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ENHANCE ACCESS TO TRUSTED DOCTORS AND APPROPRIATE CARE WHEN AND WHERE THEY ARE NEEDED

As more and more Americans experience serious health problems, it is vital that they have access to trusted doctors and appropriate care when and where they are needed. Sixty percent of Americans have at least one chronic condition, and 42% have multiple chronic conditions. The percentage of those with multiple chronic conditions is 81% amongst people ages 65 and older. Unfortunately, only half of Americans receive recommended care, and the quality of care varies across conditions, demographic groups, and communities.

If new solutions are not implemented, the United States can anticipate a continued increase in the burden of chronic diseases on the physical and economic health of our citizens. Currently, we simultaneously have underutilization of preventive care and an overutilization of medical care. Just 6.9% of American adults ages 35 and older received all recommended high-priority, appropriate preventive services in 2018, according to the most recent data available from the Department of Health and Human Services Office of Disease Prevention and Health Promotion. And in 2017, physicians reported that 21% of medical care was unnecessary.

To enhance access to care, it is critical for the United States to comprehensively shift away from a healthcare system that is incentivized to treat illness, and toward a system that is oriented around delivering improved individual and societal health outcomes. To do so requires innovative solutions that recognize and engage the complex interplay of economic, behavioral, social, and biological factors that contribute to overall health. Unfortunately, the Biden Administration's agenda of broader one-size-fits-all government involvement in healthcare doubles down on the policies of the Affordable Care Act (ACA), which has failed to solve these problems.

Enrollees in ACA plans have less ability to choose their doctor as covered provider networks for ACA plans shrink. In 2020, health plans on the individual market with more restrictive networks consisted of 78% of the plan offerings in the exchange market. For comparison, plans with more restrictive networks represented 54% of the exchange market in 2015. While narrow network designs can help keep premium costs lower for enrollees, it may mean that preferred doctors and healthcare facilities are not covered by a chosen insurance plan. This is very problematic because the foundational relationship between doctors and patients — and the ability to receive appropriate care — are essential elements of improving the health of Americans. This highlights Obama's infamous broken ACA promise: "If you like your doctor, you can keep your doctor."

One way to enhance access to trusted doctors is through direct primary care (DPC). In this model, patients pay a monthly membership fee (typically ranging from $40 to $85 per person) to a clinical practice and receive access to a defined set of services, usually consisting of primary care and preventive services. In general, DPC doctors do not contract with insurers or government payers, but they may contract with self-funded employers. They typically have smaller patient panels, which results in expanded access to clinicians, including longer office visits and same-day or next-day appointments.

Many DPC practices can also provide laboratory tests and dispense common medications at discounted rates. Patients benefit from expanded access in this model. One case study found that DPC was associated with 30% lower out-of-pocket costs and 20% lower employee premiums. Another case study found a 40% reduction in emergency department utilization. Increased access to direct patient care models would benefit patients.

Additional policy priorities should provide better care for Americans by removing barriers to competition and promoting free-market solutions. These include maximizing the supply of clinicians and appropriate facilities by removing barriers to entry and addressing misaligned incentives. Doing so would increase access to care for those who need it most.

The federal government can implement site-neutral payment policies in Medicare to ensure the same rate is paid for the same clinical care provided at different facilities. This policy change could reduce Medicare spending, reduce premiums and cost-sharing for Medicare facilities, and result in significant private sector savings through spillover effects. Importantly, it would remove misaligned incentives to provide care in higher-cost facilities, which limit patients' access and choice.

State regulations and licensing requirements should promote increased supply in the market. This includes allowing clinicians to practice at the top of their licenses and join medical licensure compacts. The latter would allow doctors to practice medicine across state lines and allow patients to maintain continuity of care. This would increase patient access to necessary care, including from highly trained clinicians at specialty centers such as MD Anderson Cancer Center and Mayo Clinic. It also involves removing bureaucratic processes regarding the development of necessary healthcare facilities through certificate of need requirements.

Additionally, patients should be able to receive care at the location that best meets their needs. Payment differentials that encourage care in higher-cost settings should therefore be equalized, and expanded access to telehealth services should be maintained in a manner that maximizes the benefit to patients and doctors.

THE FACTS

- ★ Direct primary care has been associated with 20% lower employee premiums, 30% lower out-of-pocket costs, and a 40% reduction in emergency department utilization.
- ★ Approximately 90% of the $4.1 trillion in annual health expenditures are used to treat people with chronic and mental health conditions Sixty percent of Americans have at least one chronic condition, and 42% have multiple chronic conditions.
- ★ Five percent of the population accounts for 50% of the healthcare expenditures, and 50% of the population accounts for 97% of expenditures.
- ★ Only 7% of United States adults ages 35 and older received all the high-priority, appropriate clinical preventive services in 2018, according to the most recent data available.

