Curing What Ails the U.S. Healthcare System

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About CAGW

Citizens Against Government Waste (CAGW) is a private, nonprofit, nonpartisan organization dedicated to educating the American public about waste, mismanagement, and inefficiency in government.

CAGW was founded in 1984 by J. Peter Grace and nationally syndicated columnist Jack Anderson to build public support for implementation of the Grace Commission recommendations and other waste-cutting proposals. Since its inception, CAGW has been at the forefront of the fight for efficiency, economy, and accountability in government.

CAGW has more than 1 million members and supporters nationwide. Since 1984, they have helped CAGW save taxpayers more than $2.4 trillion. CAGW publishes special reports, including the *Congressional Pig Book* and *Prime Cuts*, as well as its official newsletter *Government WasteWatch* and blog *The WasteWatcher*, to expose government waste and educate the American people on what they can do to stop the abuse of their hard-earned money. Internet, print, radio, and television news outlets regularly feature CAGW's publications and experts.

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Introduction

Healthcare costs have long been a significant concern for taxpayers and voters across the country. During the 2020 election cycle, it was the number two issue among voters after the economy.[1] That sentiment was reflected again in a February 16, 2022, Pew Research poll, which found that reducing healthcare costs was the second biggest concern for voters after strengthening the economy.[2]

The 117th Congress acted on healthcare through the Inflation Reduction Act (IRA) of 2022.[3] The legislation included an extension of Obamacare premium subsidies and price controls on pharmaceuticals, the latter of which has been the subject of numerous comments and reports by Citizens Against Government Waste (CAGW).[4] The price control provisions will be devastating to patients by stifling the innovation needed to find cures and treatments for deadly diseases. However, the IRA did not include more comprehensive reforms like the Medicare for All Act and similar bills that would have substantially expanded the role of the federal government in the entire healthcare system. The midterm elections will have a significant impact on whether such legislation will be considered in the 118th Congress.

CAGW has long advocated for comprehensive healthcare reform. Some of the organization's key recommendations were laid out in the 1998 investigative report, "Patient-Centered Healthcare: The Road to Wellville," which described how patients should be allowed to take control of their healthcare decisions. The report called for individuals to be given the same tax break that is enjoyed by employers, so they can buy health insurance with pre-tax dollars, which would both increase competition for quality healthcare and give patients more decision-making power.[5] CAGW has since promoted similar patient-centered recommendations in many blog posts, op-eds, and publications, including the 2021 issue brief, "Government-Run Healthcare Will Harm Patients and Eliminate Consumer Choice."[6]

When politicians discuss healthcare, they conflate healthcare and health insurance. While these two concepts are interwoven, they are dissimilar. The United States offers some of the best quality healthcare in the world, yet the arguments surrounding the delivery systems for insurance and who should pay for it vary. One school of thought demands a national healthcare

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[1] Carroll Doherty, Jocelyn Kiley, Nida Asheer, and Calvin Jordan, "Important Issues in the 2020 Election," Pew Research Center, August 13, 2020, https://www.pewresearch.org/politics/2020/08/13/important-issues-in-the-2020-election/.
[2] Doherty, Kiley, Asheer, and Jordan, "Public's Top Priority for 2022: Strengthening the Nation's Economy," Pew Research Center, February 16, 2022, https://www.pewresearch.org/politics/2022/02/16/publics-top-priority-for-2022-strengthening-the-nations-economy/.
[3] Inflation Reduction Act of 2022, Pub. L. No. 117-169, H.R. 5376, https://www.congress.gov/bill/117th-congress/house-bill/5376/text/rh.
[4] Christina Herrin, "The Inflation Reduction Act is a Death Sentence for Patients," *The WasteWatcher*, Citizens Against Government Waste (CAGW), August 22, 2022, https://www.cagw.org/thewastewatcher/inflation-reduction-act-death-sentence-patients; Christina Herrin, "The Inflation Reduction Act Will Raise Drug Costs and Reduce Cures," *The WasteWatcher*, CAGW, August 5, 2022, https://www.cagw.org/thewastewatcher/inflation-reduction-act-will-raise-drug-costs-and-reduce-cures; Thomas Schatz, "The Senate Must Reject Price Controls on Pharmaceuticals," *The WasteWatcher*, CAGW, July 7, 2022, https://www.cagw.org/thewastewatcher/senate-must-reject-price-controls-pharmaceuticals.
[5] CAGW, "Citizens Against Government Waste Releases Investigative Report on Patient-Centered Healthcare," November 3, 1998, CAGW, https://www.cagw.org/media/press-releases/citizens-against-government-waste-releases-investigative-report-patient.
[6] Elizabeth Wright and Thomas Schatz, "Government-Run Healthcare Will Harm Patients and Eliminate Consumer Choice," CAGW, September 2021, https://www.cagw.org/reporting/government-run-healthcare.

system riddled with layers of bureaucracy, while the other envisions a patient-centric approach to healthcare reform.

Unfortunately, government bureaucracies, subsidies, and red tape have distorted the medical marketplace, resulting in higher prices and less access for patients. The artificially lower costs subsidized by the taxpayers are part of an unsustainable system. Medicare for All and other universal healthcare proposals would shift even more decision-making power to bureaucrats, while the current federal healthcare system, the Affordable Care Act (ACA), is a costly one-size-fits-all approach that provides few options for individual healthcare needs. America's healthcare system should promote competition and innovation and give patients more choice and control.

