Physicians For Rx Reform

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Consolidated Healthcare Plan

A PHYSICIAN LED, PATIENT-CENTERED, FISCALLY RESPONSIBLE ALTERNATIVE TO THE AFFORDABLE CARE ACT

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Physician Organizations Supporting Reforms with Drafted Legislation (Reforms #1 & #2)

Physicians for Reform
Physicians Against Drug Shortages
Practicing Physicians of America
National Physicians' Council for Healthcare Policy
United Physicians and Surgeons of America

Non-Physician Supporting Organizations

Association of Mature American Citizens
SederaHealth

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A Physician Led, Patient-Centered, Fiscally Responsible Plan to Rebuild the American Healthcare System

The Question

Who should control the personal and complex process of medical decision-making? You and your physician? Or Washington? This is the central question behind the healthcare debate. Fundamentally, it is a struggle for power. The outcome of the healthcare debate will define the relationship between *We the People* and our government.

Two worldviews battle for the soul of our nation. The first believes power lies with *We the People*; government is accountable to us. The second defines good as the transfer of power to government; it then hopes government will provide for the American people.

It has been said that a government big enough to give you everything you want is a government big enough to take from you everything you have. This includes your ability to see the physician you need.

The Choice

In almost 50% of the counties nationwide, Obamacare exchanges only have one insurer to choose from. The average deductible of the least expensive Obamacare plan is $6,000 meaning those who have this coverage oftentimes cannot afford to use it. The Affordable Care Act is imploding. But what will follow?

Any future legislation will move power in one of two directions. It will either transfer power toward Washington, or it will return power to patients and their physician. This Consolidated Healthcare Plan unabashedly attempts to hand power back to patients and their physician.

The Alternative

Patient-Centered: Our plan ensures that you and your physician control the personal and complex process of medical decision-making, not Washington. This is only possible when patients and physicians have a financial, as well as a medical, relationship.

Fiscally Responsible: Our plan advances free-market, fiscally responsible solutions that seriously address our nation's $20 trillion debt and massive deficits. It also empowers states to craft lean, efficient Medicaid programs, reduce state spending, and improve patient outcomes for lower income Americans.

Reducing Costs

Healthcare spending in America now account for nearly 20% of US GDP. This limits spending on other crucial items such as education and infrastructure. There are only two ways to reduce healthcare costs:

1) Transfer power to Washington and limit access to medical care. Or
2) Transfer power over healthcare spending to patients and give them a reason to ask two simple questions that govern the entire free-market system:
   - Do I need this test? And,
   - How much does it cost?

GOALS

Consumer Choice: Our plan gives you more control over your healthcare dollar. You can select the insurance policy you want, not a plan burdened by federal mandates you do not need. You will remain free to choose a plan that allows you to keep your doctor and hospital.

***Affordability*:** In a truly competitive market, insurance companies are accountable to you, not the government. They must compete to offer you the best product at the lowest price. Real choice and competition leads to affordability. This happens best when *you* control *your* healthcare dollar.

Stability: The ever-changing rules of Obamacare forced millions of Americans to lose their health insurance, their doctor, or their hospital. It also created helped fuel the skyrocketing cost of health insurance. Our plan will bring stability and predictability back to the health insurance market and return to the rule of law.

Portability: Under our plan, if you select an individual policy you will be able to maintain coverage even if you move, change jobs, or lose your job. This plan allows individuals the same tax advantages that employers currently receive when they buy coverage.

Protection: Health care should be accessible to everyone, including people who have pre-existing conditions. Our proposal assures that everyone can get health care and guarantees that no one will be denied insurance as long as they maintain their policies.

Transferring the power over healthcare dollars is a complex task. We recommend doing this with a series of steps, done one at a time.

GUIDING PRINCIPLES

1) Craft of a series of reforms, each reform addressing one clearly identified problem in the current healthcare system.
2) Pass each reform separately.
3) Write each bill using an understandable format and keep it to a reasonable length.
4) Keep each bill clean, letting it pass or fail on its own merits. No pork, no payoffs.
5) Make the final language available to the public for seven days prior to voting. No unpleasant surprises.