THE AMERICA FIRST AGENDA

At the federal level, support policies that:

- ★ Allow Medicare and Medicaid to reimburse and contract with direct patient care providers.
- ★ Make Medicare site-neutrality policies permanent and expand as appropriate.

At the state level, support policies that:

- ★ Define direct primary care as a medical service outside of state insurance regulation.
- ★ Ensure state participation in the Interstate Medical Licensure Compact and other health professional licensing compacts.
- ★ Eliminate certificate of need requirements as appropriate.
- ★ Allow telehealth licensing registration to facilitate the ability of out-of-state providers to care for in-state patients.
- ★ Allow clinicians to practice at the top of their licenses.

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PROTECT THE MOST VULNERABLE, INCLUDING SENIORS AND PEOPLE WITH PREEXISTING CONDITIONS

As the prevalence of chronic conditions in the United States continue to rise, innovative solutions to improve care for vulnerable populations should be a top priority. Vulnerable populations encompass individuals who are not able to receive necessary care or preventive measures due to barriers and may include seniors and people with preexisting conditions. Eighty-one percent of Americans aged 65 years and older have multiple chronic conditions, but the government's Medicare program faces considerable challenges in meeting the future needs of seniors.

The United States Census Bureau expects the number of adults aged 65 years and older to increase from approximately 49 million in 2016 to nearly 95 million in 2060. Our Nation must be prepared to provide quality healthcare for all of our seniors by focusing on removing barriers to competition and promoting free-market solutions.

Unfortunately, our current system is not prepared to meet the challenges of today—or tomorrow. The Hospital Insurance Trust Fund, which pays hospitals and post-acute service providers under Medicare Part A, will become insolvent in 2028. When this occurs, revenues will be insufficient to cover program costs by a projected 10%, leading to a reduction in payments, which trustees warn could result in a rapid curtailing of access to healthcare.

Liberal lawmakers have nonetheless supported a fiscally unsustainable expansion of the Medicare program by proposing to add new benefits and lower the eligibility age from 65 to 60, further undermining the solvency of the existing program. Instead, we need to ensure seniors are protected. These policies would make Medicare's impending financial insolvency worse, which threatens access to care. Moreover, adding new dental, vision, and hearing benefits will likely put upward pressure on premiums. Seniors have access to these benefits now through supplemental plans or Medicare Advantage plans and should maintain the option to choose the additional coverage that best meets their needs.

Moreover, lowering the Medicare eligibility age would cost a projected $155 billion and provide new access to coverage for only approximately 400,000 people. In reality, much of the money would go toward shifting millions of those ages 60 to 64 years from private coverage into a taxpayer-financed, government-run system. For example, the Congressional Budget Office estimates the proposal could shift 3.2 million people with employer coverage and 2.0 million with non-group coverage into Medicare.

Liberal lawmakers have also proposed creating a new federal Medicaid program in states that did not undertake Obamacare expansion. A new federal program would undercut the long-standing state-federal partnership in Medicaid and could have unintended consequences for those the program intends to serve—those with disabilities and pregnant women, parents, and children from low-income families. This program was proposed despite evidence that previous Medicaid expansion in other states had higher enrollment and costs than projected, which impacted state budgets without a clear benefit for population health outcomes. States already spend 17.1 cents of every state- generated dollar on providing Medicaid coverage. And states that expanded Medicaid enrolled twice as many able-bodied adults as estimated, with per-person costs exceeding original estimates by 76%, leading to a combined cost

overrun of 157% on average.

A better way forward is to implement policies that target improving care for vulnerable populations, rather than broad expansions of government-run programs.

Increased access to telehealth services during the COVID-19 pandemic is an example of a targeted solution. During this public health emergency, millions of seniors gained access to telehealth services, and the technological revolution of healthcare delivery accelerated seemingly overnight. Regulatory flexibilities in Medicare, including waivers for originating site and geographic location restrictions, allowed seniors in any part of the country, rural and urban, to immediately gain access to available telehealth services from any location, including their homes.

