARKETPLACES, CONGRESS SHOULD:

- Establish a federally-funded and state-administered reinsurance program.
- Auto-enroll subsidy-eligible individuals in Marketplace plans.
- Restore cost-sharing reduction payments.
- Expand federal outreach and enrollment activities.
- Expand the availability of premium tax credits to more middle-income individuals.

According to a recent poll, health care is the top concern for most Americans in the coming elections.³ In order of importance, consumers list lowering prescription drug costs, protecting coverage for those with pre-existing conditions, and eliminating surprise medical bills.

While the national average monthly health insurance premium offered through individual Marketplace plans decreased slightly each year from 2018 to 2020, a state-level examination shows significant differences in premium changes over that same period. The national average for the lowest-cost silver level plan decreased from \$456 to \$442 over the last three years.⁴ In 2020, 16 states and the District of Columbia saw increases ranging from \$1 per month in

Massachusetts to \$99 per month in Connecticut.⁵ Perhaps even more stark is the significant variation in premiums from state to state in 2020 ranging from a low of \$294 per month for a 40 year-old at 240% of Federal Poverty Level (FPL) in Minnesota to a high of \$875 per month in Wyoming.⁶

Enrollment in the total individual insurance market in 2016 was 17 million, including 10 million who purchased through the ACA insurance Marketplaces, 4.8 million who purchased off-Marketplace ACA-compliant plans, and 2.3 million who were enrolled in non-compliant plans that were either grandfathered plans, short-term plans, or other plans.⁷

Although the number of individuals receiving coverage through state and federal insurance Marketplaces has remained relatively unchanged since 2016, the percentage of new enrollees seeking coverage dropped by 16% from 2016-19. According to the Kaiser Family Foundation, the reasons include rising premiums for ACA-compliant coverage, an increase in the number of non-compliant off-Marketplace plans now available as a result of changes in regulation, the repeal of tax-penalties for remaining uninsured, and economic trends, such as decreased unemployment and a resulting increase in the availability of employer-sponsored coverage.⁸

A number of changes to federal policy would help lower health insurance premiums, increase enrollment, and encourage new plan offerings in the individual insurance market.

Establish a Federally-Funded and State-Administered Reinsurance Program

To reduce health insurance premium costs caused by high-risk individuals, Congress should:

- **Establish a state-administered and federally-funded reinsurance program for high-cost individuals enrolled in Marketplace plans and authorize and appropriate \$30-60 billion gross over three years for the program. The reinsurance program would be administered by states, with a federal fallback program for states that do not elect to administer the program.ⁱ**

The secretary of the Department of Health and Human Services (HHS) would establish general parameters for the federal fallback program. For example, HHS would reimburse qualified health plans for 75% of costs incurred for individuals with claims over \$75,000 and up to \$350,000. States would be permitted to set their own parameters, but they could not be set at a level that increases federal spending beyond state allocation for reinsurance. States could

ⁱ Similar to the [Alexander-Murray legislation](#) S. 1771 which would have allocated \$10 billion per year for 2019, 2020, and 2021.

however, supplement federal funding with state dollars. State plans would be provisionally approved for three years.

The secretary of HHS would administer a federal fallback program in those states not electing to administer the program. The program would use a structure similar to the Transitional Reinsurance Program (TRP) that was in effect from 2014 through 2016. Under that program, qualified health insurance programs offered in the TRP received payments equal to 75% of claims between a \$75,000 attachment point and a \$350,000 cap.^{ii,iii,iv}

Policy Rationale

Prior to the enactment of the ACA, many states operated reinsurance programs or high-risk pools. These programs were financed through a combination of federal and state grants and state insurance premium taxes. The ACA TRP was designed to subsidize Marketplace health plans enrolling higher-cost individuals. The federal reinsurance program was designed to phase out over time as insurance increased in state and federal Marketplaces. In recent years, a combination of legislative and regulatory changes, including non-payment of cost-sharing reduction (CSR) payments, among other factors, has resulted in an increase in health insurance premiums. These changes have resulted in higher-than-anticipated federal payments for premium tax credits and higher premiums for consumers. In 2017, the Senate Health, Education, Labor and Pensions (HELP) Committee considered bipartisan legislation to address some of these concerns, but the legislation was not considered in the full Senate.

Auto-Enroll Subsidy-Eligible Individuals in Marketplace Plans

To increase enrollment of subsidy-eligible individuals and stabilize insurance markets, Congress should:

- **Permit states to auto-enroll subsidy-eligible individuals into Marketplace plans by providing statutory authority and technical support for states.**

Congress should provide authority to states to auto-enroll subsidy-eligible uninsured individuals into a Marketplace plan, provided that the premium is equal to or less than the amount of the individual's premium tax credit. At the request of the state, the U.S. Department of Treasury would make income and insurance coverage information available and provide technical assistance, as needed, to facilitate enrollment.

ii TRP collected contributions from all insurers to fund reinsurance payments to issuers of non-grandfathered reinsurance-eligible individual market plans, the administrative costs of operating the reinsurance program, and the General Fund of the U.S. Treasury for BY (Benefit Year) 2014-2016.

iii The TRP paid out 100% of claims between attachment point of \$45,000 in 2014 and 2015 and \$250,000 cap; 53% of claims between \$90,000 attachment point and \$250,000 cap in 2016. Total budget for TRP was BY 2014 (\$10B), 2015 (\$6B), and 2016 (\$4B).

iv TRP applied to individual QHPs offered on and off the market.

As under current law, nothing would preclude a state from adopting an individual mandate to purchase insurance coverage or impose penalties such as the laws in Massachusetts, New Jersey, Vermont, and the District of Columbia.⁹ States could apply federal premium tax credits and state-established tax credit or penalties, if applicable, to pay premiums for plans offered in the individual Marketplace. Under current law, individuals are required to repay premium tax credits based on incorrect income information;¹⁰ however, auto-enrolled individuals would not be required to repay advance premium tax credits for a tax year in which they were auto-enrolled.

Uninsured individuals, subject to current-law religious exceptions, would be auto-enrolled by random assignment into Marketplace plans with no additional cost to the enrollee, so long as a tax credit or state penalty meets or exceeds the premium cost of bronze-level coverage. States could use state tax forms to implement auto-enrollment. However, nothing in this policy would preclude states from using another means of implementing auto-enrollment.

Policy Rationale

The ACA provides premium subsidies for low-income individuals who purchase health insurance in the Marketplace.¹¹ However, many individuals who qualify for subsidies do not enroll in coverage.^{v,12} This holds true even for individuals whose subsidies would cover 100% of premium costs.^{vi,13}

Restore Cost-Sharing Reduction Payments

To create long-term stability in the individual insurance market, Congress should:

- **Enact legislation to provide a permanent mandatory appropriation for cost sharing reduction payments.**

Policy Rationale

Under current law, plans are required to waive cost-sharing for individuals with incomes below 250% of the FPL. The ACA established CSR payments to reimburse plans for those costs. The Obama Administration took the position that the language included in the ACA created a permanent mandatory appropriation for CSR payments. The Trump Administration interpreted the language as not providing a proper appropriation to support payment of the CSRs. As a result, federal CSR payments to insurers were terminated in October 2017.¹⁴

v CBO notes that “in 2019, 30 million people under age 65, or 11 percent of that population, are projected to be uninsured, an increase from 29 million in 2018 and 28 million in 2017... Among the uninsured under age 65 in 2019, 23 percent are estimated to be eligible for subsidized coverage through a marketplace but forgo it.”

vi Kaiser Family Foundation estimates that “27% of uninsured individuals who could shop on the Marketplace, or 4.2 million people nationwide, are eligible to purchase a bronze plan with \$0 premiums after subsidies in 2019.”

Federal law prohibits plans from charging cost-sharing to low-income individuals. Most states directed insurers to increase premiums of silver-level plans to offset the loss of federal CSR payments. This policy, known as “silver-loading,” resulted in higher premiums for silver-level plans. Since federal premium tax credits are calculated based on the second-lowest cost silver plan in each Marketplace, premium tax credits increased by a corresponding amount. Higher-income individuals who do not receive premium tax credits (those above 400% of FPL) saw an increase in premiums. The Congressional Budget Office (CBO) estimated the policy has resulted in a 10% increase in premiums above the level that would have occurred without the policy, and over time will increase premiums by as much as 20%. CBO has commented extensively on the treatment of scoring CSRs, and projects that a permanent appropriation for the CSRs this would eliminate the need for silver-loading and provide more stability in insurance market premiums.¹⁵

Expand Federal Outreach and Enrollment Activities

To help stabilize the individual insurance market, Congress should direct the secretary of HHS to:

- **Restore the original enrollment period of 90 days for the individual and small group markets from the current period of 45 days.**
- **Restore funding for advertising and marketing to the original level of \$100 million to encourage increased enrollment in the individual market.^{vii}**
- **Increase funding for Navigators to \$100 million, and increase associated training and post-enrollment assistance to ensure the program retains adequate operational and directional supports.**
- **Increase funding for consumer assistance programs to \$100 million to reduce burdens on states’ resources that have been left to fund them in the absence of federal support.**

Policy Rationale

According to the American Academy of Actuaries, when protections for individuals with pre-existing conditions are provided, it is important to attract healthy individuals for a balanced risk pool. Outreach and enrollment are important components of achieving that balance.¹⁶

vii Modeled on H.R. 7102, the [ENROLL Act](#), introduced under the 115th Congress, Oct 2018.

