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BLUEPRINT FOR

**IMPROVING
HEALTHCARE FOR
AMERICAN
FAMILIES**



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A handwritten signature in black ink, appearing to read 'Anthony Gonzalez', with a long horizontal line extending to the right.

Introduction

Americans deserve a healthcare system that puts families first and gives them peace of mind to live better, healthier lives. Despite significant efforts to lower costs and increase access to care, far too many Americans and businesses are struggling to find health insurance that is affordable and will meet their needs.

Last year, I made a promise to my constituents that I would put forward a health care plan that addresses these challenges and puts us on a more fiscally sustainable path. The following proposals are a culmination of that promise. Together, I believe we can create a personalized, family-oriented healthcare system that expands options, reduces out-of-pocket costs, and puts you and your doctor in control of your health.

I welcome your feedback. Please send me any thoughts or ideas of your own on how we can improve America's health care system together by emailing healthcare.gonzalez@mail.house.gov.

Executive Overview

The novel coronavirus pandemic has once again amplified the shortcomings of the American healthcare system. As the virus quickly roiled the nation, it spurred widespread job loss and forced millions of Americans to be stripped of their health insurance at precisely the time they needed it the most.¹ This is on top of the millions of Americans who already could not afford health insurance due to exorbitant costs and a confusing payment system.

Americans deserve a healthcare system that puts families first and provides them peace of mind when they get sick or injured. Despite significant efforts to control costs and increase access to care, far too many Americans and businesses are struggling to find health insurance that is both affordable and will meet their needs. Moreover, the cost of health care has grown exceedingly fast and is now the largest segment of our economy. Today it consumes nearly one out of every five dollars in the U.S. economy – twice as much as any other advanced nation.²

These failures, rightly, force us to rethink the structure and delivery of health insurance and health care services in the United States. To date, unfortunately, neither party has found an answer to our nation’s health care problem. Obamacare has burdened households with higher insurance premiums and larger deductibles across the country.³ With wages unable to keep up, over 27 million Americans are still without health care coverage and nearly one out of every two worry they won’t have enough money to pay for their care.⁴ Republicans, meanwhile, have lost significant credibility with the general public following the repeal and replace disaster of 2017.

The question then becomes, “If not these plans, what?” Last year I made a promise to the residents of Ohio’s 16th District to put forward a plan that I believe will help address many of the challenges facing Northeast Ohioans. My hope is that it will help spark a conversation on a bipartisan path forward and the changes that are needed to deliver better care at lower costs.

My plan focuses on a handful of goals. First and foremost, I do not believe any American should live in fear of going bankrupt due to one bad diagnosis or exorbitant health care costs. This means every insurance plan must have an annual out-of-pocket cap and ensure those with pre-

¹ Dorn, Stan. “The COVID-19 Pandemic and Resulting Economic Crash Have Caused the Greatest Health Insurance Losses in American History.” Families Usa, 20 July 2020, www.familiesusa.org/resources/the-covid-19-pandemic-and-resulting-economic-crash-have-caused-the-greatest-health-insurance-losses-in-american-history/.

² Papanicolas, Irene, et al. “Health Care Spending in the United States and Other High-Income Countries.” *Jama*, vol. 319, no. 10, 2018, p. 1024., doi:10.1001/jama.2018.1150.

³ Hamel, Liz, et al. Kaiser Family Foundation/LA Times Survey Of Adults With Employer-Sponsored Health Insurance. Kaiser Family Foundation, 2019, p.1, Kaiser Family Foundation/LA Times Survey Of Adults With Employer-Sponsored Health Insurance.

⁴ McCarthy, Justin. “Six in 10 Americans Worry About Higher Healthcare Premiums.” Gallup.com, Gallup, 4 Sept. 2019, news.gallup.com/poll/245312/six-americans-worry-higher-healthcare-premiums.aspx.

existing conditions have access to affordable, comprehensive coverage. Secondly, nothing is more personal than our own health and well-being. Our system needs to provide the choices and flexibility that our families deserve without the bureaucracy of a federally run healthcare system.

Finally, we need to bring the cost of the entire health care system down by increasing competition among providers in our local communities and making sure that American families stop paying more for the same drugs as those in other countries. Additionally, we need to end surprise billing so that families can plan for their physical and financial health effectively.

My proposal is a culmination and reflection of these goals. By focusing on putting families in control, providing affordable options, and entrusting doctors and caregivers over government bureaucrats, I believe that we can chart a path forward that provides certainty to families without breaking the fiscal bank. I believe this plan is a step in the right direction. Perhaps most importantly, I believe the ideas contained here can draw support across the political spectrum. There is nothing more important than the health of our families and our communities. It is about time Congress starts to recognize that.

High Cost of Care

Each year the United States spends more on health care than any other developed country, despite supplying the same level of services.⁵ One of the most significant drivers of America's higher costs is the increasing rate of market consolidation.⁶ For years, large companies in all major sectors of the healthcare industry – pharmaceuticals, health insurers, and hospitals – have consistently cornered their respective markets and dramatically increased their prices.

Take health insurers for example. Between 2006 and 2014, the top four largest health insurers in the country increased their market share for individual and group policies from 74 percent to 83 percent.⁷ Or look at the pharmaceutical industry, where just three pharmaceutical benefit managers (PBMs) control over 85 percent of the market and now work alongside drug manufacturers to drive up prices, knowing the higher the price, the greater the rebate and the more the drug manufacturer profits.⁸ Similarly for hospitals, the Herfindahl-Hirschman Index – the standard metric used by the Federal Trade Commission (FTC) to determine highly

⁵ Sawyer, Bradley, and Daniel McDermott. "How Does the Quality of the U.S. Healthcare System Compare to Other Countries?" Peterson-Kaiser Health System Tracker, 2019, www.healthsystemtracker.org/chart-collection/quality-u-s-healthcare-system-compare-countries/.