A December 2021 Department of Health and Human Services (HHS) report found that the number of Medicare telehealth visits increased from approximately 840,000 in 2019 to 52.7 million in 2020, and 92% of beneficiaries received telehealth visits from their homes. While CMS permanently expanded the number of telehealth services through regulatory authority in December 2020, certain critical flexibilities in telehealth delivery would require Congress to remove existing Medicare statutory restrictions, specifically on originating site and geographic location restrictions.

Another free-market solution to benefit seniors is to provide more choices through Medicare Advantage, the private health insurance plans that comprise one-third of Medicare's total enrollment. This was a key focus of the October 2019 "Executive Order on "Protecting and Improving Medicare for Our Nation's Seniors." A systematic review found that Medicare Advantage outperformed traditional Medicare in several key metrics. The use of Medicare Advantage resulted in more preventive care services, fewer hospital admissions and emergency department visits, shorter hospital and skilled nursing facility lengths-of-stay, and lower healthcare spending.

Care for the most vulnerable can also be improved by providing new flexibilities to pay for necessary medical services. In 2019, federal agencies expanded the use of Health Savings Accounts (HSAs) to cover healthcare services for a range of Americans with chronic conditions enrolled in high deductible health plans (HDHPs). HDHPs are not required to have a deductible for preventive care, and patients with HSAs can now pay for preventive care of chronic conditions before meeting a minimum deductible. This gives individuals more options in managing their health, and the approach could be broadened to allow insurance companies to offer condition-specific health insurance plans for the most common chronic conditions.

THE FACTS

- ★ The Hospital Insurance Trust Fund, which pays hospitals and post-acute services providers under Medicare Part A, will become insolvent in 2028.
- ★ States that expanded Medicaid enrolled twice as many able-bodied adults as estimated, with per-person
- ★ costs exceeding original estimates by 76%, leading to a combined cost overrun of 157%.
- ★ Medicare Advantage outperforms traditional Medicare, including more preventive care services, fewer hospital admissions and emergency department visits, shorter hospital and skilled nursing facility lengths-of-stay, and lower healthcare spending.

THE AMERICA FIRST AGENDA

At the federal level, support policies that:

- ★ Permanently remove originating site and geographic location restrictions for telehealth services in Medicare if evidence continues to support benefits for patients and appropriate utilization.
- ★ Allow Medicare to auto-enroll new beneficiaries in Medicare Advantage instead of traditional Medicare, with clear information on both options for all new enrollees.
- ★ Permanently expand the list of preventive care benefits for a range of chronic conditions that may be provided by a high deductible health plan.
- ★ Allow insurance companies to offer condition-specific health insurance plans for the most common chronic conditions.
- ★ Allow states to implement work requirements for Medicaid to align with other social safety net programs and create opportunities for tiered

support as job wages increase.

At the state level, support policies that:

★ Authorize states to apply for a Medicaid waiver to implement flexibility to the maximum extent of federal law. Develop a plan to submit federal waivers in coordination with their state Medicaid directors.

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Increase Affordable Health Plans and Alternative Forms of Coverage

The passage of Obamacare in 2010 established coverage mandates and new requirements for qualified health plans that led to higher costs and decreased choices. From 2011 to 2021, the average premium for family coverage increased 47%, from $15,073 to $22,221, while overall inflation was only a cumulative 20.5%. In that same period, the average general deductible for single coverage increased 92%, from $747 to $1,434. And in the individual health insurance market, premiums more than doubled between 2013 and 2017 and increased by another 27% in 2018.

As costs have risen, Americans' choices in care and coverage have decreased with the consolidation of healthcare insurance markets. High concentration leads to less competitive markets, and nearly three quarters of markets are now highly concentrated. In 2020, a single insurer's share was at least 50% in nearly half of the markets.

The individual market has also been affected. Before the passage of the Affordable Care Act (ACA) in 2013, 395 insurers sold plans in the individual market in the United States. But by 2022, only 294 insurers offered plans. This 26% reduction shows that consumers do not benefit from as much competition as they did before the ACA was enacted. This means fewer coverage choices, which often results in limited access to preferred providers, premiums above competitive markets, and healthcare provider payments below competitive markets.

The previous administration countered these negative effects with policies to increase choice and competition in America's healthcare system and remove financial penalties for people who choose to opt out of receiving traditional coverage. In December 2017, the administration eliminated the impact of the individual mandate for Americans by decreasing the individual mandate penalty to $0. New federal regulations in 2018 and 2019 made options for alternative health benefits coverage widely available, primarily through association health plans and short-term, limited-duration plans (though these rules are in litigation).