For benefit year 2020, HHS has promulgated a rule scaling back the roles and responsibilities of Navigators, indicating an increased role for web brokers and plans to enroll through non-Marketplace sites in lieu of the official government site (www.healthcare.gov) that has been used for enrollment for the duration of the ACA program.¹⁷

In recent years, the federal government has cut funding for the Navigator program and Consumer Assistance Programs (CAPs), which are designed to help people enroll in coverage and help resolve appeals related to coverage, on the assumption that as more Americans become familiar with enrolling in individual Marketplace coverage, the less education and assistance for consumers at various points will be needed.

Given that the availability of insurers, types of plans, and structures of insurance design tend to change each year on the individual and small group markets, the process of understanding what is offered and what is included in various plan options is difficult for the average consumer. The need for education on what coverage is available each year does not decrease over time, for this reason. The administration also assumes the same population of individuals continue to enroll on the Marketplace year-over-year. The individual market, however, is unique in that it is characterized by the churn of new individuals that come on and off the market year-over-year or even within a given year.¹⁸

Changes in federal policy have included a 90% reduction in spending on advertising for 2019 open enrollment (\$10 million) compared to 2017 (\$100 million);¹⁹ a 42% reduction in spending for Navigator organizations, which provide in-person enrollment assistance for consumers; and a shortening of the open enrollment period from 90 to 45 days.

Expand the Availability of Premium Tax Credits to Middle-Income Individuals

To lower health insurance premiums for more middle-income individuals Congress should:

- **Provide premium tax credits to individuals with incomes between 400 and 600% of FPL and who do not have access to employer-sponsored health coverage, in order to support the purchase of health insurance coverage through the Marketplace. The amount of the tax credit would be the greater of:**
 - ◇ **An amount that would limit premiums for the second-lowest-priced silver plan in the Marketplace to no more than 10% of income (applying the same structure as current-law premium tax credits).**

- ◇ **An advanceable minimum tax credit of \$750 per individual in households with incomes between 100% of FPL and 600% of FPL. The minimum tax credit would be indexed to grow commensurate with average premium growth nationwide for silver plans in the Marketplaces.**

Policy Rationale

The ACA established premium tax credits for individuals with incomes between 100 and 400% of FPL. For 2019, individuals with incomes between 100 and 400% FPL paid no more than the following percent of their income for the value of the second-lowest-priced silver plan in the area:²⁰

2.08%	100-133% FPL
3.11%-4.15%	133-150% FPL
4.15%-6.54%	150-200% FPL
6.54%-8.36%	200-250% FPL
8.36%-9.86%	250-300% FPL
9.86%	300-400% FPL

Individuals with incomes over 400% of FPL who purchase health insurance through the Marketplace do not receive premium tax credits to help lower the cost of health insurance. As individual market premiums have risen, this policy has resulted in a “cliff” for those who earn 400% FPL or more (often termed “middle-income”) relative to those with slightly less income who are subsidy-eligible. As noted above, the problem was exacerbated by the decision that HHS does not have the legal authority to pay CSR payments to plans.

The federal poverty level in 2019 was \$12,490 for an individual.²¹ Extending eligibility for premium tax credits to individuals with incomes between 400 and 600% of FPL (\$49,960 to \$74,940 in annual income) would reduce the economic burden on middle income individuals and families and bring more young, healthy people into the Marketplace, improving the risk pool. At the same time, providing a minimum tax credit would assure that everyone under 600% of FPL receives a minimum amount of premium assistance.

2. ADDRESS EMPLOYER-SPONSORED HEALTH INSURANCE

TO PROVIDE RELIEF AND FLEXIBILITY TO EMPLOYERS, CONGRESS SHOULD:

- Repeal the employer tax penalty for not providing workers with insurance.
- Rationalize subsidization of employer-sponsored insurance.
- Codify federal regulations for Health Reimbursement Accounts, provided the policy does not increase premiums in the individual Marketplace.

Repeal Employer Tax Penalty for not Providing Workers with Insurance

To relieve employers of the burden of collecting and reporting data, and payment of tax penalties, Congress should:

- **Repeal the tax penalty for employers that do not provide employees with qualified health insurance coverage.**

Policy Rationale

The ACA contained employer shared-responsibility provisions that require certain employers to offer minimum essential coverage that is affordable and provide a minimum value to all full-time employees or to pay a tax penalty. The mandate applies to employers with more than 50 full-time or full-time equivalent employees that work 30 or more hours per week, or 130 hours per month, on average during a calendar year. For calendar year 2018, employers subject to the requirement are assessed penalties of \$2,320 per worker.²²

Congress eliminated the tax penalty associated with the individual mandate in 2017.²³ Employers, however, will continue to pay the penalty if they do not provide affordable coverage to their full-time employees.²⁴ Together, the two policies were designed to maximize insurance coverage. Employers have argued the penalty imposes a financial burden on some employers and poses an administrative burden to all employers. In addition, some employers have raised concerns that with the repeal of the individual mandate, some healthy employees will choose to remain uninsured, resulting in higher health insurance premiums for remaining employees.²⁵

While CBO and the Joint Committee on Taxation (JCT) released the budgetary and coverage effects of a number of policies including the repeal of the individual and employer mandates, as well as other policies, they did not provide a separate analysis of the repeal of the employer mandate.²⁶

Rationalize Subsidization of Employer-Sponsored Insurance

To promote a more rational approach to subsidization of employer-sponsored health insurance coverage, Congress should:

- **Replace the recently repealed tax on high-cost employer-sponsored plans with more sustainable and progressive policy. This policy would limit the income-tax exclusion for Employer-Sponsored Insurance (ESI) at a dollar amount equivalent to the 80th percentile of single and family ESI premiums. This limitation would only be applied to expensive plans purchased by higher-income individuals. It is expected that this policy will increase federal revenue substantially relative to current law.**

While the revenue from this provision and the costs of many other proposals included in the plan are uncertain at this point, we support devoting resources to improving coverage and affordability for consumers consistent with the overall objective of also improving the fiscal outlook for the federal government. As projections for the various ideas presented here become clearer, adjustments may be possible, or necessary, to ensure the balance of these objectives that the group intends.

Policy Rationale

The ACA imposed a 40% excise tax on “high-cost” health insurance plans (i.e., insurance carriers or employers, in the case of self-funded plans). The ACA also prohibited insurers and employers from deducting the cost of the tax as a business expense. The excise tax—commonly referred to as the Cadillac tax—was intended to place downward pressure on health insurance premiums and lower health care costs as insurers and employers sought to avoid the tax premium. Congress amended the law reversing ACA policy and permitting insurers and employers to deduct the cost of the excise tax. Congress also repeatedly delayed the imposition of the tax, until it was fully repealed in December 2019. According to CBO, repeal of the tax will result in a loss of federal revenues of \$200 billion over 10 years.²⁷

There is a strong rationale for limiting the tax-preferred status of employer-paid premiums. Employer contributions for employee health benefits, including premiums and various tax-advantaged health care spending accounts, are currently excluded from workers' taxable incomes. Employee premium contributions are also paid with pre-tax dollars. This policy, known as the employer-sponsored insurance tax exclusion, has been viewed by some health economists as encouraging higher spending on insurance premiums, which leads to increased health care costs. According to the Urban-Brookings Tax Policy Center, the exclusion will cost the federal government an estimated \$280 billion in lost revenues in 2018, making it the single largest tax expenditure.²⁸

The ACA's tax on high-cost plans was repealed because it lacked sufficient support among both Democratic and Republican policymakers. While we recognize this type of reform is not easy, we should not shy away from policies that are designed to lower health care costs for consumers, employers, and the taxpayers who ultimately have to finance federal spending. We can no longer afford to delay action in implementing policies that will most efficiently allocate federal resources to secure the greatest value for the nation's investment in health care.

Monitor Impact and Codify Health Reimbursement Account Regulations

To provide additional options to employers in the offering of health insurance to their employees, Congress should:

- **Monitor the impact of current regulations and codify the rule for employers that provide sufficient funds to cover 80% of the cost of the second lowest cost silver plan, provided the policy does not increase premiums in the individual Marketplaces.**

Policy Rationale

A Health Reimbursement Account (HRA) is a group health plan that allows employers to fund medical expenses for their employees on a pre-tax basis. HRAs are funded through employer-defined maximum amount contributions and are used to reimburse employees for the qualified medical expenses of employees, their dependents, and children through age 26. Unused funds may be carried forward from year to year. Employer contributions and employee reimbursement under the accounts are tax exempt.

