MEMO

To: The Honorable Senator Lamar Alexander (Tennessee)
    The Honorable Senator Patty Murray (Washington)

From: Practicing Physicians of America (PPA¹)

Cc: Members of the Senate’s Health, Education, Labor and Pensions (HELP) Committee

Date: June 4, 2019

Re: Comment on the Lower Healthcare Costs Act of 2019

Writing on behalf of Practicing Physicians of America (PPA), we are grateful for and commend the HELP Committee’s efforts to introduce legislation aimed at reducing the varied costs of healthcare services and insurance by increasing the transparency of pricing across this sector of the economy.

It is our position that allowing market competition, with its attendant disciplines and efficiencies, can become the self-sustaining model for the delivery of medical services in the United States. Therefore, with the Lower Healthcare Costs Act of 2019 now under discussion, we offer comments and recommendations beginning on the next page.

¹ PracticingPhysician.org

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1. On Ending Surprise Medical Bills

“Surprise billing” is the direct, negative result of proprietary “networks” that are mandated and defined by the insurance industry.

To bring an end to “surprise billing,” the very concept of “the network” must be recognized for what it is—the root of which “surprise billing” grows. The solution must strike at “the network” itself, while simultaneously ensuring the protection of the patient and of the relationship between the patient and the physician.

Any feature of legislation that enshrines the viability of “networks,” or nibbles at the edges of negotiations between hospital providers and insurers who establish these “networks,” only embeds the concept and its baneful effects more-deeply into our system of healthcare.

Simply put, physicians, other providers, testing centers, and hospitals should not be forced to participate in insurance networks. The fact that providers of care must be coerced by law into doing so, implies an obvious problem.

In the context of a medical emergency, the vulnerable patient needs care that frequently only a physician can supply. Health insurance was instituted for this very reason. But insurance “networks” have actually managed to create a landscape for the delivery of healthcare where insurance abrogates their fiduciary duty, and puts patients in the position of worrying about details of insurance coverage, and the professional positioning of the physician in relation to that coverage. This absurdity is heightened in the case of medical emergencies and may be life threatening.

Of the three main options contemplated under the legislation as currently drafted, Option 1: In-Network Guarantee is slanted toward networks and is not helpful; Option 2: Independent Dispute Resolution is labor-intensive and time-consuming for all parties, imposing upon the already limited time physicians have to devote to patients; and Option 3: Benchmark for Payment puts the control in the hands of insurers.
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I. **On Ending Surprise Medical Bills** (continued)

PPA recommends cutting through this dense thicket by encouraging the elimination of “networks.”

If insurance “networks” were eliminated for both emergent and non-emergent care, we would anticipate the following:

- Healthcare entities—hospitals, physicians’ offices, and testing centers, etc.—will then be in a position to post prices (opacity down, transparency up).
- Patients will be in a position to question and negotiate where appropriate.
- Indices of quality will improve.
- Indices of efficiency will improve
- Prices will fall.
- Surprise medical bills will be a thing of the past as the patient will be in the know and in control.

Hence, we call for the dissolution of insurance “networks” and “provider contracts,” and for a return to the more-sound definition and function of insurance as a protection of the insured against large losses, not as an ingredient of all transactions.

Patients must retain the choice to be in the driver’s seat when it comes to the health services and products they seek, and the amounts to be spent. The right to choose gives patients responsibility over their own health, and stewardship of their healthcare options. Patients alone must retain the autonomy to decide matters using their own unique value systems.

The foregoing discussion begins to turn the spotlight on the underappreciated problem of **third parties and middlemen** in the American system of healthcare. Their role has been to anesthetize those who need medical care against what it costs, while simultaneously creating those conditions for those costs to climb incessantly, never to stabilize or fall in response to the normal discipline of the marketplace.

Under the next heading, **On Reducing the Prices of Prescription Medications**, we will discuss how third-party insurance and the government-sanctioned “Safe Harbor” for certain types of middlemen have raised prices and stolen value.

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II. On Reducing the Prices of Prescription Medications

PPA is supportive of the measures in this section. We have been encouraged by comments in the press release that the issue of “rebates” (government-legalized kickbacks to Pharmacy Benefit Managers (PBM) and Group Purchasing Organizations (GPO), would be addressed in the final bill.

While we support the intentions of the Braun-Romney Prescription Drug Rebate Reform Act of 2019, we must be clear in stating that the crisis in the cost of healthcare will not be resolved until the “Safe Harbor” (legal protection) for monetary remuneration from manufacturers to PBMs and from manufacturers and to GPOs are fully repealed for all payors and transactions. Again, this remuneration is often referred to as a “rebate,” although in any other industry it would be called a kickback.

This GPO and PBM “Safe Harbor” must go. Any restructuring of the kickbacks makes them permanent and leaves huge potential power in the hands of the middlemen that stand against the public interest.

For their part, the PBMs and GPOs, in their role as middlemen in the American healthcare sector, have never persuasively justified their raison d’être, instead relying on the status quo in which the United States Congress and HHS fail to exercise their powers of oversight and review as defined in the legislation that created the “Safe Harbor.”

The conflicts of interest that are inherent in this legally protected scheme are an affront to the confidence that patients and physicians must have in (a) every drug placed on insurance company formularies by a PBM, and (b) the products supplied by GPOs to hospitals and other medical facilities.