CORE REFORMS

1. Repeal the Safe Harbor Law that drives up the cost of medication and medical devices.

The 1987 Medicare Anti-Kickback Safe Harbor law unintentionally has created a $600+ billion distribution monopoly of medical supplies and medications. While legal, this led to an unimaginably corrupt, pay-to-play system of financial kickbacks that adds an estimated $200 billion of unnecessary expense to American healthcare each year.

Not only does it significantly drive up the cost of medications and medical devices, it is responsible for many of the drug shortages we see in hospitals nationwide. As a result, foreign manufacturers sometimes step in resulting in contaminated drugs that have led to patient deaths, such as the multiple deaths in 2008 resulting from contaminated heparin imported from China.

Addressing this problem would lower costs of drugs and all healthcare supplies by an estimated 30%. Further cost reductions would occur as competition replaces the fixed marketplace. Together, these could save Medicare and Medicaid an estimated $75 billion annually.

2. Allow Tax Deductions for Pro Bono Physician Care.

The Association of Mature American Citizens (AMAC) proposed “The Good Samaritan Physician Charitable Services Act of 2018” to help provide healthcare for American citizens with financial need. In the bill sponsored by Representative Daniel Webster (R-FL), physicians receive a tax deduction in return for treating indigent patients without charge. Participation is voluntary for both patients and physicians; the number of patients is capped at 20 per doctor.

The primary beneficiaries of this program would be the 27 million Americans currently without health insurance and those now covered under Medicaid. Based on surveys the plan anticipates a high rate of participating doctors and expects to provide medical care for between seven and ten million people. The projected savings? Between six and nine billion dollars annually ($75 billion in 10 years) shared between the Federal government and the states.

3. **Provide States with Block Grants to Reform Medicaid. This Will:**
   - Give States Control Over Their Budgets, and
   - Improve Patient Outcomes for Lower Income Americans

   Medicaid produces worse patient outcomes than any other form of healthcare coverage in America. In fact, patients on Medicaid sometimes fare worse than patients with no insurance at all. For example, a 2010 study of 893,658 major surgeries found that Medicaid patients were almost twice as likely to die in the hospital as those with private insurance. By comparison, uninsured patients were about 25% less likely than those with Medicaid to have an "in-hospital death." State level reforms can improve these patient outcomes.

   By giving states both the incentive and the ability to craft lean, efficient programs focused on patients who truly need assistance, our proposal of state based reform can improve patient outcomes while reducing costs. A Flexible Health Grant would be optional for the states and would exempt them from the inflexible rules of the current Medicaid system. This would allow for innovative solutions.

4. **Allow Individuals to Purchase Insurance with Individual Tax Relief**

   Employers do not pay corporate tax on money spent providing health insurance for their employees. Likewise, employees do not pay personal income tax their health benefits. Traditionally, individuals purchasing individual insurance did not enjoy these tax breaks. This discrepancy explains why the vast majority of Americans receive their health insurance through the workplace. This limits consumer choice.

   Leveling the playing field lets individuals purchase insurance with the same advantages as those who get their health insurance through the workplace. (However, even with tax equity, group rates will remain lower than individuals rates for similar plans because groups have lower administrative costs.)

5. **Establish Guaranteed Renewal Protections for the Individual Market**

   Traditionally, individual policies did not share the same protections of guaranteed renewal as the group market as group policies. Consumer protections that applied to the group market (i.e. “group-to-group” and “ “group-to-individual’ portability) should be extended to the individual market and ensure people with individually purchased insurance can renew their policies or transfer to another policy (i.e. “individual-to individual” or “individual-to-group” portability) even if they develop a serious medical condition.

6. Encourage High Deductible Plans with Health Savings Accounts (HSAs)

Milton Friedman once observed, "Nobody spends somebody else's money as wisely as he spends his own." This represents one of the most fundamental problems of our current healthcare system—the problem of the existing third party payer system. Regardless of whether it is Medicare, Medicaid, or private insurance, when someone steps in between the patient and the physician, problems arise.

Rather than giving even more power to Washington, the solution lies in giving patients more control over their own healthcare dollar. This motivates patients to ask two essential questions of their physicians: "Do I need this test?" and "How much does it cost?"

Low cost, high deductible plans combined with Health Savings Accounts (HSAs) give patients more control over medical decision-making and encourages preventative medicine. Even more, it lowers cost without the bureaucratic rationing of care.