⁶ Ginsburg, Paul. "What Is Driving U.S. Health Care Spending?" Bipartisan Policy Center, Sept. 2012, bipartisanpolicy.org/wp-content/uploads/2019/03/BPC-Health-Care-Cost-Drivers-Brief-Sept-2012.pdf.

⁷ Dafny, Leemore. *Evaluating the Impact of Health Insurance Industry Consolidation: Learning from Experience*. The Commonwealth Fund, 2015, pp. 1–2.

⁸ Sood, Neeraj, et al. *The Flow of Money Through the Pharmaceutical Distribution System*. 2017, pp. 1–9.

concentrated markets – indicates nearly 75 percent of U.S. hospital markets are no longer competitive.⁹

It should be no surprise that eliminating competitors correlates with higher prices. Consider a 2011 study analyzing 61 hospitals in 27 markets across 8 states. The analysis revealed that hospital prices for patients in concentrated markets were 44 percent higher than prices in more competitive markets.¹⁰ Moreover, a study analyzing market concentration in the health insurance industry found a 7 percent increase in premiums after health insurers Aetna and Prudential merged in 1999.¹¹

While not as consolidated, powerful pharmaceutical companies have engaged in similar anti-competitive practices to maintain market power and fix prices. For example, many drug manufacturers use tactics to extend the life of their patents or make it more difficult for generic manufactures to bring a less expensive product to market. Despite not showing any additional benefits to patients, manufacturers can spike their prices with almost zero retribution.

To be sure, consolidation and perpetual monopolies are not the only driver of high costs. An opaque pricing structure, open-ended tax exclusion for employers, and wide engagement gap between patients and payers also contribute significantly. Under the current system, reimbursement rates are negotiated between third party payers and providers, and patients are given very little information on the price of the care. This inherently limits patients from knowing exactly what their health care products and services cost and whether or not it's worth the price. Furthermore, it prevents competing insurers from knowing what hospitals are really charging for their services, making markets less competitive.

On the whole, patients have very little incentive to be price sensitive. Because of a third-party insurance system that – for most Americans – is administered by employers, patients are shielded from the overall costs of health insurance and care. This encourages both health care providers and insurers to raise costs knowing the patient has a weak financial incentive to question the need for or value of services. Not to mention that the tax exclusion for employers disproportionately benefits the top 1 percent of Americans and discourages workers from leaving their jobs for better ones.¹²

⁹ Inzerro, Allison. “Nearly 75% of US Hospital Markets Highly Concentrated, HCCI Report Shows.” AJMC, 17 Sept. 2019, www.ajmc.com/newsroom/nearly-75-of-us-hospital-markets-highly-concentrated-hcci-report-shows.

¹⁰ Robinson, James C. “Hospital Market Concentration, Pricing, and Profitability in Orthopedic Surgery and Interventional Cardiology.” *The American Journal of Managed Care*, vol. 17, no. 6, 24 June 2011, pp. 241–248.

¹¹ Dafny, Leemore, et al. “Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry.” *American Economic Review*, vol. 102, no. 2, 2012, pp. 1161–1185.

¹² Kaestner, Robert, and Darren Lubotsky. “Health Insurance and Income Inequality.” *Journal of Economic Perspectives*, vol. 30, no. 2, 2016, p. 54.

Coverage Gaps

Gaps in public and private insurance leave millions of Americans without insurance each year. According to the most recent data from the U.S. Census Bureau, 27.5 million people in the United States remain uninsured.¹³ While there are several, intervening factors that contribute to an individual or family’s decision to forego health insurance, the uninsured population can broadly be broken down into five categories¹⁴:

1. 15 million Americans – or half of the total – are either unaware or have not taken the necessary steps to sign up for Medicaid or a federally subsidized ACA marketplace plan. Given the sheer size and complexity of the healthcare system, navigating and shopping for coverage can be difficult for many. Additionally, the anticipated high costs associated with health care is enough to deter millions of Americans away from looking for coverage.
2. 3.8 million are uninsured because they have not accepted their employer-sponsored plan. Some Americans believe health insurance is unnecessary or are unable to afford the coverage offered to them by their employer.
3. 1.9 million uninsured Americans have incomes exceeding 400 percent of the FPL and are therefore ineligible for financial assistance. While some have sufficient income to purchase insurance and are choosing to forego it, many can’t take up coverage because the cost is out of their price range. This is certainly true for young individuals, who in most cases, lack the necessary income and savings to purchase expensive health insurance.
4. 2.5 million remain uninsured because they fall in the category known as the “Medicaid coverage gap”. These individuals reside in states that did not expand Medicaid and have incomes below 100 percent FPL, which makes them ineligible for subsidized coverage.
5. 4.1 million legal immigrants residing in the United States are uninsured because of cost concerns and no access to public or subsidized insurance.

¹³ Bureau, US Census. “Health Insurance Coverage in the United States: 2018.” The United States Census Bureau, 8 Nov. 2019, www.census.gov/library/publications/2019/demo/p60-267.html#:~:text=In%202018%2C%208.5%20percent%20of,7.9%20percent%20or%2025.6%20million).

¹⁴ Garfield, Rachel, et al. “The Uninsured and the ACA: A Primer – Key Facts about Health Insurance and the Uninsured amidst Changes to the Affordable Care Act.” Kaiser Family Foundation, 25 Jan. 2019, www.kff.org/uninsured/report/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act/.

An analysis of these five categories makes it abundantly clear that affordability is the greatest inhibitor to obtaining health insurance in America. In fact, 45 percent of uninsured adults cite high costs as the reason they lack health insurance.¹⁵ Developing a plan that reduces costs and expands coverage options can help fill the coverage gap and protect more American families.