This issue brief describes current problems and offers solutions to reform the U.S. healthcare system.

Reform the Affordable Care Act

The establishment of Medicare and Medicaid in 1965 was one of the major milestones promoting a government-run health system in the U.S.[7] Coverage was provided for the elderly, disabled, and low-income individuals. In 1965, the House Ways and Means Committee estimated that the hospital insurance program of Medicare was expected to cost $9 billion by 1990. Instead, the cost was 744 percent higher at $67 billion.[8]

The passage of the Patient Protection and Affordable Care Act (ACA), also known as Obamacare, in 2010 was the next largest government takeover of healthcare in the United States.[9] While the ACA increased the number of insured Americans, it also increased costs to taxpayers and left fewer options for patients with private insurance coverage. As of August 2020, 70 percent of U.S. counties either had no insurer options or only two choices, compared to 36 percent in 2016.[10]

The national average monthly premium paid by those with private healthcare coverage in 2013 was $244, and by 2019 it increased by 129 percent to $558.[11] The negative effects the ACA has had on private coverage could not be clearer. Nearly doubling the cost of insurance and subsidizing the market through tax dollars for those on government insured plans is not a viable long-term solution.[12]

Yet, many ACA proponents want to both spend more money and steer all Americans into so-called "free healthcare" through a government-run healthcare system. The Veterans Health

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[7] Barry M. Strobe, M.D., "A Role for Government," *American Journal of Preventive Medicine*, January 3, 2013, https://www.ajpmonline.org/article/S0749-3797(12)00631-9/fulltext.
[8] "U.S. Health Plans Have History Of Cost Overruns," *The Washington Times*, 2009, https://www.washingtontimes.com/news/2009/nov/18/health-programs-have-history-of-cost-overruns/.
[9] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, H.R. 3590, https://www.congress.gov/bill/111th-congress/house-bill/3590.
[10] The Heritage Foundation, "Solutions," 2021, https://www.heritage.org/solutions/.
[11] Edmund Haislmaier, "Obamacare Has Doubled The Cost Of Individual Health Insurance," The Heritage Foundation, March 21, 2021, https://www.heritage.org/health-care-reform/report/obamacare-has-doubled-the-cost-individual-health-insurance.
[12] Ibid.

Administration (VHA) is a good example of how a government-run healthcare system that lacks competition and incentives to improve care will fail. The VHA system has long wait times, price controls that have led to denial of care, bureaucratic inertia, fraud, and abuse.[13] A March 7, 2018 Department of Veterans Affairs Office of Inspector General report found $92 million in overpriced medical supplies, more than 10,000 pending appointments for prosthetics, and a lack of consistently clean storage areas for medical supplies and equipment.[14] This is the sad reality for veterans today and a warning sign against further expansion of the government's responsibility for everyone's healthcare.

Since its enactment in 2010, several unsuccessful efforts have been made in Congress to repeal the ACA. During the 117th Congress, Rep. Andy Biggs (R-Ariz.) introduced H.R. 6515, the Responsible Path to Full Obamacare Repeal Act, which would fully repeal the ACA.[15] However, the legislation has only six cosponsors, there is no Senate companion bill, and Republican candidates for Congress in 2022 are no longer calling for repeal of the ACA.[16]

The ACA is also supported by President Biden and enough Senate Democrats that attempts to repeal the program will be ultimately defeated. The best options are therefore reforming the program and shifting more power over healthcare to the states. The diversity of the U.S. population requires such state-based options instead of the failed one-size-fits-all approach required by the ACA.

ACA reforms should include lowering out-of-pocket costs, premiums, and deductibles, along with increasing private coverage options. These reforms would increase patient choice and control and lead to better healthcare outcomes.

Reform Medicaid

Medicaid operates under a partnership between the federal and state governments that provides healthcare coverage for lower-income seniors, pregnant women, individuals with disabilities, and lower-income children as well as their adult caretakers. The ACA expanded coverage to working-age, able-bodied adults with incomes up to 138 percent of the federal poverty level. While the federal matching percentage for traditional Medicaid beneficiaries has a statutory floor of 50 percent, the initial federal reimbursement rate for newly eligible enrollees under the ACA was 100 percent from 2014-2016, dropping to a permanent 90 percent in 2020.[17]

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[13] Curtis Kalin, "The VA Scandal Refuses to End," *The WasteWatcher*, CAGW, March 9, 2018, https://www.cagw.org/thewastewatcher/va-scandal-refuses-end.

[14] Department of Veterans Affairs, Office of Inspector General, "Veterans Health Administration: Critical Deficiencies at the Washington, D.C. VA Medical Center," Report #17-02644-130, March 7, 2018, https://www.va.gov/oig/pubs/VAOIG-17-02644-130.pdf.

[15] Responsible Path to Full Obamacare Repeal Act, H.R. 6515 (2022), https://www.congress.gov/bill/117th-congress/house-bill/6515.

[16] Sahil Kapur, "Republicans abandon Obamacare Repeal," October 2, 2022, NBC News, https://www.nbcnews.com/politics/congress/republicans-abandon-obamacare-repeal-rcna49538.