Association health plans allow small employers to join together to purchase health insurance and gain the benefits of the large-group market. Access to these plans was increased by creating a new pathway for small businesses, working owners, and sole proprietors. Short-term, limited-duration insurance plans are temporary insurance plans sold by insurance companies that are in effect for a predetermined amount of time. They were made more available by expanding the allowable duration from three months to 12 months with the option for renewal up to three years.

The Trump Administration also allowed states to create a more free and open healthcare market with increased flexibility by issuing guidance for Section 1332 ACA waivers. Fourteen states enacted this approach from 2017 to December 2020, and, as a result, premiums in ACA plans declined in six states. These policies gave flexibility to states and created awareness of additional health benefit options that empower consumers to choose the coverage most appropriate for their individual health needs.

Unfortunately, many of the current administration's policies will lead to fewer choices for Americans through its systematic efforts to expand the role of government. This effort includes rolling back the previous administration's policies that expanded healthcare options to increase access and affordability.

One of the first executive orders President Biden signed after taking office, the "Executive Order on Strengthening Medicaid and the Affordable Care Act," revoked two key executive orders focused on minimizing the economic burden of ACA and promoting choice and competition.

This action illustrated the stark contrast between the two potential healthcare directions in the United States. The Biden Administration's healthcare agenda clearly seems to be more focused on increasing government control and bureaucracy than on improving patient access, affordability, and health outcomes.

Federal policies should focus on increasing choice and competition to provide Americans with more affordable health plan options and alternative forms of coverage. One way to accomplish this is to make the Trump Administration's regulations permanent in federal statutes. The federal government can also empower states to determine which insurance products can be sold. State insurance commissioners can then make locally informed decisions in the best interests of their citizens with a precision that cannot be done with an expansive federal government policy. This would include applying knowledge about local and state demographics and disease burdens to facilitate condition- specific disease coverage options for the most prevalent conditions, such as diabetes, to ensure state residents can access the best care for their healthcare needs.

States also have additional options outside of the ACA's one-size-fits-all approach. Because states are the primary regulators of health insurance, they can determine which health benefits constitute health insurance, creating pathways to offer coverage outside of the ACA's strict regulatory framework. Farm Bureaus are an example of member-based, nonprofit organizations that can offer alternative health benefits to members in states that have provided exemptions from state insurance regulations.

THE FACTS

- ★ Average family premiums increased 47%, from $15,073 in 2011 to $22,221 in 2021, after the passage of the ACA.
- ★ In that same period, average general deductibles for single coverage increased by 92%, from $747 to $1,434.
- ★ Three-quarters of United States health insurance markets are highly concentrated.
- ★ Premiums for small businesses nearly doubled from 2003 to 2018, from a total cost of $9,321 for family coverage per worker to $18,296. From 2003 to 2018, 31% fewer small businesses offered coverage.
- ★ Short-term, limited-duration plan premiums typically cost significantly less than premiums for individual plans bought on the Obamacare exchanges—sometimes almost half the cost.
- ★ The Tennessee Farm Bureau has offered affordable benefits outside of insurance regulated by the state for more than 30 years. Plan premiums are up to 77% lower than other insurance options. Indiana, Iowa, Kansas, South Dakota, and Texas have authorized similar options.

THE AMERICA FIRST AGENDA

At the federal level, support policies that:

- ★ Allow Americans to purchase any health plan approved by their state insurance commissioners, including catastrophic only.
- ★ Make permanent the Trump Administration's 2018 "Definition of "Employer" Under Section 3(5) of ERISA- Association Health Plans" regulation that broadened criteria for determinations of when employers may join in a group or association to access the benefits of the large- group insurance markets.
- ★ Make permanent the Trump Administration's "Short- Term, Limited-Duration Insurance" rule to extend these plans for up to 12-month terms and allow renewal up to three years.

At the state level, support policies that:

- ★ Remove restrictions on the availability or flexibility of short-term, limited-duration insurance plans that limit this option for consumers.
- ★ Broaden association health plan availability to the extent allowed by federal law, and remove any state-level legal barriers.

★ Allow member-based, nonprofit organizations such as Farm Bureaus to offer alternative health benefits to members that are exempted from state insurance regulations.

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Promote Individual Control of Healthcare

The country's decades-long debate on healthcare has too frequently maintained the status quo of greater centralized control, rather than promoting policies that put American individuals and families first. As a result, Americans have seen their agency and control stripped away and replaced with onerous government mandates that have led to fewer choices and higher costs.

