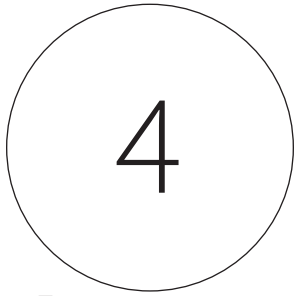
Health care



For the first time in many years, health care has not been a top political issue. Nevertheless, there are several important health care issues that the next Congress will face. To ensure better health care regulation, Congress should:

- Defeat attempts to regulate Pharmacy Benefit Managers (PBMs);
- Allow the enhanced Affordable Care Act (ACA) subsidies that were extended by the Inflation Reduction Act (IRA) to expire in 2025;
- Authorize the Centers for Disease Control and Prevention (CDC) for the first time; and
- Enact legislation expanding site-neutral payments in Medicare.

Resist PBM regulation: Pharmacy Benefit Managers (PBMs) are private businesses that developed in the free market to manage prescription drug benefits for health insurance plan sponsors. Congress is considering several bills that would restrict PBM functioning by limiting or eliminating rebates and discounts that pass through PBMs and by requiring PBMs to disclose pricing and other confidential terms of their contracting. These proposals should be rejected because they would reduce competition, increase costs, worsen health, and halt market developments that benefit patients.

Most Americans have prescription-drug coverage. Nearly all plan sponsors—including commercial health plans, self-insured employer plans, union plans, Medicare Part D plans, the Federal Employees Health Benefits Program, state government employee plans, Medicaid plans, and others—have found value in pharmacy benefit management services that PBMs provide including designing benefit plans, negotiating lower prices, and processing prescription drug claims.

PBMs enhance competition through group purchasing and negotiated discounts, much like a Costco buyers' club, providing substantial economic and health benefits for consumers and taxpayers. They negotiate lower prices from drug makers, in the form of rebates and discounts, in exchange for placement on plans' drug formularies and increased sales volume.

PBMs also select pharmacies to include in their plan networks, obtaining discounts and higher quality retailing in exchange for favorable placement in drug-plan-pharmacy networks, which drives traffic to cooperating pharmacies. Patients get more beneficial drugs at lower costs, which translates into lower insurance premiums and improved health.

PBMs generate billions of dollars in consumer and taxpayer savings resulting from manufacturer and pharmacy rebates and discounts, the value of better drug utilization in preventing more serious illness and expensive healthcare use, an increased pace of drug development, and government savings from decreased premium subsidies and premium tax expenditures.

Current legislative proposals—including the Lower Costs, More Transparency Act (H.R. 5378), passed in the House in December 2023—would limit or eliminate rebates and discounts that PBMs pass back to sponsors and require PBMs to disclose pricing and other confidential contract terms. These provisions could decrease competition and result in higher, not lower, costs, sacrificing much of the value PBMs provide. The proposals will limit the ability of smaller PBMs to compete and could lead to anti-competitive collusion.

The CBO estimated an earlier rule to eliminate rebates would cost $176 billion in extra Medicare Part D spending over 10 years. The transparency and reporting requirements in the legislation could facilitate tacit collusion and reduce price competition in the concentrated PBM industry. Information about competitors' prices can enable sellers, particularly the larger PBMs that are integrated with health insurers and pharmacies, to maintain above market, oligopoly prices. Smaller, independent PBMs, which often compete by providing more transparent contracts and other innovative arrangements, will be disadvantaged resulting in decreased competition and higher prices and spending.

ACA subsidy expiration: The 2021 American Rescue Plan enhanced the subsidies for people who enroll on the ACA market exchanges in two ways:

1. By reducing the percentage of income people were expected to pay for benchmark plans they made zero premium plans with low or no deductibles available to people with incomes between 100 to 150 of the Federal Poverty Level (FPL); and
2. By removing the upper income cap, previously set at 400 percent FPL, for subsidy eligibility.

These provisions were set to expire in 2022 but were extended through 2025 by the 2022 Inflation Reduction Act. Some legislators are pushing to permanently extend these subsidy expansions. This would be an ill-advised and costly move.

The enhanced subsidies created an incentive for people with income below 100 percent FPL or above 150 percent FPL and unscrupulous insurance brokers to mis-state their income as falling within the 100-150 FPL range to qualify for free insurance. The percentage of enrollees reporting income in this range has increased substantially since the enhanced subsidies took effect. Forty-two percent of enrollees in 2024 had fully subsidized premiums. The problem is that in many states there are more people enrolling in the 100-150 FPL range than could possibly be eligible based on income data. Nationwide, there are 4-5 million improperly enrolled people with improper subsidy expenditures of $15-$20 billion.

In addition, no one has explained why individuals and families with income above 400 percent FPL should receive additional subsidies. These wealthier people can pay their fair share of premiums.