[17] Kaiser Family Foundation, "Understanding How States Access the ACA Enhanced Medicaid Match Rates," September 29, 2014, https://www.kff.org/medicaid/issue-brief/understanding-how-states-access-the-aca-enhanced-medicaid-match-rates/#:~:text=The%20ACA%20provides%20100%20percent%20federal%20financing%20for,and%20then%2090%20percent%20in%202020%20and%20beyond.

In June 2022, Medicaid enrollment was 82.3 million.[18] This represents an increase of 17.8 million, or 27.6 percent, from the 64.5 million enrolled in February 2020, prior to the onset of the COVID-19 pandemic.[19]

Like all government programs, Medicaid is subject to waste, fraud, and abuse, including improper payments. The Centers for Medicare and Medicaid Services (CMS) estimated the FY 2020 Medicaid improper payment rate estimate was 21.36 percent or $86.49 billion.[20] According to a November 25, 2019, Mercatus Center study on Medicaid improper payments, there is higher than expected enrollment in states that adopted the expansion, eligibility reviews are full of errors, and there are an excessive number of ineligible enrollees in those states. Since the federal government pays most of the expenses, especially under Medicaid expansion, "states have little, if any, incentive to spend wisely or strictly follow guidelines."[21]

Making matters worse, the higher reimbursement rates under the ACA have given states an incentive to classify both those who were already eligible under previous criteria as well as those who were previously ineligible as newly eligible. The Mercatus Center study cites the influence of healthcare groups in the states in pushing legislators and regulators to expand coverage, since they benefit directly from the increased number of enrollees at the higher reimbursement rates. The lack of oversight, which began during the Obama administration when it cancelled reviews of Medicaid eligibility from FY 2014-2017 and continued throughout the Trump administration, has allowed several states to enroll significant numbers of both potentially ineligible and completely ineligible individuals.[22]

The Department of Health and Human Services (DHS) Office of Inspector General (OIG) has found that states fail to maintain sufficient documentation, verify income eligibility, misclassify enrollees as being newly eligible, or confirm citizenship. The OIG estimated that $520 million was issued to almost 400,000 ineligible enrollees during a six-month audit of New York's Medicaid program. While Delaware, Hawaii, Indiana, Iowa, and New Hampshire did a relatively good job to prevent improper enrollment, there was at least a doubling of ineligible enrollment in Arkansas, California, Colorado, Kentucky, New Mexico, Oregon, Rhode Island, Washington, and West Virginia, which had "the largest percentage point changes in Medicaid enrollment of adults above 138 percent of the poverty level."[23]

The Mercatus Center study made four recommendations, which should all be considered by Congress. First, states should receive fixed payments instead of unending reimbursements, and the reimbursement rate should be the same for traditional Medicaid enrollees and those who

[18] Centers for Medicare and Medicaid Services (CMS), "June 2022 Medicaid & CHIP Enrollment Data Highlights," June 2022, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.
[19] Bradley Corallo and Sophia Moreno, "Analysis Of Recent National Trends in Medicaid And CHIP Enrollment," Kaiser Family Foundation, October 4, 2022, https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/.
[20] CMS, "2020 Estimated Improper Payment Rates for Medicare and Medicaid Services (CMS) Programs," November 16, 2020, https://www.cms.gov/newsroom/fact-sheets/2020-estimated-improper-payment-rates-centers-medicare-medicaid-services-cms-programs.
[21] Brian Blase and Aaron Yelowitz, "The ACA's Medicaid Expansion: A Review of Ineligible Enrollees and Improper Payments," Issue Brief, The Mercatus Center, George Mason University, November 25, 2019, https://www.mercatus.org/publications/healthcare/aca-medicaid-expansion.
[22] Ibid.
[23] Ibid.

are covered under the ACA expansion. Second, CMS should do more to recover improper payments. Next, areas of the country that have the most serious abuses of the program should be prioritized. Finally, CBO should review the inaccuracy of its initial cost estimates and fix its model to more accurately forecast the future impact of Medicaid expansion.[24]

In addition to addressing eligibility and improper payments, Congress should continue to support the Trump Administration's Section 1115 waivers, which gave the states more flexibility to manage their Medicaid programs, including means testing and work requirements.[25] While there was criticism of the work, education, or job training requirements of 20 hours a week, the waivers allowed beneficiaries to transition away from government healthcare and other subsidies. The waiver applications also offered a form of block grants that allowed the states to tackle waste and mismanagement in Medicaid, which is a substantial financial strain on many states.

The Biden administration has taken a different approach by both revoking the waivers and trying to expand the size and scope of the Medicaid program. On May 14, 2021, the state of Texas sued the administration over its blocking of the waivers.[26] The administration pressured the 11 other holdout states that did not use the ACA to expand Medicaid and was in litigation with Texas for more than a year.[27] In April 2022, the administration backed down, and Texas's section 1115 waivers will remain in place until 2030.[28]

Medicaid reform is necessary to provide the best care for those who might otherwise not be able to afford medical care. However, expanding the program to those who do not need this assistance places vulnerable individuals and families at risk, and will increase the financial burden on all taxpayers. States must continue to be provided with the ability to manage and improve the program to fit the needs of their unique situations.