Private Health Insurance Reform

As the largest source of coverage for Americans, private insurance provides over 217 million Americans access to quality care and treatments with minimal delays.¹⁶ The high cost of this care, however, is a significant reason why millions of Americans remain uninsured or are struggling to afford their monthly premium. Correcting the distorted incentives in the private insurance market is essential to lowering costs, expanding coverage, and improving health outcomes. These reforms should be tailored around consumers and incentivize better care without excessive, unnecessary costs.

Reforms should include:

1. Increasing access to tax advantaged accounts to encourage consumers to be more informed and cost-conscious.
2. Capping the open-ended tax exclusion of employer-paid health insurance premiums.
3. Creating dependable comparative cost and quality information to inform health plan choices.
4. Establishing targeted premium subsidies that are dependent on income, age, and health need.
5. Ensuring flexibility in the design of benefits and provider payments in the insurance plans to enable insurance plans to support high-value care.
6. Improving protections for low-income and high-risk individuals to ensure the insurance markets work well for them.

Establish Medisave Accounts

The implementation of health savings accounts in the early 2000's presented a unique opportunity to achieve greater efficiency and equity in the health financing structure. These accounts were the first of their kind in the United States – granting Americans the financial means to make rational and responsible choices in their personal lives. The Obama

¹⁵ Tolbert, Jennifer, et al. "Key Facts about the Uninsured Population." Kaiser Family Foundation, 13 Dec. 2019, www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.

¹⁶ US Census Bureau. "Health Insurance Coverage in the United States: 2018." *The United States Census Bureau*, 8 Nov. 2019, www.census.gov/library/publications/2019/demo/p60-267.html.

administration, however, chose to reinforce the employer-coverage system and direct Americans towards insurance tailored by the federal government.

Congress should reverse course and build off existing federal law regarding health savings accounts to further encourage more informed, cost-conscious consumer behavior. We should also facilitate a tax system that is more neutral towards health expenditures and allows people to make choices not tailored by government. The result would be a health care system built around families, not the government, and that puts patients in charge of deciding how their own healthcare dollars are spent. Instead of relying on government bureaucrats, this approach drives down costs and improves quality by encouraging insurers and providers to compete for patients' dollars.

Currently, Americans have access to four tax-advantaged medical savings accounts: health savings accounts (HSA), health reimbursement accounts (HRA), flexible spending accounts (FSA), and medical savings accounts (MSA). These accounts share several similarities, but also some stark differences – such as, who owns them, who can contribute, how much can be contributed, and whether any unused funds from one year may be rolled over to the next.¹⁷

I believe that if we want to truly empower American families, these accounts should be simplified into one, simple and easy to use account. Based on my *Family First Medisave Empowerment Act*, my plan proposes merging HSAs, HRAs, FSAs, and MSAs into a single Medisave Account (MDA), that is owned by individuals and can be used to purchase health care services and health insurance, of any type and from any source, tax-free. Moreover, these accounts would feature the triple-tax advantages – no income, payroll, or interest taxes – that health savings accounts currently enjoy.

MDAs would be available to anyone with private insurance, regardless of their deductible, as well as those on Medicare and Medicaid. Under my proposal, every individual in a family would be able to open their own account, allowing parents to open and contribute to their children's accounts as they plan for future health expenses. Account holders could use their MDAs to pay for themselves and qualifying dependents, such as grandparents, parents, and children.

With their MDAs, Americans would be free to purchase any type of insurance from their employer, their spouse's employer, the exchange, or an insurance broker. Any individual eligible for premium tax credits on the individual market will also be given the option to turn down the offer of their employer-based coverage and receive advance premium tax credits deposited into their MDA accounts. Additionally, Americans would be permitted to use their MDAs to cover

¹⁷ Rapaport, Carol. *Tax-Advantaged Accounts for Health Care Expenses: Side-by-Side Comparison*. Congressional Research Service, 2013, pp. 1–18, *Tax-Advantaged Accounts for Health Care Expenses: Side-by-Side Comparison*.

direct primary-care arrangements, allowing patients to visit the doctor of their choice at an affordable monthly fee.

Deposits into MDAs could be made by individuals or employers on a pre-tax basis, so long as the individual obtains health insurance in the tax year. The annual contribution limits would be subject to a sliding scale based on the plan’s actuarial value – the percentage of total average costs for covered benefits that a plan will cover.¹⁸ Insurers would be required by law to report the actuarial value of their plan to both consumers and the Internal Revenue Service. To safeguard MDAs from becoming a tax-avoidance shelter for wealthy Americans, these accounts would be limited to a maximum accumulation cap of \$50,000.

Actuarial Value Scale	Individual Plans Contribution Limit
0% - 54.99% <i>Actuarial Value of Plan</i>	\$10,000
55% - 64.99% <i>Actuarial Value of Plan</i>	\$8,600
65% - 100% <i>Actuarial Value of Plan</i>	\$7,200

Recognizing the complexity of the American healthcare system, and the difficulty Americans will initially face in opening and operating their MDAs¹⁹, my proposal offers a targeted one-time refundable federal tax credit of up to \$1,000 to Americans that open an MDA account and contribute to it. Specifically, adults below 400 percent FPL will receive a matching contribution refundable tax credit of \$1 for every \$1 contributed. For adults above 400 percent FPL, they will be eligible for a matching contribution non-refundable tax credit of \$1 for every \$3 contributed to an account in the first full calendar year.²⁰

My plan also allocates grant funding to states to provide educational opportunities to Americans on the usage of MDAs and how to better evaluate health insurance benefits. This would directly benefit Americans lacking the necessary financial health literacy to evaluate insurance products and better manage their health finances.