The Patient Protection and Affordable Care Act (ACA), President Obama's signature healthcare plan, implemented two health coverage mandates—one requiring individuals to obtain health insurance, and one requiring employers with 50 or more full-time employees to provide health insurance. These mandates forfeited individual control of healthcare and forced individuals and employers to make hard choices.

Some individuals chose to pay the penalty rather than obtain health coverage. For tax years 2014 through 2017, a total of 24.4 million tax returns reported penalties for a cumulative amount of $11.97 billion. In tax year 2017, the average reported penalty per return was $774. As part of the Tax Cuts and Jobs Act of 2017 that was signed into law by President Trump, the individual mandate penalty was reduced to $0, effectively repealing the policy.

However, the employer mandate remains in effect today. Employers, particularly small businesses, still face decisions of whether to add costly new expenses or downsize their workforces. The employer mandate is a greater burden for smaller firms, as costs are approximately one-third more per worker than the costs for firms with more than 10,000 workers. The National Bureau of Economic Research found that between 28,000 and 50,000 businesses nationwide eliminated an estimated 250,000 positions to avoid being subject to the employer mandate. This mandate causes employers to lose agency in their business operations and likely leads to the shifting of health insurance costs to employees through wage reduction or a decrease in workforce size. Either scenario strips individual employees of the ability to steward their own resources and control their health coverage options.

Penalty enforcement is burdensome. It requires 114 full-time Internal Revenue Service (IRS) employees and has significantly underperformed expectations. Despite projections of $13 billion in net revenue from employer penalty payments, the IRS had assessed just $264 million in penalties and collected only $66 million as of June 2020.

The far-left Inflation Reduction Act of 2022, passed earlier this year, doubled down on ACA policies and included an inflationary subsidy structure for individual market coverage that largely benefits insurance companies. A previous estimate of the effect of these policies projected 1.6 million people would lose their employer-sponsored health insurance and be forcibly transitioned to government- subsidized coverage in the individual market. This policy will likely lead to a continued increase in United States healthcare spending while Americans will continue to see fewer choices and less flexibility in obtaining health coverage.

Instead of this approach, two policies that promote individual control of healthcare dollars should be expanded to give Americans more control. The expansion of health savings accounts (HSAs) and health reimbursement arrangements (HRAs) would help address Americans' lack of individual control over how their money is spent.

Health savings accounts are tax-advantaged accounts that can be used to pay and save for unreimbursed medical expenses. They were first

authorized in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and are associated with enrollment in high deductible health insurance plans. In 2021, 40% of covered employees in firms with 50 or more employees were enrolled in high deductible consumer-directed health plans.

Yet HSA contributions are limited by the Internal Revenue Service. In 2022, these limits are $3,650 for individuals and $7,300 for families. These funds can be used to pay for medical expenses or can be invested, which can create another avenue to grow wealth over time. Currently, 31 million Americans have HSAs. However, of the $1 trillion in employer-sponsored health insurance premiums in 2021, only a small portion of that amount—$39 billion, or 4%,—was contributed to HSAs.

Health reimbursement arrangements allow employer contributions to reimburse employee health expenses through an account-based group health plan. These come with a tax advantage to employees. In 2019, the Departments of Treasury, Labor, and Health and Human Services finalized a regulation that expanded HRAs. This adjustment provided greater flexibility for employers who want to reimburse employee health expenses through integration with individual health insurance coverage and still maintain the tax-advantaged status of the contributions. It also benefits employees by creating a portable health insurance option for Americans that allows them to keep the same policy when moving between jobs.

The Trump Administration's HRA rule is projected to be used by 800,000 employers and decrease the number of uninsured individuals by 800,000 by 2029. It is also expected to increase insurance coverage for low- and moderate-wage workers and to make it easier for individuals to retain coverage when changing jobs. A distinguishing factor between this policy and the Inflation Reduction Act is that the intent of the HRA rule is to give employers and employees more coverage options, rather than to abandon employer-sponsored insurance and shift costs to the taxpayer through government-subsidized coverage.

Importantly, this policy creates a new mechanism for offering health benefits for small employers who may otherwise be unable to do so. It also effectively equalizes the preferred tax treatment of traditional employer group coverage.

