

2017

Repeal AND Replace Agenda





Overview

As we move into the 2017 Congress, UnityPoint Health® understands that a repeal and replacement of Obamacare is necessary and will be prioritized. As the largest health system in Iowa, and serving patients in Illinois, Iowa and Wisconsin, we have several priorities and ideas for consideration within the replacement package as it develops under the Trump administration and with Congressional Leaders.

Market forces can offer many solutions to address health care's fiscal issues, while assuring protections for basic health needs of all citizens, including the most vulnerable. Ultimately, all individuals and entities should have "skin in the game" and assume responsibility for their health and associated costs.

For more information, contact:



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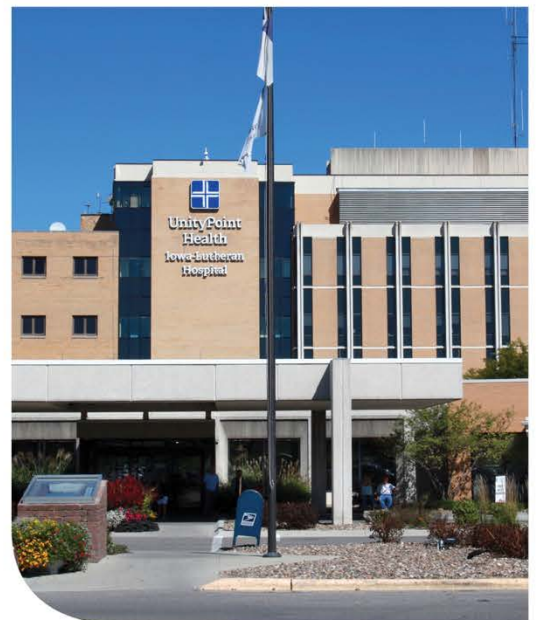
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Medicare

DRUG PRICES

In 2014, the U.S. health care system spent \$373.9 billion on drugs – 13.1% more than it did the previous year and the highest spending growth since 2001. In 2020, this line item is projected to be \$435.3 billion. To fully utilize market forces and economies of scale to decrease drug prices, we support:

- **Direct negotiation on drug prices** by the federal government for Medicare (and states for Medicaid).
 - **Include 340B Drug Pricing Program** in this negotiation.
- Removing trade barriers to permit the **purchase of drugs from other countries**.
- Market-based solutions set forth in the *Campaign for Sustainable Rx Pricing* agenda, developed by a membership that includes health plans; pharmacist, hospital and physician groups; employers; and consumer organizations. **Key market-based solutions include:**
 - Provide resources to **speed up FDA approval** for 4,000-case backlog of **generic drug applications**, especially for expensive drugs without competition.
 - **Shorten** the 12-year **market exclusivity period** for costly biologic drugs.
 - **Oppose “pay for delay” settlements** to keep generic products off the market.
 - **Support drug product transparency** and require manufacturers to disclose more drug cost information, report any planned drug price increases, and provide comparison information related to drug safety and effectiveness with others on the market.





Medicare, continued

PROVIDER REIMBURSEMENT

Insurance companies, along with the federal and state governments, have traditionally borne the risk for the cost of health care. Under Medicare Advantage (MA), health plans provide managed care to beneficiaries based on a monthly capitated fee. The MACRA legislation gives providers “skin in the game” by mandating providers assume risk for the cost of care of their patients to receive preferred reimbursement. For the most part, these risk programs have been administered by the Center for Medicare & Medicaid Innovation (CMMI).

Accountable Care Organizations (ACOs) are provider-based organizations that assume responsibility for the total cost of care for a patient population. ***For ACOs that also bear risk, these ACOs will ultimately compete with MA plans, infuse competition into the market, eliminate the middle man and provide more patient-centric care.*** These ACOs should be afforded administrative flexibility with common ground rules for participation:

- **Voluntary enrollment** for beneficiaries;
- Eligible ACOs should operate **under partial or capitated risk arrangements**, as shared savings is a flawed methodology;
- **Ability to waive beneficiary co-payments and deductibles** for preventive care and chronic care management;
- ACOs need the **option to refer to preferred providers**; and
- **Stark law should be waived for entities participating in partial or capitated risk.**



Medicare, continued

BENEFICIARY ENGAGEMENT

Medicare reform presents a real opportunity to engage beneficiaries in choices about their health status and health care options. Presently, beneficiaries have limited exposure to assume shared responsibility for curbing healthcare costs.