Reform Medicare

The Medicare program was established in 1965 to provide the elderly and individuals with disabilities with health insurance. According to CMS, "Medicare is health insurance for people 65 or older. You're first eligible to sign up for Medicare 3 months before you turn 65. You may be eligible to get Medicare earlier if you have a disability, End-Stage Renal Disease (ESRD), or ALS (also called Lou Gehrig's disease)."[29] The program is funded through two trust

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[24] Ibid.
[25] Madeline Guth, Elizabeth Hinton, MaryBeth Musumeci, and Robin Rudowitz, "The Landscape of Medicaid Demonstration Waivers Ahead of the 2020 Election," Kaiser Family Foundation, October 30, 2020, https://www.kff.org/medicaid/issue-brief/the-landscape-of-medicaid-demonstration-waivers-ahead-of-the-2020-election/.
[26] U.S. District Court, Eastern District of Texas, Tyler Division, *State of Texas; Texas Health and Human Services Commission v. Elizabeth Richter, in her official capacity as Acting Administrator of the Centers for Medicare & Medicaid Services; THE CENTERS FOR MEDICARE AND MEDICAID SERVICES; XAVIER BECERRA, in his official capacity as Secretary of the Department of Health and Human Services; the UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; and the UNITED STATES OF AMERICA,* Case No. 2: ___-cf-000___-Z, Filed May 14, 2021, https://www.texasattorneygeneral.gov/sites/default/files/images/admin/2021/Press/Texas%20v.%20Richter%20--%20Complaint.pdf.
[27] Karen Brooks Harper, "Biden administration drops fight over Texas' Medicaid waiver, now in place until 2030," *The Texas Tribute*, April 22, 2022, https://www.texastribune.org/2022/04/22/texas-medicaid-waiver/.
[28] Ibid.
[29] CMS, "Get Started with Medicare," https://www.medicare.gov/basics/get-started-with-medicare.

funds, the Hospital Insurance trust fund (HI) and the Supplementary Medical Insurance trust fund (SMI). The HI fund pays for Medicare Part A, which assists in payments for inpatient hospital services, hospice care, and skilled nursing facilities and home health services associated with hospital stays. It is financed primarily through Social Security taxes.[30] The SMI fund pays for Part B, which covers medically necessary and preventive health services, and Part D, which provides prescription drug coverage. It is financed by Congress and premiums paid by enrollees in Parts B and D.[31]

The 2021 Medicare Trustees Report estimated that Medicare Part A will be depleted by 2026.[32] Medicare beneficiaries are at risk of losing benefits, and taxpayers are at risk of payroll tax increases due to this anticipated financial shortfall. Despite these risks, Congress has yet to address the issue.

One way to lower costs would be to reduce waste, fraud, and abuse in the program. While this is not the only solution to Medicare's continued sustainability, it could make more money available to provide needed services for beneficiaries.

CMS estimated that Medicare Part A and B accounted for improper payments in fiscal year (FY) 2020 at a rate of 6.27 percent, or $25.74 billion in improper payments. For FY 2020 CMS estimated that Part C improper payments were 6.78 percent, or $16.27 billion, and Medicare Part D improper payments were 1.15 percent, or $93 billion.[33]

In a bipartisan effort to reduce improper payments and help stave off the impending bankruptcy of Medicare, Congress implemented a recovery audit contractor (RAC) demonstration project for Medicare Parts A and B that ran from 2005 to 2008 and recovered more than $900 million in overpayments to providers. Congress enacted legislation to expand the program nationwide and make it permanent, a process that began in early 2009 and was fully implemented by September 2010. Since the beginning of the RAC program more than $11 billion has been returned to the Medicare Trust Fund. Unfortunately, the program has been opposed by hospitals, and state and national trade associations that have pressured Congress and CMS to quietly shrink the scope of RAC oversight. Legislators should not give into pressure to weaken the RAC program and should aim to reinstate and safeguard the RACs to help slow the depletion of the trust fund.[34]

Despite the significant financial pressure on the Medicare program, several members of Congress are still pursuing a national approach to healthcare in the Medicare for All Act, which was sponsored by Sen. Bernie Sanders (I-Vt.) and Rep. Pramila Jayapal (D-Wash.) during the

[30] Ibid.
[31] CMS, "What Part B Covers," https://www.medicare.gov/what-medicare-covers/what-part-b-covers.
[32] CMS, The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "The 2021 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds," August 31, 2021, https://www.cms.gov/files/document/2021-medicare-trustees-report.pdf.
[33] CMS, "Fact Sheet 2020 Estimated Improper Payment Rates for Centers for Medicare & Medicaid Services (CMS) Programs," https://www.cms.gov/newsroom/fact-sheets/2020-estimated-improper-payment-rates-centers-medicare-medicaid-services-cms-programs.
[34] Ibid.

117th Congress.[35] This legislation would expand Medicare to include all Americans, which would require millions more Americans to subsist on government-run health insurance, depleting other health insurance markets, and resulting in less competition and higher prices. A complete government overhaul would offer no incentive for medical practices or hospitals to lower costs and the taxpayers would fully fund the nation's healthcare system. According to the Mercatus Center for Law and Economics, if Medicare for All had been enacted in 2018, it would have increased the federal budget by approximately $32.6 trillion during its first ten years of full implementation (2022–2031).[36]

After analyzing a single-payer system, the Congressional Budget Office (CBO) projected that federal subsidies would cost $1.5 trillion to $3 trillion more in 2030 than under current law during that same year.[37] To fund a universal healthcare system like the Medicare for All proposal, the government would have to raise taxes, introduce new taxes, reduce spending, or increase the national debt. Eventually, the well will run dry, and the U.S. will be stuck with a government-run system that has proven to be a disaster in other countries with socialized medicine.