7. Reduce Federal Regulation and Make it Easier for Consumers to Carry Health Insurance Across State Lines ("Portability")

States once served as the primary regulators of health insurance. That system worked well. However, over the past 70 years, Washington has steadily encroached on state authority.

Some conservatives have proposed we seek federal legislation that would entitle individuals to purchase health insurance sold in another state, not just their own. Creating a single national individual market, they argue, would force state legislatures to compete to reduce excessive mandates. While this approach may have some benefits, it would entail yet more federal regulation. In the end, it could lead to more mandates on the individual market, not fewer.

The proper solution is to reduce the role of the federal government in the individual healthcare market and make state lawmakers directly accountable to their own citizens. To promote interstate portability we encourage states to join an existing interstate compact designed precisely to make it easier for consumers in a state to seamlessly transfer their coverage to another state when they move.

8. Allow Insurers to Create Purchasing Pools for the Individual, Small, Medium, and Large Group Market Segments

By the nature of insurance, the more risk is spread, the lower the cost of health insurance. This means an employer of 500 people will pay far less for health insurance than an employer of 5. Conceptually, allowing small and medium businesses to join together and purchase health insurance as a group should lower costs. However, in practice, this model breeds adverse selection that actually increases cost over time.

An alternative model allows insurers to create state-wide purchasing pools for each market segment. This allows insurers to spread risk on a large scale without encouraging adverse selection.

9. State-Based Reform of Our Broken Medical Malpractice System

The primary cost of frivolous litigation is the widespread practice of defensive medicine. Reforming our broken medical malpractice system can decrease the cost of care and compensate injured patients more quickly.

10. Create State Run Risk-Transfer Pools to Address the Problem of Pre-existing Conditions

Health reform must help patients with pre-existing medical conditions, but the "no pre-existing conditions" policy of the ACA will inevitably lead to the bankruptcy of the private insurance industry and end in a federally run, single payer system.

A small minority of patients account for a significant share of healthcare costs. Removing these patients from the traditional insurance pool (for example, by placing them in a state-run, high risk pool) would significantly reduce the cost of insurance making it easier for both employers and individuals to purchase insurance. This in turn would make it easier for more people to purchase insurance, further spreading risk and further reducing costs.

But there is a downside. A state-run high-risk pool adversely impacts free market forces. Insurers are given an unwelcome incentive to move their most expensive patients into a taxpayer-funded system. For every "most expensive patient" there will always be a "next most expensive patient" the insurer will want the taxpayer to cover. A state-run high-risk pool creates a breeding ground for yet another bloated government program destined to drive states into bankruptcy.

Enter the Risk Transfer Pool. The basic concept of the Risk Transfer Pool is to keep the cost of high-risk patients inside the free market. Under this system, high-risk patients are paid for by a pool of money supplied by every insurer in the state, not the taxpayer.

Essentially, a state operating under this system requires every insurer in the state to put money into a pool. After a given amount of time (monthly or quarterly) the data is analyzed for each insurer. Any insurer who received a disproportionate number of high-risk patients receives an allotment of money from the pool. This acts as a mechanism to distribute the cost of high-risk patients over the entire market.

11. Develop a Sliding-Scale System of Tax Credits / Deductions to Enable Lower Income Americans to Purchase Private Health Insurance

Not only does the present Medicaid system produce the worst healthcare outcomes in America, it creates a "welfare cliff" that traps people in poverty. If an individual earns too

much money, he or she loses their assistance in an all-or-nothing fashion, leaving them worse off if they choose work over public assistance.

Rather than expanding Medicaid as suggested by the ACA, lower income Americans would be far better served if we reformed the system to empower them to escape poverty and achieve the American dream.

A sliding scale, premium support system administered by the Medicaid agency would enable lower income Americans to purchase private, low cost, high deductible health insurance. This system would be intentionally designed to encourage lower income Americans to increase their skill set, join the workforce, and seek higher incomes.

Because this would not be an all-or-nothing benefit program, it would empower individuals to choose self-reliance over dependency. However, their hard work would improve their lives. It would not only help restore a sense of pride and personal satisfaction, but help break the cycle of poverty for generation to come.