Critical to the success of the Medisave program is ensuring every family, no matter their income level, can control their healthcare spending. To ensure low-income Americans and their families have access to the benefits of these accounts, my plan would offer direct financial assistance to low-income individuals and families, providing a safety net to those who otherwise cannot afford

¹⁸ “Actuarial Value - HealthCare.gov Glossary.” HealthCare.gov, www.healthcare.gov/glossary/actuarial-value/#:~:text=Get%20Answers-,Actuarial%20Value, costs%20of%20all%20covered%20benefits.

¹⁹ 2018 Alegeus Consumer Health & Financial Fluency Report. Alegeus, 2018, pp. 1–17, 2018 Alegeus Consumer Health & Financial Fluency Report.

²⁰ Antos, Joseph, et al. “Improving Health and Health Care: An Agenda for Reform.” American Enterprise Institute, Dec. 2015, www.aei.org/wp-content/uploads/2015/12/Improving-Health-and-Health-Care-online.pdf.

to set money aside. Specifically, it establishes a new waiver application under which applicant states may convert the amounts they expect to be distributed to in-state patients through Cost Sharing Reduction (CSR) payments into targeted MDA distributions to individuals and families below 400 percent of the FPL.

In sum, utilizing MDAs would provide American families an unprecedented level of choice and control over their own healthcare. They also match the reality of work in the 21st Century, providing workers ownership of their benefits and needed protections if they choose to seek employment elsewhere or happen to lose their job. At a time when the employer-employee relationship is drastically changing, it is important that our institutions adapt and implement policies that ensure the portability of benefits.²¹ By ensuring portability, not only will we unleash further dynamism into the American economy, but more importantly, we will protect every American from fearing that the development of a pre-existing condition will affect their access to affordable care.

Address the tax treatment of employer-paid health insurance

Economists generally accept that the most fundamental flaw in our health care system is that its economy is driven to excess by the existence of an enormous subsidy (over \$250 billion per year²²) to health insurance through the income tax system. Established during World War II to control wages, this subsidy excludes all employer-paid health insurance premiums, no matter how large, from the definition of taxable income.²³ Eleven years after its implementation, Congress codified the tax exclusion into law, and thus, irrevocably linked our health care system to employers.

This very simple piece of legislation has unintentionally distorted the structure, cost, and availability of health insurance and health care services by:

1. Stagnating wages as employers are increasingly incentivized to offer more employer-paid health benefits. Given the current tax arrangement, if an employee takes an additional dollar of gross compensation, they get to keep 60 to 70 cents after tax. However, if they take it in health benefits, they keep the full dollar.
2. Facilitating an opaque pricing structure that benefits powerful special interest groups. By subsidizing, on average, close to 80 percent of an employee's insurance

²¹ "Designing Portable Benefits: A Resource Guide for Policymakers." *The Aspen Institute*, 6 June 2019, ru

²² *Bending the Curve: Person-Centered Health Care Reform – A Framework for Improving Care and Slowing Health Care Cost Growth*. Brookings Institution, 2013, *Bending the Curve: Person-Centered Health Care Reform – A Framework for Improving Care and Slowing Health Care Cost Growth*.

²³ "The Pivotal Role of Employer-Paid Health Insurance." *The Economics of US Health Care Policy*, by Charles E. Phelps and Stephen T. Parente, Routledge, 2018.

- premium²⁴, Americans are insensitive to changes in price, which consequently incentivizes both health care providers and insurers to raise costs knowing the patient has a weak financial incentive to question the need for or value of services.
3. Limiting the number of options individuals have in choosing an insurance policy that matches what they desire. Because employers are incentivized to cover health insurance premiums, insurance policies are almost always chosen by the employer, rather than the employee. While employers are not inclined to offer insurance their workers dislike, individuals are best equipped to choose the insurance policy they want and need.
 4. Creating an environment that discourages workers from leaving their jobs for better ones. This tendency, widely known as “job lock”, falls hardest on those with pre-existing conditions who fear loss of coverage. This undermines labor market mobility, makes it more difficult for workers to find jobs that match their skills, and ultimately cuts labor productivity.²⁵
 5. Disproportionately rewarding wealthier Americans. Because the subsidy depends upon the applicable marginal tax rate, higher-income earners receive greater subsidies than lower-income, and in turn, more generous insurance.²⁶

Architects of the ACA did at least attempt to address the exclusion and equalize the tax treatment of employer and individually-purchased health insurance. Their remedy, the “Cadillac tax”, was a 40 percent excise tax on the excess coverage benefit (plans valued above \$10,200 for individuals and \$27,500 for families) of employer provided health insurance. However, this provision had considerable shortcomings given the degree of variation in premium costs across populations and geographies and the potential financial burden on low-income earners and their families. Moreover, it didn’t just apply to health plans, but also cost-savings tools such as health savings accounts.

Rather than re-establish the “Cadillac tax”, my proposal sets a cap on the tax-free employer-paid health insurance premiums offered at \$11,200 for individuals and \$30,150 for families – the

²⁴ “2018 Employer Health Benefits Survey - Section 1: Cost of Health Insurance.” *The Henry J. Kaiser Family Foundation*, www.kff.org/report-section/2018-employer-health-benefits-survey-section-1-cost-of-health-insurance/.

²⁵ Horpedahl, Jeremy, and Harrison Searles. “The Tax Exemption of Employer-Provided Health Insurance.” *Mercatus on Policy*, 2013, www.mercatus.org/system/files/Horpedahl_TaxExemptEmployerHealthIns_MOP_071813.pdf.