Reform the 340B Program

The 340B drug discount program, created in 1992 by Congress, is overseen by the Health Resources and Services Administration (HRSA), an agency within the HHS. It requires pharmaceutical manufacturers that want to participate in Medicaid to provide heavily discounted outpatient pharmaceuticals (as much as 50 percent) to certain healthcare facilities, called "covered entities," which include federally qualified health centers; Ryan White HIV/AIDS grantees; children's, disproportionate share, free standing cancer, and sole community hospitals; and specialized clinics.[38]

The covered entity, or its contract pharmacy, is supposed to pass along the savings from the discounted drugs to their low-income patients, but that has not occurred due to vague language in the law and regulations along with other factors. The abuse of the program accelerated beginning in 2014, after the Patient Protection and Affordable Care Act expanded the type and number of entities that could benefit from the program.

In June 2020, Drug Channels reported that 340B drug purchases reached $29.9 billion in 2019, an increase of 23 percent over 2018 and more than 232 percent since 2014.[39] In 2021, the total was $43.9 billion, a 16 percent increase over 2020.[40]

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[35] Medicare for All Act of 2022, S. 4204, (2022) https://www.congress.gov/bill/117th-congress/senate-bill/4204/text, Medicare for All Act of 2021, H.R. 1976, (2021), https://www.congress.gov/bill/117th-congress/house-bill/1976/text.
[36] Charles Blahous, "The Costs Of A National Single-Payer Healthcare System," Mercatus Center, George Mason University, 2018, https://www.mercatus.org/system/files/blahous-costs-medicare-mercatus-working-paper-v1_1.pdf.
[37] Phill Swagel, "How CBO Analyzes Proposals For A Single-Payer Health Care System," Congressional Budget Office, December 10, 2020, https://www.cbo.gov/publication/56898.
[38] Health Resources and Services Administration (HRSA), "340B Eligibility," https://www.hrsa.gov/opa/eligibility-and-registration.
[39] Adam J. Fein, Ph.D., "New HSRA Data: 340B Program Reached $29.9 Billion in 2019; Now Over 8% of Drug Sales," Drug Channels Institute, June 9, 2020, https://www.drugchannels.net/2020/06/new-hrsa-data-340b-program-reached-299.html.
[40] HRSA, "2021 340B Covered Entity Purchases," https://www.hrsa.gov/opa/updates/2021-340b-covered-entity-purchases.

A January 2018 House Energy and Commerce Committee report on 340B identified insufficient oversight, unreliable data, and inadequate reporting requirements. The program's failures were the result of several factors, including the lack of clear statutory intent and definition of an eligible patient, as well as lax requirements to report savings and how that money is being used. The committee's reform recommendations included an increase in HRSA's regulatory authority and resources to oversee and administer the program, clarification by Congress of the intent of the program, and greater transparency on charity care provided by covered entities.[41]

A November 2021 Xcenda study found that since 2004, newly registered 340B disproportionate share hospitals tend to be in higher-income communities compared to hospitals that previously joined the 340B program. The study noted, "Today, there are nearly 30,000 unique 340B contract pharmacy locations compared to just 1,300 in 2010; that was the year when HRSA updated its guidance to allow hospitals and other covered entities to have an unlimited number of contract pharmacies, instead of limiting the program to covered entities with no on-site pharmacy."[42]

In a wide-ranging analysis of Richmond Community Hospital, owned by Bon Secours, which was supposed to reinvest profits from 340B drug sales into its facilities and improve patient care, a September 24, 2022, *The New York Times* article reported that the money was being used instead to invest in facilities in the city's wealthier neighborhoods. Dr. Lucas English, who worked in the hospital's emergency department until 2018, said, "Bon Secours was basically laundering money through this poor hospital to its wealthy outposts … It was all about profits."[43] Dr. Peter B. Bach, who has written about the increased number of clinics opened in wealthier areas using 340B profits, said the hospitals are "nakedly capitalizing on programs that are intended to help poor people."[44]

There have been sufficient reports by Congress, the media, and outside organizations about the corruption, cost, failure, and abuse of the 340B program. All that remains is the will to get the job done, which will both save the taxpayers money and give low-income patients the discounts on drugs that they have long deserved. Eliminating the horrors that have been exposed about this program should be a top priority for the 118th Congress.