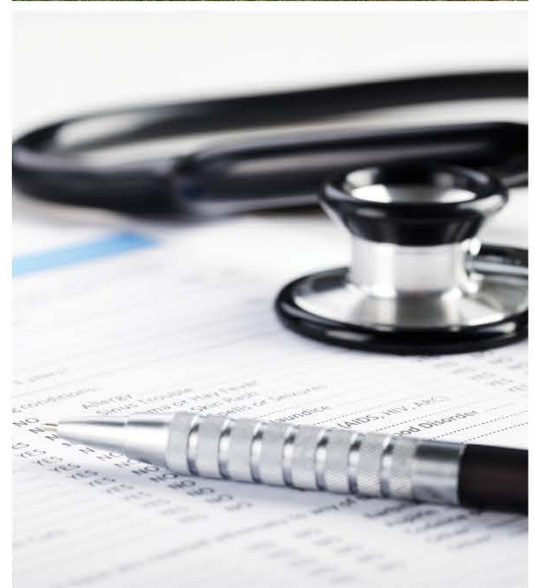
We support beneficiary engagement strategies that include:

- **Transition to a premium support structure**, as conceptualized in A Better Way – Health Care Policy Paper by Speaker Paul Ryan (R-WI), described as “Medicare Networks” in the *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment* by the Bipartisan Policy Center, and being explored by MedPAC (most recently in its November 3, 2016 meeting).
- **Revise the law to allow potential beneficiaries to opt out of Medicare, while retaining Social Security benefits.**
- **Eliminate Medicare supplemental plans.**

OTHER GOODS AND SERVICES

Competitive bidding processes generally instill accountability and affordability into the purchasing process. The Centers for Medicare & Medicaid Services (CMS) has applied this in limited fashion – the CMS durable medical equipment (DME) competitive bidding program lowered spending by 42% in the first nine regions of implementation with no apparent negative impact on beneficiary access or patient satisfaction.

We would recommend a wider application of competitive bidding processes to health care, as there are for-profit industries reaping federal taxpayer dollars without regard to value.





Medicaid

DRUG PRICES

The items listed under Medicare would apply to Medicaid to enable the states to fully utilize market forces and economies of scale to decrease drug prices.

BLOCK GRANT FUNDING

This approach would impart budgetary certainty and streamline eligibility and programmatic decisions. The current CMS waiver process requires significant time, effort and expense, which detracts from direct services to Medicaid enrollees.

Block funding attributes should include:

- **A simple funding amount formula** (whether per capita allocation or base year lump sum that includes infused funding) **that takes in to consideration:**
 - **Traditional eligibility categories** for aged, blind and disabled, children, and pregnant women; and
 - For states that expanded Medicaid, **expansion eligibility categories for adults.**

- **Embedded flexibility for states to:**
 - **Further define covered populations without waiver processes;**
 - **Contract with health plans and/or ACOs for population health management and shared risk arrangements;** and
 - **Define care settings and referral patterns** as deemed necessary.

The Health Care Consumer

BENEFICIARY ENGAGEMENT

For Medicare beneficiaries, the above engagement strategies will provide an opportunity for individuals to assume responsibility for health care expenses.

HEALTH SAVINGS ACCOUNTS (HSAs)

HSAs are tax-advantaged savings accounts, tied to a high-deductible health plans, and intended to be used to pay for certain medical expenses. HSAs enable consumers to use tax-free dollars to pay for out-of-pocket expenses, which offer an opportunity for individuals to assume responsibility for health care expenses.

We support the HSA structure set forth in the proposed “Empowering Patients First” legislation from Representative Tom Price (R-GA).

PRICE TRANSPARENCY

Price transparency is important for consumers to understand and predict health care costs. We support the following recommendations in *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment* by the Bipartisan Policy Center that insurers should provide:

- Pricing data to better **understand out-of-pocket costs before accessing care**; and
- **Estimates of average cost of out-of-network care** for various types of providers, locations and services.

Medicare Outside of the Box

Would Medicare be more effective if operations were delegated to each state for its residents?

In support of this concept, would it be possible to “block grant” Medicare dollars to states with some protections for outliers?