²⁶ Kaestner, Robert, and Darren Lubotsky. “Health Insurance and Income Inequality.” *Journal of Economic Perspectives*, vol. 30, no. 2, 2016, p. 54., doi:10.1257/jep.30.2.53.

same threshold most recently used for the “Cadillac tax” after inflation.²⁷ This ensures only employer sponsored insurance that is uncommonly robust is subject to the cap and closes the gap between the growth of insurance premiums and consumer prices.

Exceptions to this cap would be preserved for high-risk occupations such as law enforcement and fire protection and potentially other industries as determined by the Department of Health and Human Services (HHS).²⁸ The cap would only be instituted for employer-sponsored premiums, making employer contributions to Medisave accounts exempt.

In addition to setting a cap, my proposal encourages states to adopt minimum aggregate attachment points for self-insurance stop-loss deductibles and reduce the incentive for small-firms to self-insure. Under current law, small employers with healthier employees often self-insure, which can lead to higher premiums for those employers remaining under modified community rating rules in the fully insured market. Encouraging states to set floors for self-insurance stop-loss deductibles would mitigate the issue of adverse selection brought about by small employers self-insuring and encourage insurers to compete based on value and coverage design.²⁹

Maintain Consumer Protections

To create a competitive marketplace that is fair and socially desirable, it is important to establish a set of rules and standards for health insurance plans.³⁰ Such rules and standards ensure that health insurers are competing to offer first-rate plans that provide access to high quality care.

1. Protect Pre-existing Conditions

The first, and most important standard, is to protect pre-existing conditions by prohibiting plans from excluding or restricting coverage because of prior medical conditions. I would keep the guaranteed issue and guaranteed renewability provisions of the ACA intact to ensure everyone has access to care. Furthermore, to protect individuals who leave or lose their employer insurance plan, my plan would allow them to carry their premiums with them or right to purchase insurance at non-risk-rated premium rates.

²⁷ Rovner, Julie. “Cadillac Tax’ On Generous Health Plans May Be Headed For Repeal.” *NPR*, NPR, 14 Aug. 2019, www.npr.org/sections/health-shots/2019/08/14/750859901/cadillac-tax-on-generous-health-plans-may-be-headed-to-congressional-junkyard.

²⁸ Roy, Avik. “Bringing Private Health Insurance Into the 21st Century.” *Medium*, FREOPP.org, 19 June 2019, freopp.org/bringing-private-health-insurance-into-the-21st-century-d1df138f1f0c.

²⁹ Hall, Mark A. “Regulating Stop-Loss Coverage May Be Needed To Deter Self- Insuring Small Employers From Undermining Market Reforms.” *Health Affairs*, vol. 31, no. 2, 2012, pp. 316–323., doi:10.1377/hlthaff.2011.1017.

³⁰ Enthoven, Alain C. *Health Plan: The Only Practical Solution to the Soaring Cost of Medical Care*. Addison-Wesley, 1981.

However, I would reform the ACA provisions that regulate premiums by community rating, which charges buyers with different expected expenses under a given policy the same premium.³¹ While community rating attempts to address a serious issue – helping high-risk individuals obtain affordable health insurance – they drive low-risk individuals out of the market by increasing their premiums without expanding the benefits they expect to receive.³² Put differently, community ratings are an inequitable tax on young and healthy Americans who often lack the necessary means to afford it. Because it is not technically considered a tax, and is significantly opaque, healthy Americans blame insurers for their high premiums when federal regulators are really at fault.

A better way to ensure every American has access to affordable insurance is to establish a federally funded reinsurance program that subsidizes and therefore reduces the premiums of high-risk individuals, who are not already enrolled in continuous coverage.³³ In other words, rather than force healthy enrollees, no matter their income-level, to foot the bill for the sickest fraction, the extra cost would be shared by all Americans.

Rep. Bruce Westerman and Avik Roy, President of the Foundation for Research on Equal Opportunity, recently put forward a strong reinsurance proposal that my plan would mirror. Specifically, it would appropriate \$200 billion over ten years (\$20 billion annually) to establish state-run reinsurance programs. States would receive a block grant composed of an appropriately portioned amount determined by HHS to run separate pools – contingent on measures of coverage for high-risk individuals and their financial situations. These programs would serve as a backstop against high medical costs by directly offsetting them and stabilizing premiums. Because the reinsurance program would drive down premiums, much of the cost of this program would be covered by the reduction in premium assistance tax credits.

To ensure the reinsurance program is not hijacked by healthy patients, my proposal establishes parameters on which sort of health risks and above-average premium offers will be covered by federal subsidies to state reinsurance programs.

2. Guaranteed Baseline of Benefits

The second standard is requiring plans to cover a minimum uniform set of benefits. Consumers are certainly capable of understanding deductibles, coinsurance, and copayments, but it can be

³¹ “Community Rating: the Worst Possible Way to Do a Good Thing.” Health Reform Without Side Effects, by Mark V. Pauly, Hoover Institution Press, 2013, p. 23.

³² Pauly, Mark V, and Bradley Herring. *Risk Pooling And Regulation: Policy And Reality In Today's Individual Health Insurance Market*. Market Watch, 2007, p. 776, *Risk Pooling And Regulation: Policy And Reality In Today's Individual Health Insurance Market*.

³³ Roy, Avik. “Bringing Private Health Insurance Into the 21st Century.” *Medium*, FREOPP.org, 19 June 2019, freopp.org/bringing-private-health-insurance-into-the-21st-century-d1df138f1f0c.

difficult to parse through the several exclusions insurers design to protect themselves from financial losses and make price comparisons difficult. A list of basic health services reduces this burden on consumers, protecting them from misleading “fine print” exclusions of important services and allowing them to focus on the quality and accessibility of services and price. More importantly, it provides a safety net for covering health care needs and promotes services that are medically effective.