THE FACTS

- ★ The ACA created a tax penalty for Americans without health insurance. From tax years 2014 through 2017, 24.4 million tax returns showed individual mandate penalties amounting to $11.97 billion.
- ★ The ACA's employer mandate is a greater burden to smaller firms, as costs are approximately one-third more per worker than the costs for firms with more than 10,000 workers.
- ★ Approximately 250,000 jobs were eliminated by businesses nationwide to avoid being subject to the ACA's employer mandate.
- ★ In 2021, 40% of covered employees in large firms were enrolled in high deductible health plans that are eligible for health savings accounts (HSAs).
- ★ 31 million Americans currently have HSAs. Of the $1 trillion in employer-sponsored health insurance premiums in 2021, only a small portion of that amount—$39 billion, or 4%—was contributed to HSAs.
- ★ The Trump Administration's health reimbursement arrangement rule is projected to be used by 800,000 employers, and to decrease the number of uninsured individuals by 800,000 by 2029.

THE AMERICA FIRST AGENDA

At the federal level, support policies that:

- ★ Return
- ★ Nullify the employer insurance mandate in the Affordable Care Act, as was done for the individual mandate.
- ★ Remove unnecessary restrictions on health savings accounts:
  - Increase individual and employer contribution limits;
  - Remove the required association with high deductible health plans; and
  - Allow individuals to purchase any health plan and direct care services with funds from health savings accounts.

★ Make the Trump Administration's health reimbursement arrangements rule from 2019 permanent to provide more health coverage flexibility for employers and employees.

At the state level, support policies that:

★ Utilize health reimbursement arrangements in state employee health plan benefits to allow employees to choose their own coverage and have portability between jobs.

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LOWER PRESCRIPTION DRUG PRICES

Too many Americans have trouble affording prescription drugs. Ninety-four percent of Americans think the cost of prescription drugs in America is higher than it should be, and 84% expect costs to increase during the next year. Nearly one in five adults report that they or someone in their household skipped prescribed medications in the past year to save money, and 30% are concerned they will not be able to pay for needed medications in the next 12 months. High prescription drug prices are hurting Americans and must be lowered—without increasing government control and sacrificing innovation.

Even though prescription drugs are expensive, there has been some limited relief in recent years. The percent year-to-year change of prescription drugs, according to the Consumer Price Index, decreased from a high of 6.2% from 2015 to 2016, to -2.4% from 2019 to 2020. However, out-of-pocket costs and certain high-cost medications can make prescription drug costs prohibitive for patients in some cases.

According to 2018-2019 data, out-of-pocket spending for prescription drugs exceeds $500 for more than one in five seniors with Medicare and nearly one in 16 adults with private coverage from 2018 to 2019. Of the total spending on prescription drugs, $46.5 billion was out-of-pocket, and $297.6 billion was paid for by health insurance.

Generic medications are one way to reduce cost exposure for patients. They are usually more affordable for patients than branded alternatives. According to the Food and Drug Administration (FDA), 90% of filled prescriptions are for generic medications, yet generics account for only 18% of prescription drug spending. The average generic copay is $6.61, while the average brand-name copay is $55.82.

Payer spending on prescription drugs is highly concentrated, with a disproportionate share of spending on high-cost drugs that lack significant generic competition. For example, in 2019, the top 50 drugs in Medicare Part B and top 250 drugs in Medicare Part D (by top spending with one manufacturer and no generic or biosimilar competitors) accounted for 80% and 60% of total Medicare Part B and Medicare Part D spending, respectively.

Additionally, spending growth has varied by payer. Medicare Part B drug spending per enrollee grew by 8.1% from 2006 to 2017, compared to per capita growth of only 3.4% for Medicare Part D and 2.9% for overall retail prescription drugs.

The international context of prescription drug prices is critical to understanding this trend. It is well-known that Americans unfairly subsidize biopharmaceutical innovation for the world, with the United States paying significantly more for the same medications than other developed nations that have government-run health systems. The White House Council of Economic Advisers found evidence of increased foreign "free-riding" over the past 15 years: "The prices of many high-sales volume pharmaceutical drugs in European countries have decreased from costing on average 51% of United States prices in 2003 to approximately 32% of United States prices in 2017." This is largely due to price controls in foreign countries, which require pharmaceutical products to be sold below fair market value, leaving Americans to pay a greater share of research and development costs.

During the past several years, lawmakers have proposed an array of policies in an effort to lower prescription drug costs, which is a top priority of Americans. Liberal policy proposals tend to have top-down government involvement and interfere with plans in the private market. These policies can have harmful unintended consequences, such as compromising access to lower-cost generic medicines, which would be counterproductive to lowering drug costs.

America First policies should address persistent market failures and increase competition while supporting the innovation that leads to improved health outcomes. The Trump Administration demonstrated a commitment to addressing Americans' concerns with prescription drug costs by implementing this approach. From 2017 to 2019, the Trump Administration's FDA issued a record-breaking number of generic drug approvals that saved patients an estimated $26 billion in 2017 and 2018. This contributed to

the 2.4% annual price decrease in 2019 and marked the largest annual price decrease in nearly 50 years.