Because HRAs are considered to be group health plans, previous rules have prohibited the use of HRAs to pay for premiums in the individual insurance market. Under federal rules, HRAs were required to be offered in conjunction with an ACA-compliant group health plan because the limit on the accounts resulted in the plans being non-compliant with ACA requirements that prohibited limits on essential health benefits and the requirement that preventive services be offered without beneficiary cost-sharing.

HHS, the Department of Labor and the Department of the Treasury issued a final rule permitting employers to provide an HRA that is offered in conjunction with an “integrated” individual health insurance plan, which the agencies define as one offered in the individual insurance market and fully-insured student health insurance.

The new integrated HRA may pay premiums for individual coverage, specific employer-defined medical care expenses or cost-sharing. Employees who are offered or receive an “affordable” integrated HRA are not eligible for premium tax credits. It also permits employers to offer new “excepted benefits HRAs,” funded up to \$1,800 and used to pay premiums for excepted benefits, short-term plans, and Consolidated Omnibus Budget Reconciliation Act of 1985 premiums.

Opponents of this policy have expressed concerns that employers will use the policy to move high-risk employees into the insurance Marketplaces, driving up premiums in the individual Marketplace.²⁹ Supporters are skeptical of that analysis. Some of the Future of Health Care leaders would like to codify the policy and while not directly objecting, others of the group would like to move forward if the policy does not adversely impact premiums in the Marketplace.

3. REDUCE SYSTEM-WIDE HEALTH CARE COSTS

TO REDUCE SYSTEM-WIDE HEALTH CARE COSTS ACROSS PAYERS, CONGRESS SHOULD:

- Lower hospital costs in non-competitive markets.
- Establish a single all-payer claims database.
- End surprise medical bills.
- Promote the availability of Health Savings Accounts.
- Eliminate barriers to prescription drug competition.

Lower Hospital Costs in Non-Competitive Markets

To promote competition in non-competitive markets, Congress should:

- Permit hospitals in markets with a Herfindahl-Hirschman Index (HHI) score above 4,000 to enter into negotiations with the Federal Trade Commission (FTC) to bring the HHI score under 4,000, unless market consolidation was the result of a regulatory exception to the Department of Justice (DOJ) guidelines related to hospital mergers. Hospitals that do not enter into negotiations with FTC would be prohibited from charging private insurers more than an amount outlined below:

Option 1: The maximum rate paid by a private insurer to a hospital for a service would be the average Medicare Advantage (MA) rate for that service in the market, with private rates phased down to MA rates over five years:

Year 1 & 2 – HHS secretary and FTC define market concentration, and notify providers

Year 3 – 178% of Medicare Advantage Rates

Year 4 – 150% of Medicare Advantage Rates

Year 5 – 130% of Medicare Advantage Rates

Year 6 – 110% of Medicare Advantage Rates

Year 7 – 100% of Medicare Advantage Rates

Option 2: The maximum rate paid by a private insurer to a hospital would be a rate that reflects the average private insurance rate in a competitive market (defined as an HHI score of 2,500 or below) relative to the average Medicare Advantage rate in that market. For example, in a market with an HHI index below 2,500 with average MA payment for a service of \$100 and an average commercial rate of \$200, the maximum commercial rate would be 200% of Medicare Advantage rates.

- **Direct the FTC to publish a list of markets with an HHI score of 4,000 or greater. In determining HHI scores, the FTC must work with the secretary of HHS to define market concentration. This would allow for analysis that more accurately reflects today's markets, rather than being limited to inpatient admissions. Factors could include overall admissions and discharges, but would also allow specialties that may include outpatient-only services.**

This policy would not apply to hospitals located in counties with a population below the U.S. median. At the same time, our leaders recognize that high market concentration has a significant impact in counties with populations below the national median, including rural areas. Some state attorneys general have taken steps at the state level to address high costs resulting from market consolidation, and we are supportive of those efforts.

- **Prohibit hospitals from using non-competitive contracting requirements, such as all-or-nothing requirements, which require plans to contract with an entire network in order to contract with a single hospital or provider group. Nothing in this provision would relieve plans of the responsibility of meeting network adequacy requirements.**
- **Increase funding for FTC enforcement of hospital mergers.**

Policy Rationale

BPC's Future of Health Care leadership has proposed a number of policy recommendations designed to stabilize individual Marketplace plans, but price increases are not unique to the individual insurance market. The cost of employer-sponsored insurance also continues to grow, with family coverage now averaging \$20,000 per year.³⁰ Among primarily self-funded plans, a survey of Fortune 500 Companies conducted in 2018 by the Pacific Business Group on Health found that employers projected a 5% increase in health care costs in 2019 for the sixth consecutive year—increasing at twice the rate of employee wages.³¹

Medical loss ratio requirements (MLRs), included in the ACA, have had an impact in bringing down health insurance costs for insured plans. According to an analysis by the Kaiser Family Foundation, private insurance companies are expecting to pay out at least \$1.3 billion in rebates to consumers based on their

share of premium revenues devoted to health care expenses in recent years, surpassing the previous record high of \$1.1 billion in 2012.³²

Growth in private insurance has primarily been driven by provider costs. Between 2007 and 2014, hospital inpatient prices grew 42%, and physician inpatient prices grew 18%. A number of issues are driving hospital price increases, including labor and supply chain costs.³³

The FTC uses the HHI to measure market concentration when considering corporate mergers in other industries. According to DOJ and the FTC, HHI is calculated by “squaring the market share of each firm competing in the market and then summing the resulting numbers” such that 10,000 is the maximum score (where the market is controlled by a single firm) and the score approaches zero when the market is comprised of many firms of varying size. Using the index as a measure, any market above 2,500 points is considered highly concentrated. DOJ has issued guidelines that will be considered in the case of hospital mergers. It is also important to note that the FTC scrutinizes proposed mergers to determine competitive impact, but many markets are already highly consolidated.

Market consolidation is increasingly common, in part because of federal payment policy that encourages more integrated care and incentivizes provider risk. Leaders recognize that not all mergers are anti-competitive and that some, while leading to significant market concentration, may be done to preserve access to care, particularly in low-income communities. In some cases, consolidation has helped facilitate delivery system reform and preserved access to care, but in others the consolidation has resulted in increased market share and higher prices. Hospitals argue that consolidation helps lower hospital costs through increased efficiency.

However, multiple studies over more than a decade have demonstrated that hospital mergers lead to higher prices. According to a 2018 analysis conducted by the Petris Center on Health Care Markets and Consumer Welfare for *The New York Times*, in the 25 metropolitan areas with the highest rates of consolidation, prices increased in most areas by 11% to 54% in the years following the merger.^{34,35} The study also discusses trends in hospital acquisition of physician practices, concluding that this practice exacerbates market consolidation, leading to higher prices.³⁶

In January 2018, nearly half of all physicians in the U.S. were employed by hospitals or large health care systems that contain on average, one dominant, two to three smaller systems, and other independent hospitals in a state.³⁷ About half of all markets in the U.S. have a high market concentration (HHI of 2,500 or higher), about one third of markets are moderately concentrated (1,500-2,500 HHI), and the remaining one sixth are low concentration or unconcentrated (100-1,500 HHI).³⁸ In some of the more concentrated markets, the purchase of specialty practices has resulted in a disincentive for providers to negotiate rates because they know that plans must contract with them in order to meet health insurance network adequacy requirements.

This lack of competition negatively affects health insurance premiums, particularly in non-group insurance markets. A number of proposals seek to address the problem, including increased funding for the FTC to increase antitrust enforcement or providing incentives to states to eliminate or pre-empt state laws that hamper competition or address provider rates.

One FTC commissioner has expressed frustration over the commission's lack of authority to enforce antitrust law for non-profit hospitals, as well as a lack of funding to enforce federal antitrust laws. Funding for FY 2019 FTC enforcement activities was approximately \$310 million. The FTC has indicated that HHI may not be the most accurate predictor of market share and that new screening tools have proven more accurate in determining anti-competitive mergers.

In recognition of the valid concern that in some cases mergers or acquisitions may be done to preserve access to care, leaders urge the secretary of HHS to work with the FTC to review HHI as a screening tool for hospital mergers, new methods to develop more accurate predictors, and to include an analysis of these tools on access to care where policies designed to address high consolidation would reduce access to care for vulnerable populations.