Eliminate Price Controls

Government price controls on pharmaceuticals were included in H.R. 5376, the Inflation Reduction Act of 2022 (IRA), which was signed into law on August 16, 2022.[45] The price

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[41] House Energy and Commerce Committee, "New E&C Report Examines the 340B Drug Pricing Program," press release, January 10, 2018, https://republicans-energycommerce.house.gov/news/press-release/new-ec-report-examines-340b-drug-pricing-program/.
[42] Amerisource Bergen, Xcenda, "340B and health equity: a missed opportunity in medically underserved areas," 2021, https://www.xcenda.com/-/media/assets/xcenda/english/content-assets/white-papers-issue-briefs-studies-pdf/xcenda_issue_brief_340b_muas_nov2021.pdf?la=en&hash=43F8AA8291C2A71A014B1B10BB1E4F4616882938.
[43] Katie Thomas and Jessica Silver-Greenberg, "How a Hospital Chain Used a Poor Neighborhood to Turn Huge Profits," *The New York Times*, September 24, 2022, https://www.nytimes.com/2022/09/24/health/bon-secours-mercy-health-profit-poor-neighborhood.html.
[44] Ibid.
[45] Ibid., Inflation Reduction Act.

controls will devastate future research and development of new life-saving medicines, and significantly reduce future treatments and cures. CAGW has released numerous reports on the damaging impact of price controls since 2000, including the provisions of the IRA.[46]

An August 2021 Congressional Budget Office (CBO) report on the Simulation Model of New Drug Development projected that H.R. 3, on which the price control provisions of the IRA are based, would decrease the number of new drugs entering the marketplace by 8 percent in the third decade following enactment, resulting in at least 60 lost treatments.[47]

Another analysis of government price controls over the pharmaceutical marketplace deemed the CBO projection too conservative, finding the potential loss of future cures to be much greater.[48] In a November 29, 2021 issue brief, University of Chicago economists Dr. Thomas Philipson and Troy Durie found that H.R. 5376 would reduce R&D spending by $663 billion and that "188 new indications will not get new prevention, treatment, or cures through 2039 … and lead to 331.5 million fewer life years through 2039 … 31 times as large as the 10.7 million life years lost from COVID-19 to date.[49] These estimated effects on the number of new drugs brought to market are 27 times larger than projected by CBO,[50] which finds only five drugs will be lost through 2039, equaling a 0.63 percent reduction."[51]

CAGW has long been concerned about the push toward increased government overreach into the medical marketplace and the negative consequences price controls have on research and development. Congress has continually attempted to implement price control legislation disguised as "negotiations" for Medicare Part D coverage, like the language included in both the H.R. 3 and the Build Back Better Act, and enacted in the IRA during the 117th Congress, which will have a significant negative impact on future cures, leaving "an invisible graveyard of patients."[52] Instead of imposing additional price controls on the innovative biopharmaceutical marketplace, Congress should instead incentivize new drug development by creating an environment that encourages innovation and remove burdensome regulatory barriers, including a more expedited drug approval process that would bring pharmaceuticals to market sooner and at a lower cost.

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[46] Thomas Schatz, "The Senate Must Reject Price Controls on Pharmaceuticals," *The WasteWatcher*, CAGW, July 7, 2022, https://www.cagw.org/thewastewatcher/senate-must-reject-price-controls-pharmaceuticals; Christina Smith, "Senators Need to Check Their Conscience Before Voting for Price Controls," *The WasteWatcher*, CAGW, July 28, 2022, https://www.cagw.org/thewastewatcher/senators-need-check-their-conscience-voting-price-control; Christina Smith, "The Inflation Reduction Act Will Raise Drug Prices and Reduce Cures," *The WasteWatcher*, CAGW, https://www.cagw.org/thewastewatcher/inflation-reduction-act-will-raise-drug-costs-and-reduce-cures; Christina Smith, "The House Should Avoid Making the Senate's Terrible Mistake on Healthcare," *The WasteWatcher*, CAGW, August 8, 2022, https://www.cagw.org/thewastewatcher/house-should-avoid-making-senates-terrible-mistake-healthcare.

[47] Congressional Budget Office, "CBO'S Simulation Model Of New Drug Development," August 2021, https://www.cbo.gov/system/files/2021-08/57010-New-Drug-Development.pdf.

[48] Thomas Philipson and Troy Durie, "Issue Brief: The Impact of HR 5376 on Biopharmaceutical Innovation and Patient Health," The Kenneth C. Griffin Department of Economics, University of Chicago, November 29, 2021, https://ecchc.economics.uchicago.edu/2021/11/30/issue-brief-the-impact-of-hr-5376-on-biopharmaceutical-innovation-and-patient-health/.

[49] Ibid., pp. 7-8.

[50] Congressional Budget Office, "Estimated Budgetary Effects Of Title XIII, Committee On Ways And Means, H.R. 5376, The Build Back Better Act," November 18, 2021, https://www.cbo.gov/publication/57626.

[51] Ibid., Philipson and Durie, "Issue Brief: The Impact of HR 5376 on Biopharmaceutical Innovation and Patient Health."

[52] Christina Smith, "Price Controls Will Create an Invisible Graveyard of Americans," *The WasteWatcher*, CAGW, December 17, 2021, https://www.cagw.org/thewastewatcher/price-controls-will-create-invisible-graveyard-americans.

Congress should also repeal the price controls that were included in the IRA, as proposed by Sen. Mike Lee (R-Utah) in S. 4953, the Protection Drug Innovation Act.[53] Sen. Lee said, "Price controls never work. Instead, they exacerbate the problems they seek to resolve. Mandating fixed prescription drug prices will ultimately result in the shortening of American lives. Instead of repeating past mistakes, it's time we address what's driving the cost of prescription medications and adopt a regulatory environment that works to everyone's advantage."[54] Passage of Sen. Lee's legislation would help to eliminate the adverse impact of price controls and ensure continued access to future cures and treatments for all Americans.