Other policies enacted between 2017 and 2021 sought to end "free-riding" in the global market and provide discounted access to lifesaving drugs such as insulin and epinephrine to uninsured patients. Additional policies sought to end kickbacks to middlemen to ensure patients directly receive the benefit of discounts, allow the importation of prescription drugs from Canada to lower costs, and end gag clauses, thus allowing pharmacists to inform patients of the best prices for needed medications. Not all of the policies were implemented, due to court proceedings and the different approaches of the Biden Administration. Nonetheless, creating and implementing America First policies should remain a priority.

At the federal level, the Medicare Part B program currently incentivizes providers to choose more expensive medications by reimbursing at 106% of the average sales price of a drug, while Medicare Part D allows for private plan negotiation. Thus, transitioning the highest-cost Medicare Part B drugs to the Medicare Part D program would address the current market distortions.

The problem of foreign "free-riding" by other developed countries also requires serious attention. Our country should develop a new trade policy that would create economic disincentives for specific developed countries to pay less than market value for prescription drugs. The FDA can also implement innovative policies to appropriately switch prescription-only medications to available over-the-counter drugs to increase access and lower costs for patients.

States can also work to address high prescription drug costs by implementing policies for greater transparency into the practices of manufacturers, pharmacy benefit managers, and insurers. Since 2016, 14 states have passed prescription drug price transparency legislation. States can also provide savings for uninsured individuals by allowing them to buy prescription drugs at post-rebate prices plus an administrative fee. Texas passed a law creating this type of savings program in 2021. Further, states can evaluate establishing a prescription drug importation program. Florida has developed a program that is awaiting FDA approval and expects to save $150 million in the first year alone.

Additionally, states can implement policies that give patients greater control of their prescriptions by requiring pharmacies to transfer the prescription when requested by the patient. This policy would build on the Trump Administration's 2020 rule to increase medical record interoperability and facilitate consumer shopping. States can also remove restrictions on physician dispensing of prescription drugs in settings such as direct care practices.

THE FACTS

- ★ 94% of Americans think the cost of prescription drugs in America is higher than it should be, and 84% expect costs to increase during the next year.
- ★ Nearly one in five adults report they or someone in their household skipped prescribed medicine in the past year to save money, and 30% are concerned they will not be able to pay for needed medicines in the next 12 months.
- ★ 90% of filled prescriptions are for generic drugs, which are generally cheaper. Generics account for only 18% of prescription drug spending.
- ★ In 2019, the top 50 drugs in Medicare Part B and top 250 drugs in Medicare Part D accounted for 80% and 60% of total Medicare Part B and Medicare Part D spending.
- ★ As evidence of increased foreign "free-riding," European countries paid 32% of United States prices in 2017, compared to 51% of United States prices in 2003 for many high-sales volume pharmaceutical drugs.
- ★ From 2017 to 2019, the FDA approved record-breaking numbers of generic drugs that contributed to the 2.4% annual price decrease in 2019—the largest in nearly 50 years.

THE AMERICA FIRST AGENDA

At the federal level, support policies that:

- ★ Transition the highest-cost Medicare Part B drugs to Medicare Part D.
- ★ Implement a new trade policy to address foreign "free-riding" for prescription drugs and create economic disincentives for specific developed countries to pay less than market value for prescription drugs.
- ★ Make more prescription-only medications available to patients over-the-counter.

At the state level, support policies that:

- ★ Create transparency in prescription drug pricing for manufacturers, pharmacy benefit manufacturers, and insurers.
- ★ Establish a prescription drug savings plan for uninsured state residents by allowing them to buy drugs at post-rebate prices, plus an administration fee, through a partnership with a pharmacy benefit manager and the creation of a specific state fund.

- ★ Evaluate the merits of establishing a prescription drug importation program.
- ★ Require healthcare providers to electronically transfer a patient prescription and current medication history to pharmacies not owned by the same company when requested by the patient.
- ★ Permit physicians to dispense medications directly to patients in appropriate clinical contexts and settings.

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PROMOTE TRANSPARENT, UPFRONT PRICING

Two-thirds of Americans worry about being able to afford unexpected medical bills. This concern, along with being able to afford health insurance deductibles and prescription drug costs, account for three of the top four concerns among general household needs. These rank ahead of paying for rent or a mortgage, monthly utilities, and food. The high cost of healthcare in the U.S. affects the health and financial well-being of millions of Americans, and uncertainty about costs can create real stress.