Promote All-payer Claims Databases

To facilitate the use of all-payer claims databases (APCD) in improving transparency, Congress should:

- **Pass legislation to transition to a single APCD that is compliant with the Health Insurance Portability and Accountability Act (HIPAA), building on those established by states.**

Congress should provide grants to states through the Agency for Healthcare Quality and Research, to enhance existing state-level APCDs to achieve uniformity in data collection and formatting. Once state databases are transitioned, states should be provided access to the combined database, including information from employer plans that were not otherwise required to report to states.

Policy Rationale

APCDs have been promoted as a useful tool in controlling health care costs by a broad range of stakeholders, including consumers, employers and insurers, researchers, and policymakers as a means of increasing health care spending transparency and helping inform decision-making. However, APCDs vary widely by state in terms of the standard data elements included, availability to researchers, price, and comprehensiveness. Further, the Supreme Court has held that the Employee Retirement Insurance Security Act (ERISA) precludes states from compelling employers to report data to APCDs. Development of a single database at the national level permits state access to data from plans that are exempt from state regulation under ERISA and provide a single data source for research.

End Surprise Medical Bills

To prevent consumers from being billed for out-of-network specialty provider costs for services received at an in-network facility, Congress should:

- **Require out-of-network providers to accept a benchmark payment that represents the insurer's median in-network rate, when provided to a consumer receiving services at an in-network facility.**

Policy Rationale

Patients receive “surprise medical bills” when they receive services from an out-of-network provider at an in-network facility. In 2017, 18% of all emergency visits and 16% of in-network inpatient hospital stays had at least one out-of-network charge.³⁹ Generally, patients receive services from certain specialty physicians who practice in hospital settings, including emergency physicians, anesthesiologists, radiologists, and pathologists who are unwilling to accept in-network insurance rates. This trend has escalated as hospitals are increasingly using third-party staffing companies to contract with physicians and ambulances. These physicians can often use the threat of staying out-of-network to negotiate for higher in-network rates.⁴⁰

Despite widespread agreement on the need for patients to be protected from these unexpected costs, Congress is divided over how reimbursement for these out-of-network payments should be settled with insurers pitted against physicians and hospitals on opposing sides. An early and bipartisan version of Senate HELP Committee legislation tied provider reimbursement to a benchmark payment that represents the median in-network rate. This decision was influenced by a CBO report that found greater federal savings associated with using a benchmark rate.⁴¹ CBO has calculated the proposal would reduce commercial rates by 1% and reduce the federal deficit by \$25 billion over 10 years.⁴²

Policymakers differ on whether to link provider payments to a benchmark for all out-of-network payments or to allow independent arbitration between physicians and insurers. CBO estimates that allowing arbitration in some cases would increase costs relative to an option that tied all payments to a benchmark set at median rates.⁴³

We support a policy that relies on private negotiations between the parties to resolve the problem, backed by a limit on payments tied to a median rate as recommended in the bipartisan proposal originally reported by the Senate HELP Committee. Arbitration is unnecessary in our view and risks increasing costs, which could drive up premiums for consumers. Further, arbitration benefits larger group practices that can afford to hire attorneys over small and independent physicians' practices.

Promote Health Savings Accounts (HSAs)

To make HSAs more widely available and transparent for consumers, Congress should:

- Require insurers participating in the state and federal Marketplaces to establish and integrate beneficiary-owned HSAs for payments of deductibles and cost-sharing. Consumers enrolled in any Marketplace plans would be able to make deposits into HSAs. Insurers would be required to deposit any unused premium tax credits (above the cost of the premium) into an HSA owned by the enrollee.
- Require insurers to give enrollees the option of taking CSR support in the form of a deposit to HSAs.
- Establish a state option under which states would be able to require insurers to establish HSAs, or similar tax-preferred accounts, into which the CSR payments would be deposited on behalf of a qualified individual, rather than going to the insurer. The HSA could be used to pay out-of-pocket costs. If an individual has no out-of-pocket costs in that year, funds could be carried over and used for other health-related expenses.
- Allow HSA funds to be used to pay monthly fees for accessing direct primary care. States would not be allowed to consider these monthly fees as insurance premiums for purposes of state insurance regulation.
- Require the secretary of HHS to first test and then promulgate a system of posted and transparent pricing for standardized services that all HSA enrollees would be allowed to pay when getting care. In developing pricing, the secretary would be required to:
 - ◇ Establish a list of services upon which selected providers would need to post a price (with age-adjustments) that all HSA enrollees would pay (as payment in full) for the service. The list of standardized services should include: the monthly fees charged for a package of direct primary care services; high-volume procedures; other services which lend themselves to a bundled price for standardized care.
 - ◇ Require providers and organizations to post prices on the established list, including potentially all Medicare-participating providers. Accountable care organizations (ACO) and large systems would be required to post prices for all of the services; other providers, such as individual physician offices, would be required to post prices relevant to their practice.

Policy Rationale

Proponents have argued that HSAs encourage beneficiaries to be more engaged in and cost-conscious in making their health care decisions. As health insurance costs increase, one way that insurers and employers are keeping premiums down is by increasing enrollee out-of-pocket costs, often in the form of high deductibles. As high deductibles become more commonplace, many policymakers are seeking to improve the availability and usefulness of tax-preferred savings accounts from which individuals may make withdrawals to cover these out-of-pocket expenses.

Eliminate Barriers to Prescription Drug Competition

To prevent brand name manufacturers from delaying generic drug availability, Congress should:

- **Pass the Protecting Consumer Access to Generic Drugs Act (H.R. 1499) that prohibits brand name drug and biologic manufacturers from compensating generic and biosimilar manufacturers to delay market entry of a generic drug or biosimilar.**^{44,viii}

Policy Rationale

Drug manufacturers have avoided competition by offering patent settlements that pay generic companies to delay the launch of lower-cost alternatives in the market. According to an FTC study, these agreements cost consumers and taxpayers \$3.5 billion in higher drug costs every year. While the FTC has filed lawsuits to stop some of these deals, the agency supports legislation to end these settlements.⁴⁵ CBO estimates that H.R. 1499 would save \$613 million over 2019-2029.⁴⁶ Similar legislation was included in both the recently passed House bill (H.R. 987) and the Republican House prescription drug bill (H.R. 19).

To prohibit brand pharmaceutical manufacturers from engaging in anti-competitive practices, Congress should:

- **Closely monitor the implementation of the Creating and Restoring Equal Access to Equivalent Samples (CREATES) Act of 2019, which increases access to brand drug samples needed for generic development.**⁴⁷

viii House version reported from the House Energy and Commerce Committee by voice vote in April. H.R. 1499.

Policy Rationale

Generic competition has been delayed through anti-competitive behavior that has led to higher cost prescription drugs. Brand companies limit access in a number of ways, including refusing to sell drug samples to generic companies for testing and exploiting rules requiring agreement with generic manufacturers for shared Risk Evaluation and Mitigation Strategies (REMS).⁴⁸ The CREATES Act allows generic drug manufacturers to bring legal action against brand-name drug manufacturers for withholding drug samples and enables an alternative to the single, shared REMS when an agreement cannot be reached. CBO has indicated that the House version of the legislation will save \$3.9 billion over 10 years.^{ix,49} This provision was enacted into law as part of the end of year supplemental spending bill and should be implemented in a timely manner to promote more affordable medications.

To determine the value of government funding in the overall value of new drugs brought to market, the secretary of HHS should:

- **Quantify the government's contribution toward the intellectual property of the patent holder in terms of total market value. Congress should require that the secretary of HHS convene an expert panel to quantify the value of the government-financed research (i.e., National Institutes of Health) provided during a drug's development relative to the overall market value of the patent and exclusivity provided to the drug manufacturer and have such quantified values verified by a neutral third-party.**

Policy Rationale

The government makes financial contributions to drug research and development. However, the value of those investments is not regularly quantified. Understanding the value of federal research would provide additional information to policymakers as they seek to address the costs of development relative to prices charged.

ix Reported by a vote of 51-0 from the House Judiciary Committee.

4. IMPROVE MEDICARE

TO IMPROVE MEDICARE, CONGRESS OR THE SECRETARY OF HHS SHOULD:

- Streamline annual enrollment.
- Accelerate value-based payment models in Medicare.
- Modernize the Stark Law and Anti-Kickback Statute.
- Reform payments for post-acute care.
- Modify the Medicare prescription drug (Part D) benefit.
- Address increasing costs for prescription drugs in Medicare Part B.

Streamline Annual Enrollment

To increase transparency for Medicare beneficiaries, Congress or the secretary of HHS should:

- **Develop and implement a more streamlined enrollment process that facilitates comparison and choice of coverage options and provides total cost-sharing estimates.**

A uniform enrollment pathway should be developed for traditional Medicare fee-for-service (FFS), Medicare Advantage (MA) plans, and alternative payment models (APM). Under this proposal, Medicare beneficiaries would be directed to complete annual enrollment in Medicare through a user-friendly website on which they compare and enroll in MA plans, traditional Medicare FFS, provider-led risk-bearing APMs (e.g., Accountable Care Organizations), Part D prescription drug plans, and supplemental benefit (Medigap) plans.