Expand Association Health Plans

Expanding the opportunities to shop for and purchase health insurance would improve the healthcare system. Even though the manner in which Americans work today has evolved with new options to work using the gig economy, contracting, or other self-employment options, attaching health insurance to employment, which was first implemented during the 1940s, remains the primary method.[55]

Nearly 80 years later, attaching health insurance to employment is an archaic process that has left millions of Americans with few options. This issue was exacerbated during the COVID-19 pandemic, when nearly 12 million Americans lost employer-sponsored coverage.[56] Linking employment to healthcare no longer makes sense and puts Americans at risk. Instead, healthcare insurance should be easily shopped and purchased like home and auto insurance, not offered mostly through one's employer or the government.

One solution to increase marketplace choices for consumers would be to expand Association Health Plans (AHP), which allow patients to group as members of an association to access health insurance coverage and care, thus lowering costs and increasing options. This allows small companies, freelancers (like those engaged in the gig economy), and self-employed individuals to access health insurance savings, like those available to large group medical insurance coverage.[57] Sen. Rand Paul (R-Ky.) has long been an advocate of expanding association health plans to grant eligibility to more groups and individuals.

Expand Health Savings Accounts

Health savings accounts (HSAs) offer tax advantages for healthcare expenses by allowing pre-tax contributions up to $3,650 for individuals and $7,300 for families with high

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[53] Protect Drug Innovation Act, S. 4953, 117th Congress (2022), https://www.congress.gov/bill/117th-congress/senate-bill/4953.
[54] Mike Lee, US Senator for Utah, "Lee Introduces Bill to Roll Back Price Controls," press release, September 27, 2022, https://www.lee.senate.gov/2022/9/lee-introduces-bill-to-roll-back-price-controls#:~:text=Washington%2C%20D.C.%20%E2%80%93%20Sen.%20Mike%20Lee%20%28R-UT%29%20introduced,passed%20through%20Congress%20without%20a%20single%20Republican%20vote.
[55] Ramtin Arablouei and Rund Abdelfatah, "History of Employer-Based Health Insurance in the U.S.," National Public Radio, October 7, 2020, https://www.npr.org/2020/10/07/921287295/history-of-employer-based-health-insurance-in-the-us#:~:text=In%20the%201940s%2C%20the%20government,it%20much%20cheaper%20for%20employers.
[56] Annie Nova, "Millions Of Americans Have Lost Health Insurance In This Pandemic-Driven Recession. Here Are Their Options," CNBC, August 28, 2020, https://www.cnbc.com/2020/08/28/millions-of-americans-lost-health-insurance-amid-pandemic-here-are-options.html.
[57] Kev Coleman, "What Is an Association Health Plan?," Association Health Plans.com, November 18, 2020, https://www.associationhealthplans.com/ahp/what-is/.

deductible health plans (HDHP).[58] HSAs are a great savings tool, but must be coupled with a HDHP, meaning millions of Americans don't have access to an HSA, including many Medicare patients. Even though Medicare patients have Medicare Advantage they still don't have access to the additional benefits of an HSA. Of the patients with HDHP's and access to HSAs more than 63 million utilize the benefits of a health savings account.[59]

Expanding HSAs to all Americans would improve their ability to save and make more affordable healthcare choices available to all. Eliminating the requirement that HSAs be coupled with HDHPs is a clear and simple fix. By casting a broader net to include all Americans, especially those who are younger, and allowing them to save and invest in an HSA, patients will be empowered to make their own medical decisions, while pursuing financial independence instead of relying on the government.

Increase the Availability of Telehealth

Unlike traditional healthcare, telehealth offers alternative means for underserved communities, particularly in rural or remote areas of the country, to access much-needed medical care primarily online using smartphones, computers, or tablets. Telehealth is not intended as a substitution for in-person care, but it provides an alternative pathway for patients to connect with their doctor and other providers.

Since the passage of the ACA in 2010, 129 rural hospitals in the United States have closed.[60] On August 3, 2020, President Trump issued an Executive Order (EO), "Improving Rural Health and Telehealth Access," to further expand telehealth services and ensure continued access to healthcare for rural Americans during the pandemic.[61] Following the release of the EO, more than 60 services were added to the Medicare telehealth list.[62]

The administration also called upon Congress to further expand telehealth options across the country. Former Centers for Medicare and Medicaid Services Administrator Seema Verma stated, "Telehealth has long been a priority for the Trump Administration, so we started paying for short virtual visits in rural areas long before the pandemic struck. But the pandemic accentuated just how transformative it could be. Several months in, it's clear that the healthcare

