

Questions for the Record

Dr. Scott Gottlieb

Rep Michael C. Burgess

1. There are a number of methods/tools available to the insurance industry that could help keep rates competitive and low without shifting a large proportion of the burden to physicians. One would be to offer consumers plan designs that provide transparency around issues of price and relative value, and structured insurance products that leave more choices with consumers based on these considerations. The insurance industry has talked about value-based designs for many years, but at each juncture has been largely unable to implement these designs, or otherwise simply prefer to pursue the more restrictive schemes. This is probably a consequence of administrative ease, and the relative complexity of providing greater transparency around price and outcomes and structuring insurance designs to empower consumers to make choices based on these considerations.

2. I believe the physician networks will continue to erode in 2015. More states are pursuing regulations that will exert greater scrutiny to the adequacy of the networks. This may force some plans to expand networks in certain areas. But we will see networks contract in others areas, and will also see more physicians drop out of these schemes. On balance, I wouldn't expect the networks to look any better in 2015, and in some areas (for example, access to specialists) could be appreciably worse. In the first year some insurers were offering PPO style options on the exchanges. I would expect to see more narrow network plans supplant the handful of more flexible arrangements that were available as the insurers become more adept at managing selection on the exchanges, and more experienced in dealing with the low pricing and costly regulation that is imposed on them.

3. I believe on balance these networks will remain very restrictive. Insurers can expand them in ways that are noticeable to consumers and the political class without affecting the real issues of access and adequacy. For example, they can expand the number of doctors they enroll in a single institution but still restrict patients to that institution. Have consumers really benefited from greater choice in such a scenario? They may have access to more of the doctors in a local hospital, but they are still confined to that facility to receive all their care.

4. In year one, there weren't any reliable criteria applied. On the whole, insurers sent contracts to providers, and networks were formed on the basis of those doctors that opted in. We will see more insurers force providers to take exchange coverage by making it a condition of participation in the insurer's other lines of business. Physicians will lose discretion as a consequence of the consolidating insurance market. This is one way insurers are going to gain leverage as the providers themselves consolidate, mostly around hospitals. In the post-ACA marketplace, the ongoing goal of providers and insurers is to gain market heft to exert this sort of leverage. On the whole the contracting is not accounting for patient severity risk,

and providers don't have any more insight into the capitated arrangements to gauge this risk than they possessed when wholesale capitation was pursued in the 1990s. This is one of the principal reasons why capitation failed. The providers, including hospitals, had poor insight into the risk they were assuming under these contracts, and had no reliable way to price the capitation arrangements.

Rep Gus Bilirakis

1. The tools available to patients were wholly inadequate. Patients had better selection tools when Medicare Part D was rolled out, and that plan was implemented during a time when the information technology was far less advanced. Consumers were able to compare Part D plans based on the drugs they used. The IT for enabling these kinds of capabilities is widely available. While we should expect to see more plans have better tools during the 2015 enrollment season, the fact is that the health plans are not incented to provide this sort of transparency. The incentives are directed toward imposing restrictions on access. The most significant complexity will surround the drug plans that accompany these ACA plans. There are so many terms and conditions; consumers will continue to have a hard time evaluating what their liability is under different clinical scenarios.

2. The restrictive rules are a consequence of three principal forces at work in the exchanges: first insurance market changes restricted how plans could use other cost-saving tools (high deductibles and cost sharing to steer utilization, underwriting based on risk, etc) to lower costs; second regulations imposed costly federal requirements on what benefits had to be included in coverage; and finally, insurers were restricted from raising premiums beyond a certain threshold in order to adequately price their products to the new costs that regulations imposed. The end result is that the ACA plans are largely the same within each insurer's particular line. The only thing that typically varies is the co-pay structure. The benefit design is the same. The single most significant reform to enable greater choice would be to lift all of the federal regulations and allow states to regulate the plans based on rules that pre-dated the ACA, and enable any plan that previously met state eligibility requirements to be sold in the new exchanges. This would enable greater choice in some state exchanges. We will certainly see these narrow designs rolled out in the commercial marketplace. The ACA popularized these designs, and insurers will import these same constructs into their other product lines now that these cost-saving approaches have been deemed acceptable by our political class. The inevitable outcome here is that the restrictive plans will ignite calls for still greater regulation, and we will be engaged in a cycle of more federal rules, and rising costs.

Rep Renee Ellmers

1. The essential benefit mandate has increased the costs of these plans, and created a market where consumers don't have a real choice of benefit design. All of the plans have conformed to the federal rules and are, for practical purposes, the same benefit design. Insurers are no longer competing on the basis of the underlying benefit. The

idea was to push competition to cost alone. What it's done is push insurers to adopt escalating tactics to cheapen the cost of delivering this mandated benefit by hollowing out the provider networks. This is similar to how Medicaid plans operate.

2. There is ample evidence that the consolidation of care, and especially oncology services, into hospital-based settings increases costs. 340B is contributing to this consolidation by giving hospitals a lucrative incentive to buy oncology practices. As I noted in a previous op ed article for Forbes, hospitals are buying private oncology practices so that they can book more drug purchases at the 340B discount rates. More than 400 practices have been acquired since the passage of the ACA. Between 2005 and 2011, the amount of chemotherapy infused in doctor offices fell from 87- to 67 percent according to an analysis of Medicare billing data done on behalf of community oncology groups. When cancer care shifts to hospital clinics it's not only less comfortable for patients, but also more costly. Owing to hospital inefficiency, a patient treated in a hospital clinic costs \$6,500 more than the same person treated in a private medical office. The cost of infusing the drugs alone rises by 55 percent. This doesn't account for the drop in provider productivity that we know ensues when providers shift from an outpatient to an owned arrangement.

3. The protected classes were implemented as a way to protect certain vulnerable patients from formulary designs that would inadvertently, or deliberately, exclude them by denying coverage for certain pivotal drugs. While such regulation can add to the costs, and decrease competition, the fact is that patients are being put at a significant hardship by regulations that encourage these restrictive designs. It may be that the only way to protect patients from the adversities created by the ACA is to implement such regulations. This is another example how ACA regulations are creating market failures that beget still more regulation to protect patients from the pernicious effects of the initial rules. This is how a regulatory arms race ensues, which regulators at CMS always one step behind that consumers are facing.

Rep Gene Green

1. I believe the single most significant reform that we can make, to encourage more choice and competition, would be to peel back the federal mandates and revert to state regulation of the insurance products. This would enable, in many states, more competition in the exchanges around benefit design, and give consumers a wider choice of affordable options. The consequence of the federal regulation has coalesced the market around a single template for benefits, with competition on price alone. It has created a race to the bottom on cost of goods where insurers are focusing on how to cheapen the mandated benefit by squeezing providers and networks. While price competition is important, we should also encourage competition based on the quality and breadth of the benefits, and give consumers a wider choice. In a viable risk pool, we shouldn't require that everyone buy the exact same benefit package as the only way to spread risk and costs. There is nothing inherently wrong with state-level exchanges as a way to pool consumers and facilitate purchasing. There is nothing inherently wrong with providing subsidies, in

the form of tax credits, to help consumers who are priced out of affordable coverage. The most pernicious flaw in the ACA is the top-down, federal regulation that limits the choices that consumers have, and in so doing, ends up driving up costs and forcing plans to compete on an increasingly narrow set of variables.