The platform would build on the Medicare website for MA plans and Medicare FFS plus Part D and would follow the structure of Guaranteed Renewability for Medigap plans described in The Omnibus Budget Reconciliation Act of 1990.⁵⁰ Current enrollees would benefit from a side-by-side comparison of coverage options, but may keep their current plan. Beneficiaries who fail to complete the process during the open enrollment window would be enrolled into Medicare FFS as a default. Under this proposal, beneficiaries would no longer be passively assigned to providers through attribution.

Policy Rationale

Although Medicare.gov provides a process for enrolling in Medicare Advantage and provides options on Medicare Supplemental Insurance, beneficiaries are not currently provided a simple streamlined process that allows them to fully understand all options available to them, including premiums, copays, and enrollment-based Accountable Care Organizations. Enrollment periods for Medicare FFS and MA prevent a comparison of options, particularly in light of recent cost-sharing reductions and beneficiary incentives for certain models.

Accelerate Value-Based Payment Models in Medicare

To accelerate the move from volume-based to value-based care, the secretary of HHS should:

- **Require ACOs to incur down-side risk throughout the contract period.**
- **Facilitate beneficiary enrollment in value-based payment models, including financial incentives for seeking in-network services.**
- **Permit ACOs to subcontract or limit concurrent enrollment with Medicare Supplemental Insurance plans if the plan's cost-sharing structure complements the ACO model.**
- **Establish a beneficiary-driven risk-bearing primary care pathway for those not enrolled in an ACO or Medicare Advantage plan. Under this approach, beneficiaries would select a primary care provider (PCP) who would receive a per member per month (PMPM) payment for providing a standard set of services, including regular electronic communication. Providers would be reimbursed on a two-tiered, risk-based PMPM payment, determined by actuarial value of services. Beneficiaries would see a significant reduction in copayments for services received from their PCP. Beneficiaries who do not select a PCP would pay current law cost-sharing.**

Policy Rationale

Evidence has shown that provider-led models and those under two-sided risk, in which the provider shares in the savings and any losses, have performed better than hospital-based or one-sided risk models where the provider is not responsible for losses.^{51,52} The Centers for Medicare and Medicaid Services has accelerated risk-bearing for ACOs and offered new provider-based payment models through the Primary Care Initiative.⁵³ However, additional actions are necessary.

The Center for Medicare and Medicaid Innovation (CMMI) recently announced the Primary Care First Model, which is a new attribution-based option for providers caring for at least 125 Medicare beneficiaries. While the model offers another opportunity for transitioning to population health, beneficiary engagement remains limited.⁵⁴

Modernize the Stark Law and Anti-Kickback Statute

To promote value-based care models, Congress should:

- **Modernize and better align the Stark Law and Anti-Kickback Statute (AKS) to promote value-based care, while protecting consumers. Consistent with those regulations, Congress should:**
 - ◇ **Direct the secretary of HHS to extend Stark/AKS waivers to include more value-based care programs.**^{55,56}
 - ◇ **Direct CMS and the Office of the Inspector General (OIG) to clarify definitions of key terms, such as “volume and value of referrals” and “fair market value” to remove confusion about the application of exceptions and safe harbors.**^{57,58}
 - ◇ **Create alternative sanctions for “technical noncompliance,” which is often unintentional, but is penalized the same as purposeful violations under the current law.**⁵⁹

Policy Rationale

The physician self-referral law, commonly known as the Stark Law, and the Anti-Kickback Statute are fraud and abuse laws that were created as consumer guardrails in the health care system and apply to the Medicare and Medicaid programs.^{60,61} The AKS, passed in 1972, prohibits receiving anything of value from referrals that charge federal programs. Stark, passed in 1989, prevents physicians from referring their patients for certain designated health services for which they would receive financial gain, including lab services, radiology, durable medical equipment, physical/occupational therapy, speech pathology, home health services, some prescription drugs, and inpatient/outpatient hospital services.

These laws were created during a time when fee-for-service was the major payment model for health services and when physicians and other health entities commonly held ownership in distinct entities, such as medical imaging and testing facilities. Because referrals to these other practices and services could result in financial gain, this likely led to overuse in the system and increased costs for both patients and federal health programs, such as Medicare and Medicaid.⁶²

As the system moves from volume to value, the Stark Law and AKS have not been comprehensively updated or aligned with each other. Although HHS has the authority to grant waivers to value-based programs, such as ACOs within the Medicare Shared Savings Program, and there are exceptions (“safe harbors”) for each, there is still confusion about when they apply. They are also very limited in scope; many activities do not fall neatly within one exception, leading to extensive paperwork and the need for legal expertise to determine the presence of a violation.⁶³

For these reasons, some providers and health system executives are hesitant to enter into value-based contracts. Many have cited Stark and AKS as major drivers of cost within the health care system due to the measures required for compliance, as well as the lofty fees associated with hiring lawyers to ensure Stark and AKS have not been violated.

It is important to note, any updates to the Stark Law and AKS should be made with caution, as fraud and abuse can and does occur within value-based programs.⁶⁴ The consumer guardrail functions of both laws are incredibly important in protecting patients from unnecessary medical procedures and taxpayers from higher federal health care program costs.

On October 9, 2019, HHS released proposed rules updating the Stark Law and AKS to support value-based care. Both create new exceptions and safe-harbors for value-based arrangements and new technologies, in addition to offering guidance and clarifications for terms such as “fair market value” and “volume and value” of referrals.

Reform Payments for Post-Acute Care

To correct overpayment of post-acute care (PAC) in certain settings, Congress should:

- **Direct the secretary of HHS to develop and implement, as soon as feasibly possible, a unified PAC payment system that reimburses providers based on patient characteristics rather than site of service.**

Policy Rationale

According to the Medicare Payment Advisory Commission (MedPAC), certain PAC services are overpaid relative to costs.⁶⁵ On average, Medicare margins for skilled nursing facilities (SNFs), Home Health Agencies (HHAs), and Inpatient Rehabilitation Facilities (IRFs) have been greater than 10% for most of the last 10 years.⁶⁶ In contrast, hospitals are likely to operate at a -11% Medicare margin in 2019.⁶⁷

The Bipartisan Budget Act of 2018 requires a restructuring of the HHA payment system in 2020. Planned changes include shifting payments to nursing services (facility-based) from therapy services (freestanding) and from larger to smaller facilities. CMS also has plans for SNFs in 2020 to re-value services to increase reimbursement for higher complexity patients and remove incentives that favor lower-cost rehab patients over medically-complex patients or those needing higher cost Part B drugs.

Rather than address payment for the four separate sites of post-acute care, a more comprehensive solution must be undertaken. The Improving Medicare Post-Acute Care Transformation Act of 2014 requires the secretary of HHS, with the help of MedPAC, to develop a single prospective PAC payment system for SNFs, HHAs, IRFs, and long-term care hospitals (LTCH).⁶⁸ MedPAC presented the secretary of HHS with a unified payment system prototype, which bases reimbursement on episodes of care and patient characteristics, rather than site of service. Under the model, rates are risk-adjusted and based on the average cost for providing services for a diagnosis, similar to the Diagnosis Related Group methodology.

Modify the Medicare Prescription Drug (Part D) Benefit

Align Medicare Part D Incentives Across the Drug Supply Chain

To improve incentives for competition, reduce beneficiary out-of-pocket costs, and reduce federal liability for increasing costs in Medicare part D, Congress should:

- **Decrease federal reinsurance payments to 20% of costs from current law of 80%.**
- **Increase Medicare direct subsidies and decrease individual reinsurance subsidies above the catastrophic out-of-pocket (OOP) threshold. A shift of financial burden would provide an incentive to prevent beneficiaries from reaching the catastrophic threshold.**
- **Prohibit Medicare Part D plans from including brand name pharmaceutical manufacturer rebates provided in the Part D coverage gap (i.e. the “donut hole”) when calculating the catastrophic OOP threshold.**
- **Require the 5% beneficiary coinsurance be eliminated for drugs purchased over the catastrophic threshold, creating an OOP cap to protect beneficiaries with greater health expenditures over the catastrophic threshold.**

Modify the Part D Low-Income Subsidy

To encourage the use of lower-cost drugs, Congress should:

- **Authorize the secretary of HHS to modify cost-sharing to establish stronger incentives for Low-Income Subsidy (LIS) beneficiaries to select generic and low-cost brand drugs when clinically appropriate. Provided that CMS determines that substitution is clinically appropriate, copayments will be eliminated for LIS beneficiaries utilizing generic and low-cost drugs, while copayments for non-preferred brand drugs will be slightly increased. Therapeutic classes must be reviewed every three years to ensure that substitution remains appropriate.^{x,69}**

LIS payments to Medicare Part D plans that subsidize the deductible and cost-sharing must be limited to the amount that the government would pay for a low-cost alternative, if available, unless a higher-cost drug is prescribed as medically necessary.