While it is important to guarantee a basic set of benefits, the ACA was overly prescriptive in ways that make it difficult for the basic insurance package to evolve with advances in medical technology. Moreover, the ACA overburdened both insurers and providers with a litany of requirements that drove up costs for patients and took away flexibility for states to tailor benefit designs suited to their populations’ health needs. A better alternative is to turn over the decision making and regulatory structure to states. Returning regulatory authority to the states will allow insurers and local officials to jointly design exchange-based policies that are attractive to the communities they serve.

3. Purchase Insurance Across State Lines

Consumers concerned with the robustness of their state’s insurance offerings, or the high costs imposed by state regulations, will be afforded the option to purchase it across state lines. To carry this out, insurers would be able to select a “primary” state to regulate the policy and then sell such policy in other states so long as it abides by guaranteed issue and guaranteed renewal laws. “Secondary” states would retain their authority in several areas such as network adequacy rules, compliance with delinquency proceedings, and laws relating to fraud and abuse. If states wish to maintain community ratings, they would be given the option to opt-out from the proposal. States that do partake in the program will be provided federal funding to handle any increase in administrative costs.

4. Annual Out-of-Pocket Caps

Lastly, all qualified insurance plans will be required to place clearly stated annual caps on direct out-of-pocket payments by the policy holders. When gross medical expenses become large, the patient is very likely to be seriously ill or injured and not susceptible to the economic incentives of being cost-conscious. Requiring each policy to have annual limits for covered services will not only protect patients against major medical expenses and potential bankruptcies, but also guarantee that insurers do not compete by offering inadequate benefits that would leave those with higher risks either uninsured or reliant on public insurance.

Expand and Strengthen the Individual Market

One of the provisions most worth applauding in the ACA is the establishment of health insurance exchanges. Established to serve as venues for consumers to consider insurance offerings based

on price, benefits, and other features, exchanges were intended to simplify the experience of obtaining health insurance. Unfortunately, these exchanges have struggled to offer consumers effective options because of administrative efforts to utilize them as both a regulator and marketplace. Because of this confusion, they have largely served as high-risk pools for lower-income Americans.

Any reform of the exchanges should start with increasing access to young adults and low-risk individuals. By attracting younger, healthier adults into the market, insurers are better able to spread risk and therefore reduce premiums across all age groups.³⁴ To expand coverage to young adults, my plan would improve upon the bipartisan Alexander-Murray proposal and expand access to catastrophic coverage plans, commonly referred to as Copper plans, to any enrollee.³⁵ These plans would be required to have an actuarial value minimum of 50 percent and be included in the single risk pool for pricing premiums, alongside other metal plans. Doing so will ensure the insurance plans provide adequate coverage and, additionally, help lower costs of all plans by increasing the risk pool.

In addition to implementing this policy, my plan would protect older, low-income Americans from higher premiums by adjusting premium assistance to incorporate recipients' age. Under current law, premium tax credits are only adjusted by income. It would also provide direct financial support to individuals and families struggling to afford their out-of-pocket medical costs by restoring the CSR program and expanding it to 400 percent FPL.

Lastly, I would provide Americans with more flexibility and options by allowing recipients of tax credits and CSR payments to purchase any policy on the exchange. Under current law, enrollees can purchase a bronze, silver, or gold plan with their tax credit, but may only receive CSR payments when purchasing silver plans. Individuals should be given maximum freedom to choose the policy they desire and set aside unused funds in their MDA, if possible.

Lower Prescription Drug Costs

Prescription drugs are one of the most valuable and cost-effective features of our health care system today. If administered properly and timely, they can prevent more expensive hospitalizations and treatments in the future. However, they also represent a major financial burden to millions of Americans.

³⁴ Roy, Avik. "Bringing Private Health Insurance Into the 21st Century." *Medium*, FREOPP.org, 19 June 2019, freopp.org/bringing-private-health-insurance-into-the-21st-century-d1df138f1f0c.

³⁵ "Bipartisan Health Care Stabilization Act of 2017." Congressional Budget Office, 25 Oct. 2017, www.cbo.gov/publication/53232.

Like almost every other component of the healthcare sector, the current alignment of policies has established programs that feature perverse incentives and drive up the price of lifesaving drugs. For example:

1. Medicare is required to cover almost all Part A and Part B drugs, regardless of their clinical benefit. In Part B, drugs are reimbursed at the average sales price (ASP) plus 4.3 percent. The 4.3 percent represents the commission a physician will receive for administering the drug, thus incentivizing the use of the costliest drug.³⁶
2. Medicare beneficiaries cost sharing is tied to the list price of a drug, rather than the net price. While patients' spending on prescription drugs and rebates from drug manufacturers to PBMs have ballooned over the last decade, net prices have remained constant. This suggests PBMs are steering patients to costlier drugs and pocketing a larger share of the rebates instead of passing them on to patients. Furthermore, it forces beneficiaries with higher out-of-pocket costs to subsidize lower premiums for all beneficiaries.³⁷
3. Under the Medicare Part D benefit design, after a beneficiary hits their deductible the insurer covers 75 percent of the costs. However, after the enrollee reaches \$3,820 in total spending, they only cover 15 percent. This structure disincentivizes insurers to seek lower drug costs or encourage less expensive generic drugs.³⁸

Medicare Negotiation

Stretched to the limit by rising health care costs, too many of our nation's seniors are struggling with financial stress due to the high cost of prescription drugs. According to a recent report by the Kaiser Family Foundation, in 2017, over 1 million seniors had out-of-pocket spending exceed \$3,200.³⁹ This level of spending is unacceptable, and we owe it to our seniors to protect their health and financial well-being. My proposal promises to rectify these costs and keep prescription drugs accessible and affordable to seniors.