12. Modernize Medicare and Return it to Fiscal Sustainability

For 50 years, Medicare has provided seniors with continuous coverage and a strong measure of financial security. However, left unreformed, Medicare will put intense pressure on the federal budget and generate unsustainable future debt. Without reform, care for our nation's seniors will be compromised.

Patient choice, clarity in pricing, and transparency in performance, combined with intense competition among plans and providers, would ensure more direct accountability to patients. Such a new market would not only control cost, but also stimulate innovation in health plan benefit designs.

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APPENDIX I

LOWERING HEALTHCARE COSTS THROUGH SAFE HARBOR REPEAL

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ABSTRACT

The 1987 Medicare Anti-Kickback Safe Harbor statute exempted hospital Group Purchasing Organizations (in-patient side) and later, Pharmacy Benefit Managers (out-patient side), from criminal penalties for taking rebates/kickbacks from suppliers. This law unintentionally created a $600+ billion nationwide distribution monopoly of medical supplies and medications.

While legal, this misguided "Safe Harbor" statute gave rise to an unimaginably corrupt pay-to-play system. This distribution monopoly collects administrative fees, marketing fees, advances, conversion fees, pre-bates, rebates, and "sharebacks" simply to let a given medication or medical device gain access to the healthcare marketplace. These fees add an estimated $200 billion of unnecessary expense to American healthcare every year. In short, the 1987 "Safe Harbor" statute legalizes contracts and payments that in any other industry would be subject to criminal prosecution.

Repeal of the "Safe Harbor" provision would reduce costs of drugs and healthcare supplies by an estimated 30% and save Medicare and Medicaid approximately $75 billion annually. Over time, renewed free market competition would produce additional innovation and further cost reductions.

THE PLAYERS

- **Hospital Group Purchasing Organizations (GPOs)** control the purchase of over $300 billion annually of drugs, devices and supplies for about 5,000 hospitals and thousands more outpatient clinics and alternative care facilities.

  The GPO industry is highly concentrated. According to the Government Accountability Office (GAO), four giant GPOs account for over 90% of total annual GPO contracting volume. In size order, they are:
  1) Vizient Inc.
  2) Premier Inc.
  3) HealthTrust
  4) Intalere

- In 2003, **Pharmacy Benefit Managers (PBMs)** quietly asserted control over outpatient drugs and devices after petitioning HHS OIG to extend the "Safe Harbor Law" to cover the PBM industry. Drug manufacturers compete with each other to get their products on PBM formularies by paying ever-larger rebates/ kickbacks. They then raise their prices to offset these excess costs.

The PBM industry is highly concentrated as well. Three huge companies control over 80% of the PBM market and more than 70% of all prescriptions dispensed in the United States. In 2016, these three PBMs reported aggregate net revenue of $303.7 billion. In size order, they are:

1) CVS Caremark
2) Express Scripts
3) Optum Rx

- To give a sense of the magnitude and power of this distribution monopoly, in December of 2017, CVS Caremark (the largest PBM) announced its $69 billion purchase of Aetna (the nation's largest health insurer). This is the market equivalent of a trucking company that delivers soft drinks purchasing Coca-Cola or Pepsi.

BACKGROUND

In brief, here is how this system works:

- Long before online ordering and "just-in-time" inventory, the first hospital GPO was founded in New York City in 1910. GPOs were specifically developed to reduce members' supply costs by buying in bulk. Under that cooperative business model, hospitals paid dues to the GPOs to cover administrative expenses. By design, the "bulk savings" outweighed the "administrative" costs.

  That system worked well for about 80 years because GPOs served member hospitals. Payments and incentives aligned with consumer interests.

- That business model changed in 1987 when Congress enacted the anti-kickback "Safe Harbor" provision. GPOs were now exempted from criminal prosecution for taking kickbacks from healthcare suppliers. After the Inspector General of the Department of Health and Human Services implemented the "Safe Harbor" rules in 1991, vendors, not hospitals, paid GPO "administrative" expenses.

  Rather than reducing costs for member hospitals, GPOs could now extract a variety of fees from both suppliers and the medical supply chain for the "privilege" of a given medication or medical device gaining access to the healthcare market. Rather of serving member hospitals by cutting costs, GPOs rapidly became a highly paid middleman.