Policy Rationale

Decreasing or eliminating copayments could selectively encourage the use of generic drugs, preferred multisource drugs, and biosimilars. In addition to providing a stronger incentive for LIS beneficiaries to select lower-cost drugs, Medicare Part D plans should have stronger incentives to ensure that lower-cost brand and generic alternatives are available for LIS beneficiaries.

Reform the Drug Rebate Structure within Medicare Part D Plans

To control out-of-pocket costs, manufacturer discount structures should benefit high-cost Medicare enrollees without adversely affecting premiums for the majority of Part D beneficiaries, Congress should:

- **Require all Medicare Part D plans to offer an option that bases beneficiary cost-sharing on actual cost, net of manufacturer rebates. This option, which is now offered to private self-insured plans, would allow Medicare beneficiaries with higher cost-sharing to elect a Medicare Part D plan that passes on manufacturer discounts to beneficiaries.**

x Current LIS copays are \$1.25 (generics)/\$3.80 (brand) for full-subsidy and \$3.40/\$8.50 for partial subsidy.

Policy Rationale

Pharmacy benefit managers (PBM) negotiate prices with manufacturers under the current system. Most actuaries (including the administration's Office of the Actuary) project that prescription drug costs would be higher without rebates. The effects of the drug rebate program on competition are unclear. PBMs and plans retain discounts and price reductions do not directly lower beneficiary out-of-pocket costs at the point of service.⁷⁰

The inclusion of rebates in the OOP calculation for the catastrophic threshold is not reflective of plan spending and artificially propels beneficiaries through the stages of coverage, resulting in premature entry to the catastrophic phase. This removes financial responsibility from the manufacturers and lowers costs for Part D plans.

Address Increasing Costs for Prescription Drugs in Medicare Part B

Institute a Flat-Rate Add-On for Medicare Part B Reimbursement

To reduce Medicare Part B drug spending without adversely affecting care, Congress should:

- **Replace the average sales price (ASP) add-on percentage payment with a flat rate add-on amount to remove the financial incentive for physicians to administer more expensive medications. Under this proposal, a flat payment would be set separately for each therapeutic class (as designated by the secretary of HHS). Savings would be generated through increased selection of lower-priced drugs without limiting access to innovative medications.**

Policy Rationale

Medications administered by physicians are covered under Medicare Part B in a manner that often incentivizes the utilization of higher-cost drugs and discourages the use of lower-cost drugs, even when they are equally or more effective. Providers are reimbursed for both the cost of purchasing the medication, based on ASP, and an additional statutorily-defined, 6% of ASP to cover handling costs.⁷¹

The practical effect of this payment system is that physicians earn more from prescribing and administering more expensive Part B drugs when the actual cost of handling may be essentially equivalent for drugs in the same

therapeutic class. Notably, addressing spending through across-the-board sequestration cuts adversely affects oncologists and other providers who administer certain high-cost, life-saving medications.

Lower drug reimbursement based on wholesale acquisition cost

To reduce overpayment of newly released drugs, Congress should:

- **Direct the secretary to lower the wholesale acquisition cost (WAC) add-on payment to 3% for single-source drugs, biologics, and biosimilars, which conforms to the 2019 payment rules for other newly released drugs.**

Policy Rationale

When a new drug comes to market, it is necessary to gather information on sales prices to determine an average. Until ASP data is available, physician reimbursement for Part B drugs is based on the WAC. The WAC represents the manufacturer list price, excluding any discounts, and is generally higher than the ASP. Handling costs for these drugs are paid as an add-on percentage, as is done for ASP-based payments. However, that percentage is not specified by law. Until 2019, Medicare applied the same 6% add-on required for ASP to drugs reimbursed using the WAC. The secretary has since decreased the add-on payment for newly released drugs, without ASP data, to 3% of WAC to account for the overestimation of costs. Single-source drugs, biologics, and biosimilars, however, are excluded from this regulation and continue to be reimbursed at 6% of WAC.⁷² Preliminary estimates from CBO reveal that reduced WAC payments for biosimilars, biologics, and single-source drugs would reduce federal spending by \$230 million from 2019 to 2029.⁷³

Require Manufacturer Price Data Reporting

To increase competition for Part B drugs, the secretary should:

- **Require all manufacturers to submit ASP data to CMS for use in Medicare.**
- **Establish significant penalties for failure to report.**
- **Require manufacturers to pay a rebate to Medicare or adjust beneficiary cost-sharing amounts when price increases exceed an inflation benchmark, such as the CPI-U.**

Policy Rationale

Manufacturer ASP data is necessary for CMS to ensure accurate payment for Part B drugs. CMS updates prices quarterly with the most recent data, but incomplete data can artificially alter the ASP, resulting in underpayment or overpayment of certain drugs. In situations where no ASP data exists, such as for newly-approved drugs, CMS may use the WAC to determine provider reimbursement.⁷⁴ Because the WAC is generally higher than ASP, there is an incentive to delay ASP reporting.

Section 1927 of the Social Security Act requires manufacturers with Medicaid drug rebate agreements to submit timely reporting of ASP data. Failure to report data within 30 days of the close of the previous quarter incurs civil monetary penalties of up to \$10,000 per day beyond the deadline. The HHS Office of the Inspector General has recommended similar ASP data reporting requirements for the Medicare program, but CMS has not pursued the change, citing its absence from the president's budget.⁷⁵ According to CBO, expanding this requirement to Medicare would reduce direct federal spending by approximately \$3.6 billion over 10 years.⁷⁶

In recent years, drug prices have seen an annual median increase of 9.5%.⁷⁷ To protect federal spending, the Medicaid program requires drug manufacturers to provide rebates for cost increases that exceed inflation. CBO estimates that a similar stipulation for the Medicare Part B program would save the federal government \$10.7 billion over 10 years.⁷⁸ Similar legislation is included in the Elijah E. Cummings Lower Drug Costs Now Act (H.R. 3), which passed in the House, and the Finance Committee's Prescription Drug Pricing Reduction Act of 2019 (S. 2543).^{79,80} Not all of the Future of Health Care leaders support requiring manufacturers to pay a rebate to Medicare when Part D drug prices exceed an inflation benchmark, out of concern that it could cause higher prices.

Consolidate Billing Codes for Biologics and Biosimilars

To stimulate competition among manufacturers of biologics, Congress should direct the secretary to:

- **Use a common billing code to pay for a reference biologic and its biosimilars.**

Policy Rationale

The generic drug pricing policy utilizes a consolidated billing code for generics and the associated brand drug. However, reference biologics and their biosimilars are paid under individual billing codes, eliminating market influence from reducing prices over time. Combining similar medications under a single billing code and reimbursing that code at the average of all included ASPs induces competition and tends to decrease costs across the board.

For example, CMS established a consolidated billing code for two asthma medications based on the volume-weighted average of 106% of the ASP for both drugs. The first was a single-source drug that had seen an increase in ASP of 4% annually; the second, was a multiple-source drug including generics with an ASP that had remained unchanged for several years. Under the consolidated billing code, Medicare's payment rate declined from \$0.53 per unit to \$0.44 per unit in three quarters.⁸¹

Establish A Voluntary Part B Drug Value Program (DVP)

To control drug costs, Congress should direct the secretary of HHS to:

- **Establish a voluntary Part B Drug Value Program (DVP) through which providers purchase drugs, as described by MedPAC.⁸² The DVP would utilize a small number of private vendors to negotiate prices for Part B products, which could not exceed 100% of ASP. Under the DVP, vendors would be equipped with tools unavailable to providers, such as formularies and binding arbitration, which would increase the ability to negotiate. Providers would continue to purchase drugs in the market, but at the price negotiated by their DVP vendor. Medicare would then pay providers that DVP-negotiated price and pay the vendors an administrative fee.**

The DVP would provide opportunities for sharing savings among DVP vendors, providers, the Medicare program, and Medicare beneficiaries, in the form of reduced cost-sharing. During implementation of the DVP, the ASP add-on payment (i.e., for non-DVP participating providers) will be reduced annually until ASP reimbursement equals 100% of ASP (i.e. ASP plus 0%). MedPAC estimated federal cost savings of \$1 billion to \$5 billion over the first five years of the program.⁸³

Policy Rationale

This model introduces price negotiation for Medicare Part B drugs and offers an alternative to the current ASP add-on payments. It addresses some limitations to the competitive acquisition program (CAP), including minimal physician enrollment and vendor contracting issues.⁸⁴ Under the CAP, providers had to acquire drugs directly from vendors, which created additional burden, and vendors were limited in their negotiations with manufacturers, as they were unable to exclude any single-source drugs or biologics.⁸⁵

5. IMPROVE MEDICAID

TO IMPROVE MEDICAID, CONGRESS SHOULD:

- Create a state option for 12-month continuous eligibility for adults.
- Provide flexibility in Medicaid Section 1115A (Section 1332 of the ACA) coverage expansions.
- Promote fiscal responsibility in 1115 waivers.
- Redirect supplemental payments to Medicaid providers - promoting integrity and access.
- Require Medicaid outcomes measures and shared savings initiatives.
- Address Medicaid coverage of prescription drugs.