³⁶ Roy, Avik. "What Medicare Can Learn From Other Countries on Drug Pricing." Medium, FREOPP.org, 20 Mar. 2020, freopp.org/what-medicare-can-learn-from-other-countries-on-drug-pricing-bf298d390bc5.

³⁷ Trish, Erin, et al. "How Would Sharing Rebates at the Point-Of-Sale Affect Beneficiary Cost-Sharing in Medicare Part D?" USC Schaeffer, 6 Apr. 2020, healthpolicy.usc.edu/research/how-would-sharing-rebates-at-the-point-of-sale-affect-beneficiary-cost-sharing-in-medicare-part-d/.

³⁸ Aaron, Henry, Joseph Antos, Loren Adler, James Capretta, Matthew Fiedler, Paul Ginsburg, Benedic Ippolito, Alice Rivlin. Cost-Reducing Health Policies: A Response to Chairman Alexander and the Senate Committee on Health, Education, Labor, and Pensions." March 1, 2019.

³⁹ Cubanski, Juliette, et al. "How Many Medicare Part D Enrollees Had High Out-of-Pocket Drug Costs in 2017?" Kaiser Family Foundation, 25 July 2019, www.kff.org/medicare/issue-brief/how-many-medicare-part-d-enrollees-had-high-out-of-pocket-drug-costs-in-2017/.

In almost every other market, the greatest purchaser of a product is provided the lowest bulk price. Yet this generally accepted principle is not true in Medicare Part D, where U.S. seniors represent the largest market in the world for prescription drugs but pay astronomically higher prices. My belief is that if drug makers want access to Medicare seniors, they should have to sit down and agree on a price that will preserve their company's innovation without breaking the bank for seniors.

Specifically, my plan would allow Medicare to establish its own Part D formulary and grant the Secretary of HHS the authority to negotiate with drug companies on the prices of drugs provided through the newly created formulary. To ensure seniors are getting the best possible price, my plan would instruct the Patient Centered Outcomes Research Institute (PCORI) to assist the Secretary in creating the formulary.

To be clear, this would not involve any government price setting. Both drug makers and HHS would be free to walk away from the negotiating table without penalty. Moreover, this new plan would run alongside existing private Part D plans (PDPs), who would be barred from negotiating until the Secretary has completed his formulary for the upcoming year. Therefore, it would function similarly to how Medicare Advantage plans operate today.

Eliminate Perverse Incentives

Next, my proposal would eliminate the ASP plus 4.3 percent and replace it with a fixed fee. This will ensure doctors and physicians do not game the system for a higher commission. My plan would also tie both Medicare Part D and private insurance beneficiary cost-sharing to net prices and require plans to share rebates with beneficiaries at the point-of-sale. The net impact of this policy change would be lower out-of-pocket spending and a greater utilization of generic and biosimilar drugs.

Furthermore, my plan would include provisions from the bipartisan Senate Finance Committee legislation, which would reform the Medicare Part D benefit design by reallocating responsibility for paying for prescription drugs. Specifically, it would cap patient's out-of-pocket spending and require insurers to pay 75 percent of the drug costs until the catastrophic threshold is met and 60 percent thereafter. By placing more cost responsibility on insurers, they will work harder to lower drug prices and weed out ineffective, high-cost drug consumption.

Address Foreign Free Riding

Another issue my plan would address is the foreign free riding of American pharmaceutical innovation. Currently, U.S. consumers spend three to four times as much on certain single-source brand name drugs as consumers in the United Kingdom (U.K.), Japan, or Ontario.⁴⁰ Although

⁴⁰ Kang, So-Yeon et. al. (2019). Using External Reference Pricing in Medicare Part D to Reduce Drug price

some of this can be attributed to the greater use of new and higher strength medicines in the U.S., much of the gap arises because foreign countries pay lower prices for the same drugs.

To close the gap, my plan would allow HHS to make Medicare Part B drug payments based on an international pricing index (IPI model) that uncovers the average price among comparably wealthy nations – necessitating countries with market-based drug prices be weighted heavier than those with government-controlled markets or prices. Additionally, it would establish a drug czar position in the Office of the United States Trade Representative to more carefully scrutinize foreign drug-pricing schemes. As trade agreements are re-examined, this official will work to ensure countries pay their fair share for U.S. drugs.

Spur Competition to Lower Hospital Prices

While much of the public’s attention is steered towards health insurance companies, hospital prices have received far less scrutiny. Recent analysis suggests hospital costs are a significant factor in the overall health care cost increases – outpacing physician prices by 24 percent in inpatient settings and 19 percent in outpatient settings.⁴¹ Furthermore, research indicates hospital mergers and acquisitions are a main driver for these price increases as they eliminate competitors and expand negotiating strength with health insurers.⁴² Some executives will claim these costs are a trade-off for improvements in care and services. However, Harvard researchers have found just the opposite – concluding hospital acquisitions by another hospital produce modestly worse patient experiences and no significant changes in readmission or mortality rates.⁴³

Make no mistake, our hospitals and frontline health care workers are heroes. Since the COVID-19 pandemic struck, they have worked around the clock to provide world class care while suffering significant financial losses. But once our nation and our healthcare sector overcome this period, we must implement policies that reduce hospital prices and encourage better health outcomes. To carry this out, we must have two goals in mind. The first is to make hospitals more public facing and provide enhanced transparency of their negotiated prices to consumers. The second is to implement policies that will beef up antitrust enforcement and restrain unwarranted consolidation of small physician practices or other hospital systems.

Differentials with Other Countries. Health Affairs Blog. Retrieved from <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2018.05207>

⁴¹ Cooper, Zack. “Hospital Prices Grew Substantially Faster Than Physician Prices For Hospital-Based Care In 2007–14.” Health Affairs, 1 Feb. 2019, www.healthaffairs.org/doi/10.1377/hlthaff.2018.05424.