- While GPO's service the in-patient side, the PBM industry services the out-patient side. PBMs allocate market share and may confer "Preferred Distributor" status to middle market distributors. (Sometimes these distributors are entirely owned by PBM shell corporations.) PBMs use secret contracts to manipulate pricing. Manufacturers and distributors unwilling or unable to pay the kickbacks are removed from the supply chain.

- Predictably, this gave rise to a pay-to-play system. Suppliers literally buy market share by paying exorbitant fees to the GPOs/PBMs in return for contracts giving their products exclusive access to GPO-member hospitals and PBM preferred distributors.

  This system created supplier monopolies by slashing the number of suppliers of vital generic drugs, devices, and other medical supplies; it also discouraged potential competitors from entering the marketplace. Most importantly, the GPO/PBM cartel is a powerful Buyers' Monopoly, or Monopsony. This is the rarest and most harmful type of monopoly.

- Under this perverse system, purchasing agents, *not clinicians*, typically decide which drugs, medical devices and supplies physicians can use for their patients. These decisions are based largely on how much kickback revenue these products generate for the GPO or PBM, *not what is best for patients*. Patients and healthcare workers are often denied access to lifesaving, cost-effective goods including drugs, hip implants, pacemakers, pulse oximeters, safety needles and countless other products.

- Under the safe harbor rules, "admin" fees were to be limited to 3% of sales. If they exceeded that amount, the GPOs were supposed to report the fees to their member hospitals. The available evidence indicates that total kickbacks paid by suppliers to GPOs/PBMs have often exceeded half of the suppliers' annual revenue for a single drug! Because kickbacks are generated on a percentage of total contract volume (sales), the higher the price of a medication or medical device, the larger the kickback for the GPO/PBM.

- The HHS Inspector General was empowered to request data excess GPO/PBM fees. However, it has often chosen not to do so. In fact, a 2012 GAO investigation—requested by three U.S. Senators—found that the HHS OIG had not exercised its oversight authority in years.

- These anti-competitive contracting and pricing practices, self-dealing, conflicts of interest and other abuses have forced many firms to stop making inexpensive generic drugs rather than produce them at a loss. They've also crippled the ability of other manufacturers to maintain their plants, equipment, and quality control, resulting in tainted drugs, adverse FDA inspections, and plant closings.

- The deadly 2012 meningitis outbreak, which was caused by contaminated drugs sold by an unregulated compounding pharmacy, was a direct result of this crisis. After two FDA-regulated generic drug makers stopped making a widely-used steroid pain killer because it had become unprofitable, many providers were forced to buy this medication from now-shuttered New England Compounding Center (NECC).

- Years before the drug shortages made headlines, four Senate Antitrust Subcommittee hearings, federal and state investigations, media exposés, antitrust lawsuits and independent academic studies found that GPOs, instead of saving money for hospitals by purchasing in bulk, actually inflated healthcare costs.

- Various investigations revealed that many GPO and hospital executives have enriched themselves personally through this system. GPO executives have received stock options in firms they do business with, while hospital officials have gotten "patronage fees" and "sharebacks" from GPOs and lavish perks from suppliers.

- Thanks to aggressive GPO/PBM lobbying and campaign contributions, there is virtually no disclosure, transparency, regulation, or oversight of the powerful, secretive GPO/PBM industry. Few, if any, outsiders know where the billions of dollars are going.

ACTION ITEM/RECOMMENDATIONS

Physicians for Reform (PFR) is helping assemble and lead a broad network of organizations to reframe the healthcare debate and lay out a free-market, patient centered vision for the future of American healthcare. Repealing the "Safe Harbor" law is the first of twelve separate reforms.

Physicians Against Drug Shortages (PADS) is a key member of this network. For the past six years Dr. Robert Campbell, PADS chair and co-founder, and his colleagues have investigated this issue at the highest levels. They have concluded there is no path to affordable, high quality healthcare until free-market competition is restored to the drug/medical supply marketplace. This is possible only if Congress repeals the 1987 Medicare anti-kickback "Safe Harbor" provision.

Legislation has already been drafted in both the House and the Senate. However, we must change the politics of the issue through public education before these bills can be successfully brought to the floor. This represents a unique and historic opportunity to save money, save lives, and make American healthcare great again.

Please contact us if we can be of further service.

Sincerely,

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