Create a State Option for 12-month Continuous Eligibility for Adults

To permit states to avoid Medicaid eligibility “churn” for adults, Congress should:

- **Permit states to offer continuous 12-month eligibility for adults.**

Policy Rationale

Under current law, states have the option to provide children with 12 months of continuous coverage through Medicaid and the Children's Health Insurance Program, even if the family experiences a change in income during the year. Continuous eligibility helps states ensure that children stay enrolled in the health coverage for which they are eligible and have consistent access to needed health care services.

States do not have the option of offering continuous enrollment to adults in Medicaid. Adults may lose coverage as a result of fluctuations in monthly income, but may also lose coverage if they failed to submit paperwork on time. According to studies, this “churn” in eligibility results in disruptions in the continuity of care and causes individuals to forgo primary and preventive care that can prevent more costly health care utilization.⁸⁶

Provide Flexibility in Medicaid Section 1115A (Section 1332 of the ACA) Coverage Expansions

To provide additional state flexibility in coverage expansions for low-income individuals, Congress should:

- **Direct the secretary to define the guardrail in section 1115A that requires federal deficit neutrality to permit the requirement to be applied across programs waived when combined with a section 1115 waiver (i.e., tax credits and Medicaid), provided waivers assure full and affordable coverage for lower-income individuals before providing assistance to those with higher incomes.**

Policy Rationale

Section 1115A of the Social Security Act (Section 1332 of the ACA) gives states the opportunity to redesign health care delivery by permitting states to request waivers of certain provisions of law related to the structure of their health insurance markets. These waivers must adhere to four constraints, or “guardrails,” required by federal law. States must demonstrate that the waiver will:

- Provide coverage that is at least as comprehensive as would be provided absent the waiver.
- Provide coverage that is at least as affordable as would be provided absent the waiver.
- Provide coverage to at least a comparable number of residents of the state as would be provided absent a waiver.
- Not increase the federal deficit.^{xi,87}

Similar to Section 1115 waivers, the secretary of HHS and the secretary of the Treasury are prohibited from approving 1115A waivers that increase the federal deficit. Under current federal guidance, when Section 1115 and 1115A waivers are submitted as part of a coordinated waiver application, savings accrued under one waiver are not factored into the assessment of deficit neutrality under the other waiver. By failing to take into account potential combined savings, states have less flexibility in designing coverage, and the full fiscal impact of the proposed waivers are not being considered.⁸⁸ In considering these combined waivers, the secretary must assure that priority in coverage is given to lower-income populations.

xi CMS released new guidance in 2018 updating its previous 2015 guidance on Section 1332 waivers. The 2018 guidance provides a more flexible interpretation of the Section 1332 waiver guardrails than the previous guidance and it renames the 1332 waivers, “State Relief and Empowerment Waivers” rather than “State Innovation Waivers.” Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services; Department of the Treasury. “[State Relief and Empowerment Waivers](#),” Guidance, Oct 22, 2018.

Promote Fiscal Responsibility in 1115 Waivers

To ensure fiscal responsibility and improve administration of waivers, Congress should:

- **Codify budget neutrality as a requirement of 1115 Medicaid waivers for states and also the inclusion of certain cross-program effects, including the waiver’s budgetary effects on other federal mandatory programs. For example, if a Medicaid 1115 waiver results in Medicare savings or costs, those savings or costs would be considered in the budget neutrality calculation as part of the waiver application process.**

Policy Rationale

Under Section 1115 of the Social Security Act, states may request waivers allowing use of federal funding for purposes not otherwise authorized by law for “experimental, pilot, or demonstration” projects that the secretary of HHS determines are “likely to assist in promoting the objectives of” the Medicaid program.⁸⁹ Although not in statute, longstanding federal policy requires Section 1115 waivers to be budget neutral for the federal government, meaning that federal spending under the waiver must not exceed projected federal spending absent the waiver.^{90,xii} In calculating whether an 1115 waiver is budget neutral to the federal government, CMS does not account for potential costs or savings related to other federal programs. To ensure budget neutrality and more accurately determine the fiscal impact of an 1115 waiver, CMS should include costs or savings in other programs when calculating budget neutrality.

Redirect Supplemental Payments to Medicaid Providers – Promoting Integrity and Access

To promote integrity and to make sure that Medicaid beneficiaries have access to care, Congress should direct the secretary of HHS to:

- **Finalize state reporting of upper payment limit (UPL) supplemental payments, but delay proceeding with other aspects of the November 2019 regulations, pending a review of those reports and the submission of a comprehensive plan to reform these payments while ensuring access to care.**
- **Review distribution of UPL supplemental payments and submit recommendations to Congress on ways to phase out these payments over five years, while incentivizing states to increase the base rate providers are paid for serving Medicaid patients to ensure the link between payment and access, quality, and value.**

xii To assess budget neutrality, CMS currently subjects each demonstration to a budget neutrality test, which results in limits that are placed on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of Federal Financial Participation (FFP) that the state would likely have received in the absence of the demonstration.

- **Provide 100% federal medical assistance percentages (FMAP) for payments to primary care providers for 5 years to improve access to care, and to determine whether a longer period would have a greater impact on access to primary care services.**
- **Regularly monitor and evaluate Medicaid payment provider base rates to ensure they are consistent with the requirements of Section 1902(a)(30)(A) of the Social Security Act, which requires states to have methods and procedures to assure that payments to providers are “sufficient to enlist enough providers so that care and services are available under the plan at least to the same extent that such care and services are available to the general population in the geographic area,” (the “access requirement”), and, for states with managed care, ensure that rates are consistent with Section 1903(m)(2)(A)(iii) of the Social Security Act, which requires states also certify that payments to risk-based managed care plans are actuarially sound.**
- **Provide guidance and a clear process for states to monitor and ensure access so that supplemental payment changes do not result in access problems for beneficiaries. Consistent with previous guidance on beneficiary access, state Medicaid agencies should be required to demonstrate access to care by documenting—in an access monitoring review plan—their consideration of enrollee needs, the availability of care and providers, and the utilization of services.⁹¹**

Policy Rationale

States generally set Medicaid payment rates for providers, and the federal government provides matching funds based on a formula, which accounts for state per capita income.⁹² These federal payments, known as federal medical assistance percentages (FMAP), range from 50% to 83%.⁹³ The applicable federal requirements that states must meet in setting base payment rates to providers depends on how the state delivers services. Under a fee-for-service delivery system, states must establish Medicaid payment rates for providers that are “consistent with efficiency, economy, and quality of care and...sufficient to enlist enough providers so that care and services are available” to the same extent they are available to the general population in the same geographic area.⁹⁴ Under a managed care delivery system, states must certify, subject to federal review, that payments to risk-based managed care plans are actuarially sound.⁹⁵ CMS has interpreted this to mean that the “rates are projected to provide for all reasonable, appropriate, and attainable costs” required under the contract for the covered population and that the rates meet certain prescribed requirements for approval by CMS.⁹⁶ In practice, state payment levels vary widely across the nation.

In addition to reimbursing Medicaid providers for services rendered, many states make separate supplemental payments to providers. These supplemental payments are often made in a lump sum and not tied to services rendered.⁹⁷ There are two types of supplemental payments recognized in federal law: disproportionate share hospital (DSH) payments, which are required by statute and non-DSH supplemental payments that are permitted by law. This second group of payments are subject to an upper payment limit and are often referred to as “UPL payments.” States primarily make UPL payments to hospitals and nursing facilities, but some states make these payments to intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs), physicians, and freestanding nonhospital clinics.⁹⁸ In addition, some states make supplemental payments with funds authorized by section 1115 waivers, including uncompensated care pools and delivery system reform incentive payment (DSRP) programs.⁹⁹ There is no separate stream of funding in Medicaid for Graduate Medical Education (GME); states typically use the UPL payment authority to make GME payments.

UPL supplemental payments permit states to supplement low base payment fee-for-service payment rates. According to the Medicaid and CHIP Payment and Access Commission (MACPAC), Medicaid fee-for-service base payments are, on average, below hospitals’ costs of providing Medicaid services and below comparable Medicare payment rates.¹⁰⁰ The UPL supplemental payment is typically made as a lump-sum payment, filling in the gap between the Medicaid base payment rate and what Medicare would pay for a comparable service delivered by a particular class of facilities.¹⁰¹ The upper payment limit is calculated separately for specified classes of providers; the aggregate payment for the class must be below the upper payment limit.¹⁰² States have flexibility to target the UPL supplemental payments to particular providers within the class of providers receiving the supplemental payment.¹⁰³ Like all Medicaid payments, states and the federal government share the cost of UPL payments.