The Congressional Budget Office (CBO) estimates that permanently extending these subsidies would increase the federal budget deficit by $335 billion over the 2025–2034 period. CBO also estimates that half of new enrollees if the subsidies are permanently extended will have incomes above 400 percent FPL. It estimates that the average annual premium tax credit for enrollees with incomes at 750 percent FPL—that's nearly a quarter of a million dollars for a family—would be $2,030. In an era of exploding deficits, the country cannot afford this massive addition to the deficit and to subsidize the wealthy. Congress should let the subsidies expire.

Authorize the CDC: The CDC has acknowledged its poor performance during the Covid-19 pandemic but appears to have little insight into what went wrong. Instead of introspection and reform, it has proposed little more than increased funding.

The CDC has never been fully authorized by Congress. Instead, it grew in a haphazard manner into a large, diffuse agency with priorities that are far afield from its core mission of controlling and preventing communicable disease outbreaks with programs that duplicate those of other agencies and departments. This lack of focus left the agency unprepared for the pandemic and distracted it from an effective response.

Congress should comprehensively authorize the CDC for the first time and reaffirm the agency's original mission to combat communicable, infectious diseases. It should eliminate or move the many areas where the CDC does not have expertise and duplicates other authorized agencies' programs such as prevention initiatives, social determinants of health, environmental issues, and violence prevention, to agencies where they can be, or already are, better addressed. This will restore public trust, likely reduce spending and leave the CDC better prepared to combat the next pandemic.

Site-neutral Medicare payments: Medicare pays more for the same services performed in hospital outpatient departments (HOPDs), whether on the hospital campus or off-campus, than it does when the services are provided outside of a hospital owned setting such as physicians' offices or Ambulatory Surgery Centers.

Many private payers, following Medicare's lead, also pay higher reimbursements for services in HOPDs. Medicare's reimbursement system creates an incentive for hospitals to acquire physician practices and incorporate them into HOPDs, leading to healthcare consolidation, decreased competition, and higher spending. It also increases out-of-pocket costs for patients in traditional Medicare through higher Part B deductibles and cost-sharing amounts. MedPAC estimated that aligning Medicare payment rates for a set of outpatient service categories that could be safely performed outside of HOPDs would have reduced Part B spending by $6 billion and beneficiary cost sharing by $1.5 billion in 2021.

The Bipartisan Budget Act of 2015 restricted this differential payment system to older, grandfathered HOPDs. Nevertheless, both Medicare and patients continue to pay billions of dollars more for the same services provided in the older, exempted HOPDs than in other settings despite no evidence of any difference in quality.

There have been multiple proposals to reverse this wasteful practice and establish site neutrality. The Lower Costs, More Transparency Act (H.R. 5378) contains problematic provisions regarding PBMs, but includes a provision that would equalize Medicare Part B payments for drug administration services in off-campus HOPDs with payments made in other provider settings. CBO estimated it would save $4 billion over 10 years. The Site-based Invoicing and Transparency Enhancement (SITE) Act (S.1869) would end the exemption from site-neutral payment requirements for off-campus HOPDs under Medicare. Neither bill has advanced.

President Trump's 2021 budget proposal included broader site-neutral payment reforms. CBO estimated that his proposal to extend reforms to all services in off-campus HOPDs would save $39 billion and his proposal to align payments for on-campus HOPDs for services commonly provided in non-hospital settings would save $102 billion over ten years.

There is no rationale for continuing the current, wasteful Medicare payment policy. Congress should extend site-neutral payments to the providers who remain exempted under the 2015 Budget Act.

Expert: Joel Zinberg

For further reading:

Joel Zinberg, *A Free Market Solution for Drug Distribution: How PBMs Enhance Competition, Lower Costs, and Improve Drug Utilization and Health,* Competitive Enterprise Institute, Sept. 2023. https://cei.org/wp-content/uploads/2023/09/prescribing-drugs-final.pdf

Joel Zinberg, "The FTC Goes Evidence-Free: Lina Khan's newest strategy is to ignore years of scholarship that proves the value of Pharmacy Benefit Managers," Wall Street Journal, July 23, 2024. https://www.wsj.com/articles/the-ftc-goes-evidence-free-lina-khan-pbm-healthcare-14076225

Joel M. Zinberg and Drew Keyes, *Unauthorized & Unprepared: Refocusing the CDC after COVID-19,* Competitive Enterprise Institute and Paragon Health Institute, July 2023. https://cei.org/studies/unauthorized-and-unprepared-refocusing-the-cdc-after-covid-19/

Brian Blase and Drew Gonshorowski, *The Great Obamacare Enrollment Fraud,* Paragon Health Institute, June 2024. https://paragoninstitute.org/wp-content/uploads/2024/06/The-Great-Obamacare-Enrollment-Fraud_FOR_RELEASE_V2.pdf