Patients generally do not know the cost of their care until they receive a bill. This puts patients at risk of suffering financial hardship that may have been preventable if they were able to make an informed choice when seeking care. It also insulates large medical providers from competition when setting prices. Healthcare price transparency is an essential policy reform that can address these shortcomings.

Policies that remove uncertainty about the cost of medical care and increase competition enhance the ability of families to plan and pay for future healthcare expenses as they make comparisons across providers. Doing so may lead to fewer people delaying necessary care, which could result in better outcomes regarding disease prevention and treatment, as well as overall health nationwide.

Fully 87% of surveyed voters support healthcare price transparency as a way to help control costs and increase access for their families, according to a September 2020 poll by the Foundation for Government Accountability. Last year, 51% of adults surveyed reported that they had delayed or gone without certain medical care during the past year due to cost. Higher out-of-pocket costs are a particular concern, with 46% of adults reporting difficulty affording costs not covered by their insurance.

Prices for the same medical service can vary significantly by hospital. For example, routine colonoscopies can range from $148 to $15,789 in just the Dallas area. Some consumers may feel that lower-cost care may not be quality care. However, the price of care does not always directly correlate to quality, so consumers should use available price and quality tools to inform decisions about where to receive care. Price transparency will enable consumers to see prices, compare them from provider to provider, and shop for the best rates. Notably, previous price transparency efforts in cohorts of employees have resulted in lower costs.

Federal hospital price transparency requirements have been supported by the Trump and Biden Administrations. On November 15, 2019, the Centers for Medicare and Medicaid Services (CMS) finalized a rule effective January 1, 2021, requiring hospitals operating in the U.S. to provide clear, accessible pricing information online for a wide range of procedures.

However, hospital compliance with this rule has been subpar since it took effect. Last year, only 53% of hospitals in the U.S. disclosed any prices, and just 16% were in full compliance as of August 2022. This hinders consumers from thoroughly comparing prices for services in their area.

In November 2021, the Department of Health and Human Services finalized a rule to increase the financial penalties for noncompliance with the Trump Administration rule. Hospitals in violation of the rule will now be fined a minimum of $109,500 to upwards of $2 million for a full year of noncompliance. The increased penalties took effect on January 1, 2022. CMS

issued the first two financial penalties for noncompliance in June 2022, and had issued more than 350 warning letters to hospitals by that time.

Hospital price transparency, if successfully implemented, is one policy solution with the potential to give patients more control over their health and finances while also putting pressure on providers to create greater value for patients. Research on the impact of the federal hospital price transparency requirements found that hospitals are more likely to disclose their prices if others in the area do so as well. This compliance effect will benefit consumers who take advantage of available pricing information to shop for services.

Research also shows that prices vary within hospitals based on the form of payment. Cash prices, one of the standard charges required by the CMS rule, are often lower than commercial insurance prices for specific services. Transparency regarding these price dynamics can help consumers determine the best method to pay for services. Federal and state policies should encourage full implementation and enforcement of hospital price transparency rules. This will give patients more control as they plan for and consume medical care and services, which can potentially contribute to increased competition, lower healthcare costs, and improved health outcomes for Americans.

THE FACTS

- ★ 87% of voters support price transparency to help control costs.
- ★ Two-thirds of Americans worry about being able to afford unexpected medical bills.
- ★ In 2021, 51% of adults reported that they delayed or went without certain medical care during the past year due to costs.
- ★ Prices for the same medical service can vary greatly by hospital. For example, routine colonoscopies can range from $148 to $15,789 in just the Dallas area.
- ★ Only 53% of hospitals in the United States disclosed any prices last year, and just 16% were in full compliance with the CMS Hospital Price Transparency Rule this August.

THE AMERICA FIRST AGENDA

At the federal level, support policies that:

- ★ Make permanent the federal hospital price transparency requirements.
- ★ Ensure enforcement of the federal hospital price transparency requirements to the extent allowed by federal law.
- ★ Make compliance a condition of participation in Medicare and Medicaid if hospital compliance with the price transparency requirements remains subpar after enforcement.

At the state level, support policies that:

- ★ Bolster state hospital compliance with federal hospital price transparency requirements by aligning state and federal policies.
- ★ Policy options include additional financial and administrative penalties for noncompliance beyond the current federal civil monetary penalties, including conditioning hospital licensure on compliance, and additional consumer protections.

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