[58] CMS, "Health Savings Account (HSA)," 2022, https://www.healthcare.gov/glossary/health-savings-account-hsa/.
[59] Devinir, "HSAs gain traction with older and younger Americans alike, covering more than 63 million people across all 50 states at the end of 2020," June 21, 2021, https://www.devenir.com/hsas-gain-traction-with-older-and-younger-americans-alike-covering-more-than-63-million-people-across-all-50-states-at-the-end-of-2020.
[60] CMS, "Trump Administration Drives Telehealth Services in Medicaid and Medicare," October 14, 2020, https://www.cms.gov/newsroom/press-releases/trump-administration-drives-telehealth-services-medicaid-and-medicare.
[61] White House Archives, "President Donald J. Trump Is Expanding Access to Telehealth Services and Ensuring Continued Access to Healthcare for Rural Americans," The White House, August 3, 2020, https://trumpwhitehouse.archives.gov/briefings-statements/president-donald-j-trump-expanding-access-telehealth-services-ensuring-continued-access-healthcare-rural-americans/.
[62] CMS, "Trump Administration Finalizes Permanent Expansion of Medicare Telehealth Services And Improved Payment for Time Doctors Spend with Patients," December 1, 2020, https://www.cms.gov/newsroom/press-releases/trump-administration-finalizes-permanent-expansion-medicare-telehealth-services-and-improved-payment.

system has adapted seamlessly to a historic telehealth expansion that inaugurated a new era in healthcare delivery."[63]

The COVID-19 pandemic opened America's eyes to successes and failures in the medical marketplace, as well as the critical need for alternative healthcare options during times of crisis. During the height of the pandemic, 41 percent of patients abstained from necessary medical care due to restrictions imposed to help avoid the spread of the disease.[64] To help increase access for these patients, the Trump administration expanded coverage for Medicare telehealth services and providers.[65]

In April 2020, the Federal Communications Commission launched a program to promote telehealth opportunities in response to the COVID-19 pandemic, providing more than $200 million to providers under the Coronavirus Aid, Relief, and Economic Security Act to assist in starting up telehealth programs for their patients.[66] As of January 26, 2022, 447 awardees had received funding through the program, with commitments totaling $256,378,567.[67]

H.R. 1332, the Telehealth Modernization Act, introduced by Rep. Buddy Carter (R-Ga.), would expand telehealth services by making certain COVID-19-related telehealth services permanent for Medicare.[68] Unleashing American innovation and permanently expanding telehealth will provide better options for far more patients. Telehealth offers accessible care for patients and should be prioritized as an approach to patient-centered care.

Conclusion

Healthcare decisions should be made by individuals along with their healthcare providers, rather than by a cumbersome federal bureaucracy forcing them to rely on programs fraught with waste, fraud, and abuse. These programs must be reformed and utilized as originally intended for the most vulnerable in society. Adopting free market reforms that increase competition and spur innovation should be a top priority.

The U.S. healthcare system is at a tipping point. The recommendations in this report will help to avoid increased government control of the healthcare system and provide patients with greater choice and control.

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[63] Susan Morse, "Congressional Action Is Needed for Telehealth Not To Return To A Rural Benefit, CMS Administrator Seema Verma Says," *Healthcare Finance News*, December 1, 2020, https://www.healthcarefinancenews.com/news/congressional-action-needed-telehealth-not-return-rural-benefit-cms-administrator-seema-verma.

[64] Mark É. Czeisler, Kristy Marynak, MPP, Kristie E.M. Clarke, MD, et al., "Delay or Avoidance of Medical Care Because of COVID-19-Related Concerns – United States, June 2020," Centers for Disease Control and Prevention, September 11, 2020, https://www.cdc.gov/mmwr/volumes/69/wr/mm6936a4.htm.

[65] CMS, "President Trump Expands Telehealth Benefits For Medicare Beneficiaries During COVID-19 Outbreak," March 17, 2020, https://www.cms.gov/newsroom/press-releases/president-trump-expands-telehealth-benefits-medicare-beneficiaries-during-covid-19-outbreak.

[66] Federal Communications Commission (FCC), "COVID-19 Telehealth Program (Invoices & Reimbursements)," https://www.fcc.gov/covid-19-telehealth-program-invoices-reimbursements.

[67] FCC, "FCC Announces Final Set of Commitments for COVID-19 Telehealth Program," January 26, 2022, https://www.fcc.gov/document/fcc-announces-final-set-commitments-covid-19-telehealth-program.

[68] The Telehealth Modernization Act, H.R. 1332, (2021), https://www.congress.gov/bill/117th-congress/house-bill/1332.

The Health Policy Consensus Group, facilitated by the Galen Institute, and composed of healthcare policy analysts who provide recommendations on a variety of healthcare policy issues released, "Health Care Choices 2020: A Vision for the Future."[69] The plan encompasses free market solutions to healthcare problems including continued use of HRAs; expanding HSAs, building off of the Trump administration's successful plan to give states more control over federal healthcare dollars by instituting high-risk pools, "invisible risk pools," reinsurance, and other risk adjustments that provide specialized care for people with chronic or preexisting conditions; more regulatory flexibility for the states; expanding telemedicine; providing an alternative to the No Surprise Billing Act; and lowering federal regulatory burdens that hinder competition and innovation.[70]

Patients have been stripped of their healthcare choices and left with either a big government socialist program that is failing, or a private coverage market that has been heavily distorted by government manipulation. If Congress works to unleash the free market, competition will drive down costs, and American ingenuity will bring about the best choices for patients.

[69] Health Policy Consensus Group, "Health Care Choices 20/20: A Vision for the Future," November 2020, https://www.healthcarechoices2020.org/wp-content/uploads/2020/11/HealthCareChoices2020_Proposal.pdf.
[70] Ibid.