⁴² Berenson, Robert A., et al. “The Growing Power Of Some Providers To Win Steep Payment Increases From Insurers Suggests Policy Remedies May Be Needed.” Health Affairs, 1 May 2012, www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.0920.

⁴³ Beaulieu, Nancy D., et al. “Changes in Quality of Care after Hospital Mergers and Acquisitions: NEJM.” New England Journal of Medicine, 7 May 2020, www.nejm.org/doi/full/10.1056/NEJMsa1901383.

Incorporate Price Transparency

To ensure greater transparency, my proposal would codify the Trump administration’s rule requiring hospitals to post price information on their websites for each item and service they provide. Additionally, it would codify the upcoming rule from the Department of Labor and the Treasury, which will require insurers to post the actual rates they pay to hospitals and other health care providers. Codifying these rules into law will provide Americans with the information they need to effectively shop for routine health care services, apply public pressure on high-cost providers, and provide insurers more leverage in their negotiations with large hospital systems.

Ensure Competition

My plan would also enforce tighter regulation of hospital consolidation. First, it would build off the Trump administration’s site-neutral payment reform by establishing equivalent reimbursement rates for Medicare Part A inpatient hospital care and Medicare Part B outpatient services for substantially similar services. Second, it would include provisions from my colleague Rep. Jim Banks’ legislation, the *Hospital Competition Act*, which authorizes a \$160 million increase in Federal Trade Commission (FTC) funding to increase the size of FTC antitrust staff investigating hospital consolidation.

Next, it would reduce incentives for hospital mergers by requiring hospitals in highly concentrated urban areas to accept the average commercial reimbursement rate. To protect care to patients in rural areas, it would exempt hospitals in Medicare-designated rural areas and increase the allowable cost reimbursement in the Critical Access Hospital Formula from 101 percent to 110 percent. Lastly, it would grant the FTC authority to evaluate anti-competitive actions perpetrated by non-profit hospitals. The FTC is currently able to block hospital mergers among non-profit entities; however, they are prohibited from investigating other anticompetitive behavior.⁴⁴

Instead of pouring more subsidies into our health care system, we should implement policies that spur competition. For too long, hospital systems have been shielded from the market pressures

⁴⁴ For example, the Commission generally cannot challenge anti-competitive conduct, such as collusive behavior, by nonprofit hospitals. In three past enforcement actions, the Commission alleged that groups of physicians and hospitals had participated in unlawful price-fixing arrangements but was able to sue only the physicians and a for-profit hospital. See *Piedmont Health Alliance*, 138 F.T.C. 675 (2004) (consent order), <https://www.ftc.gov/enforcement/casesproceedings/0210119i/piedmont-health-alliance-inc-et-al-matter>. Accessed July 29, 2020; *Tenet Healthcare Corp./Frye Regional Medical Center*, 137 F.T.C. 219 (2004) (consent order), <https://www.ftc.gov/enforcement/casesproceedings/0210119h/tenet-healthcare-corporation-frye-regional-medical-center-inc>. Accessed July 29, 2020; *Maine Health Alliance*, 136 F.T.C. 616 (2003) (consent order), <https://www.ftc.gov/enforcement/casesproceedings/0210017/maine-health-alliance-william-r-diggins-matter>. Accessed July 29, 2020.

every other industry endures. Improving competition among hospitals and other health care providers will not only enable us to reduce cost, but also facilitate innovation in the delivery of health care services.

End Surprise Billing

Today's news clips are littered with stories of patients receiving massive, unexpected medical bills after obtaining treatment, often in emergency situations, from a health care provider, doctor, or ambulance who is outside of their insurance plan's network. In fact, one in five hospital admissions that originate in the emergency department lead to a surprise medical bill.⁴⁵ While some of these bills may be modest, many are not, and they can create considerable financial difficulties for many families.

Under no circumstances, should a patient be left on the hook for thousands of dollars in medical expenses because they received treatment "out-of-network". As briefly mentioned above, most of these cases occur when patients are treated during an emergency and incapable of making an informed decision. They therefore have little to no power in avoiding providers who engage in this exploitative practice. Because of this market failure, action is needed to ensure patients are financially protected and have peace of mind when they seek out care. My plan would tackle surprise billing by eliminating both higher out-of-network charges and balance bills for emergency services and out-of-network services provided at in-network facilities. It would do so by requiring providers to accept the median-in-network price for any out-of-network care. If the cost of the care is above \$1,000, an insurer or provider would be able to appeal the case through an independent dispute resolution (IDR) process.

45 Chartock, Christopher Garmon and Benjamin, and Benjamin Chartock. "One In Five Inpatient Emergency Department Cases May Lead To Surprise Bills." Health Affairs, 14 Dec. 2016, www.healthaffairs.org/doi/10.1377/hlthaff.2016.0970.

Conclusion

Our nation needs a fundamental move towards a consumer-driven system – one that empowers Americans to choose an insurance plan that best fits their needs, protects them from financial calamity, and meets appropriate standards in his or her area. This type of system would put market forces to the test to promote efficiency, improve quality of services, develop more choices for consumers, and ensure patients are receiving valued care for their money.

Getting from here to there is no easy task. Reforming a complex system requires a protracted campaign, and lawmakers need to negotiate in good faith and offer each side piecemeal gains if we are to accomplish anything worthwhile.

As I continue my discussions with lawmakers, I want to make sure I am incorporating Northeast Ohio's best ideas. I encourage you to send me an email or call my office to share your thoughts on how to make our health care system better. For written feedback on this proposal, please email: healthcare.gonzalez@mail.house.gov. Together, we can ensure every generation of Americans has access to affordable, high-quality health care.