States also make payments to managed care plans with directions to the plan to pass through the payment to certain providers.¹⁰⁴ These pass-through payments are being phased out under proposed rules issued in 2016 and 2017, although the rules permit states to continue payments to offset the cost of graduate medical education.¹⁰⁵ The proposed rules provide states with a 5-10 year period to phase out existing pass-through payments and prohibit new pass through payments. States can transition these payments to base rates or to permissible, directed payments that tie payment to utilization of services, access or quality, but are not required to do so. States may finance the non-federal share of supplemental payments through general funds, provider taxes,

and local government funding from intergovernmental transfers (IGTs) and certified public expenditures—the same options available to states to finance other aspects of their Medicaid program. However, states tend to rely more heavily on provider taxes and IGTs to finance UPL payments.¹⁰⁶

UPL payments have been subject to scrutiny because they lack transparency. Additionally, rather than being tied to services or improvements in quality, the payments are often distributed based partly upon which providers paid the nonfederal share, such as through a provider tax or IGT.¹⁰⁷ The United States Government Accountability Office has issued reports on inappropriate arrangements in which states have received federal matching funds by making large supplemental payments to certain government providers, then requiring the providers to return all or most of the money to the state government.¹⁰⁸ While legislative and congressional action have been taken to address some concerns related to supplemental payments,¹⁰⁹ MACPAC has estimated that these payment arrangements lead to increases in the federal share of Medicaid spending by 4.7%.¹¹⁰

In light of these criticisms, CMS released a proposed rule in November 2019 to improve fiscal integrity related to supplemental payments through greater transparency and reporting requirements. The rule does not prohibit supplemental payments, but it takes a number of steps to constrain the financing mechanisms that support these payments, an approach that can have broader implications for state finances and access to care. These financing mechanisms do not just fund supplemental payments, but also fund Medicaid covered services, including outpatient hospitals, clinics, and physician services..¹¹¹

Reforms related to UPL supplemental payments need to be coupled with initiatives that do not unduly constrain a state's ability to finance the Medicaid program and that ensure access to care for Medicaid beneficiaries. Provider groups, including primary care physicians, are historically underpaid.

Require Medicaid Outcomes Measures and Shared Savings Initiatives

To ensure high-quality care in Medicaid and to better align financial incentives, Congress should:

- **Direct the secretary of HHS to work with states to establish a set of core outcomes measures and establish shared savings initiatives to incentivize states to further improve Medicaid program outcomes.**

CMS and the states—in collaboration with health providers, beneficiary groups, and quality experts—should establish a set of core outcomes measures aimed at ensuring high quality care. In developing these measures, the secretary of HHS should assure consistency across programs, including Medicare and standards used by private insurers. Congress should require CMS and the states to work together to establish target shared savings initiatives and should require CMS to invest new federal dollars into a robust data reporting and outcomes measurement initiative over the next five years. Savings to the Medicare program as a result of improved outcomes in Medicaid should be shared with the states.

Policy Rationale

In recent years, states have moved to improve Medicaid payment and delivery to focus more directly on outcomes. Metrics such as the early diagnosis of illness, incidence of low-birthweight infants, maternal mortality, and the efficiency of care delivered could form the basis of such measures. Although there has been some recent progress identifying a core set of measures for children and adults, more are needed. There have also been efforts to improve measures for long-term services and supports. However, disability and aging advocates support revising outcomes measures to better incentivize a non-medical, person-centered framework for home and community-based services.¹¹² Critical to the success of this outcomes-based effort, is the commitment of financial resources to help policymakers better understand how state and federal dollars are invested to improve outcomes.

Address Medicaid Coverage of Prescription Drugs

To lower Medicaid spending on prescription drugs while continuing to provide necessary treatments to beneficiaries, Congress should:

- **Direct the secretary of HHS to develop standards that permit states to use the same tools available to private and Medicare part D plans to limit coverage of drugs for which there is inadequate evidence of clinical effectiveness. In developing these standards, which would apply to both Medicaid fee-for-service and managed care, the following should occur:**
 - ◇ **The secretary of HHS would be required to develop guidelines under which a drug would be considered to have limited or inadequate evidence of clinical effectiveness.**
 - ◇ **States that choose to exclude drugs under this standard would continue to be eligible for rebates for drugs that are covered under the state program.**

- ◇ **In establishing the standard, the secretary of HHS must guarantee that Medicaid beneficiaries are afforded the same protections guaranteed to enrollees in Medicare part D, Section 1860D-4(3)(B-G) of the Social Security Act, establishing requirements for formularies, inclusion of drugs in all therapeutic categories and classes, provider and patient education, notice before removal of a drug from a formulary, periodic evaluation of protocols, and required inclusion of drugs in certain categories and classes.**
- ◇ **The secretary of HHS should prohibit states from making coverage decisions on the basis of diagnosis or disability.**
- ◇ **Require pharmaceutical manufacturers to provide the Average Manufacturer Price and “best price” to state Medicaid directors 90 days prior to the launch of new medicinal therapies, so that states may initiate any state administrative processes for covering new drugs prior to the launch of the drug.**

Policy Rationale

Although pharmacy services are an optional benefit under the Medicaid program, all states currently provide coverage of prescription drugs.¹¹³ Federal law requires drug manufacturers enter into a rebate agreement with the secretary of HHS in order for states to receive federal Medicaid funding for the manufacturer’s drugs.¹¹⁴ Under the federal Medicaid Drug Rebate Program, states that offer Medicaid prescription drug coverage must cover almost all FDA-approved prescription drugs in exchange for the drug rebates.^{xiii} States may, however, limit coverage by excluding coverage for off-label use, prior authorization, preferred drug lists, or limiting the number of prescriptions provided each month.¹¹⁵ Rebates under the Medicaid Drug Rebate Program are shared between states and the federal government based on FMAP; rebate formulas differ for brand-name and generic drugs. Most states also negotiate supplemental rebates from drug manufacturers in exchange for placing certain products on the state’s preferred drug list, which typically include a list of drugs that do not require prior authorization.¹¹⁶

xiii Under §1927(d)(2) of the Social Security Act, states may exclude from coverage or otherwise restrict the following classes of drugs: “(A) Agents when used for anorexia, weight loss, or weight gain; (B) Agents when used to promote fertility; (C) Agents when used for cosmetic purposes or hair growth; (D) Agents when used for the symptomatic relief of cough and colds; (E) Agents when used to promote smoking cessation; (F) Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations; (G) Nonprescription drugs, except, in the case of pregnant women when recommended in accordance with the Guideline referred to in section 1905(bb)(2)(A) [of the SSA], agents approved by the Food and Drug Administration under the over-the-counter monograph process for purposes of promoting, and when used to promote, tobacco cessation; (H) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee; (I) Barbiturates; (J) Benzodiazepines; (K) Agents when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration.”

In FY 2017, states and the federal government spent \$64 billion on outpatient prescription drugs in Medicaid and collected \$34.9 billion in rebates, which resulted in net spending of \$29.1 billion.¹¹⁷ Even though net drug spending in Medicaid is among the lowest of any payer,¹¹⁸ gross Medicaid drug spending has continuously risen since FY 2014.¹¹⁹ States have traditionally employed a preferred drug list, requiring prior authorization for non-preferred drugs. Under those programs, states approve approximately 90% of those requests. While the national generic substitution rate is at 90%, only 66% of Medicaid dispensed drugs that have a generic alternative are dispensed as generic.

Massachusetts sought to limit drug spending by seeking authority from CMS to implement a closed formulary to exclude coverage of drugs that have limited or inadequate evidence of clinical efficacy. CMS declined to provide that authority. Under federal law, if a state chose to exclude a single covered drug, the state would be required to forgo the rebates for all Medicaid-covered drugs.¹²⁰



Conclusion

BPC's recommendations represent a pragmatic, forward-thinking effort that is achievable in today's polarized political environment. They represent a middle ground between "Medicare for All" and "repeal and replace" that provides the tools to reform our current public-private health care system to better meet the needs of all Americans. This package of proposals at its core aims to reduce health care costs for consumers and improve access to insurance coverage and health care. It would increase stability and affordability and improve competition throughout the health care sector.

Sustainable solutions must address Americans' concerns about the high cost of care in a way that does not disrupt the way they receive care. BPC's leaders appreciate the efforts of Congress and the administration in seeking workable solutions. These policies would build on those efforts and improve coverage and quality while bringing down costs and preserving public and private insurance coverage.

This effort is an example of what can be done when policymakers set politics aside and put people first. These policies, taken together, represent an opportunity to break the nation's health care reform stalemate and create real reforms that both parties can embrace.

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