In addition, when market share can be bought, the fragile supply chain that results from such a distortion is primed for the development of critical drug shortages, which themselves erode quality of care and cause price increases. The shortages documented by the FDA should be examined more closely.² Many are shortages of essential, life-sustaining medications. The shortages hurt those with pre-existing conditions, especially minority populations, and those cared for by rural hospitals. Maternal and child health are affected also.

² https://www.accessdata.fda.gov/scripts/drugshortages/default.cfm

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II. *On Reducing the Prices of Prescription Medications* (continued)

The complete proceedings[^3] of the FDA-sponsored, Duke-Margolis Center symposium on drug shortages, held November 27, 2018, should be studied. Nearly all industry players admitted that the problem was rooted in the perversity of the financial relationships; many discussed the need for transparency; others suggested the need for governmental agencies to work together coherently. 

PPA concurs with the above primary findings. 

Governmental agencies can and should collaborate for the sake of American patients. 

The Senate can and should demand that the HHS OIG request a study of (a) the contracts for every drug currently or previously in shortage and (b) all previous contracts for these medications since the “Safe Harbor” for legalized kickbacks was first enacted in 1987 and then expanded in 2003. 

A thorough review by several independent entities that have no conflict of interest will keep the process honest. And because the United States Congress enacted the law that led to the public’s harm, the public should have access to the findings regarding the contracts. Further, the contracts themselves should be made public for scrutiny by all. 

For a start and for comparative purposes, it would be helpful to demand review all of all contracts related to OXYCONTIN®—a drug never known to have been in short supply. 

A GAO document[^4] shows that the OIG within HHS has the authority to request the contracts, but has never exercised that authority granted by the original statute. 

We cannot say the following forcefully enough. There is no path to affordable healthcare in this country unless the United States Congress fully repeals the “Safe Harbor” protections (i.e., protections for kickbacks) afforded to PBMs and GPOs under 42 U.S.C. 1320a-7(b)(3)(C). It is long past time to cut the middlemen down to size and pry their hands out of the pockets of America’s sick.

[^3]: [https://healthpolicy.duke.edu/events/drug-shortage-task-force](https://healthpolicy.duke.edu/events/drug-shortage-task-force)  
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III. On Improving Transparency in Healthcare

Here is an idea having great potential: Designation of a nonprofit, non-governmental entity to dive into the accumulated data related to the care of patients to understand more-fully the costs of healthcare, to understand where the money really goes and monitor with vigilance the state of the “pie” when it comes to how the American healthcare dollar is sliced up and served.

Perhaps the yearly or biannual selection of a new or an existing nonprofit would be a practical starting point. Yearly or biannual selection would allow for free-market competition and efficiency.

Independent physicians should be adequately represented in this endeavor.

Professional organizations of independent physicians, such as PPA and others with whom PPA collaborates, such as the entities under the umbrella of the nascent Free to Care Organization, can provide the knowledge, experience, education and solutions—organic, free-market solutions that will greatly benefit patients and physicians while keeping the process free of conflicts of interest.

IV. On Improving Public Health

No thinking person can argue with the goals of the draft legislation.

PPA, however, suggests alternatives to achieving those goals, alternatives that would better the collaboration of federal, state and even local entities.

In Section 403, instead of the federal government calling for HHS to develop guides on obesity prevention and control, consider (a) a search by HHS for programs at the local level that are actually working, and (b) the compilation and commendation by HHS of those programs.

We would recommend a hold on Section 405, which discusses modernizing the system for collecting information on public health programs. These programs are in flux. It would be more-prudent to allow programs for improving public health and the education of the public in health matters to develop organically, and then overhauling and modernizing the system.
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IV. On Improving Public Health (continued)

Regarding Section 407 and its authorization of grants for programs that train the public and support the public’s health, the points made above in connection with sections 403 and 405 apply. The federal government should first search for programs that do those very things and have been proven to be effective. Only after that exercise should grants be extended.

Our thinking under this heading is captured in the following quotation from the “Free to Care” White Paper issued at the beginning of April during the symposium held in the Library of Congress, and written, in part, by Dr. Marion Mass and Dr. Craig M. Wax.

“Prevention, nutrition, exercise, diabetic care, vaccination, sunscreen, dental care, prenatal care, parenting, care of the elderly during their twilight years—all of these are matters on which patients seek the guidance of physicians. ... Tax-deductible, donated time for community forums would foster educational engagement between practitioners and the public. While not a substitute for the face-to-face personal encounter, the repetition provided by forums and the ability to address questions would support robust, cost effective, public health education. The obvious benefits of increased engagement between practitioners and the public would foster trust—a much-needed seed for the growth of patient compliance. Poor compliance by patients with instructions received from practitioners leads directly to higher costs and waste in medical care...

“Innovative incentives for voluntary efforts—true charity—should be created. Here are a couple of possibilities: a state tax credit for donations to agencies that pay medical bills for needy patients (the agencies, not the state, would decide how funds are allocated); and state assumption of the cost of malpractice liability insurance for doctors who have donated their services at charity clinics. WE ASK for tax deductions to be extended to physicians and nurses who donate time in public settings to educate the public and to address legislative bodies on state-based incentives for true pro-bono care.”

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V. On Improving the Exchange of Healthcare Information

For the last two decades, the legislative and regulatory thrust of the federal government has been to force those entities that participate in Medicare and Medicaid to adopt electronic health records (EHRs) in keeping with certain government criteria. These criteria were later expanded by the requirements of the Medicare Access and CHIP Reauthorization Act (MACRA).

While well-intentioned, these requirements surrounding the EHR have only increased the costs in money and time incurred by virtually everyone involved in seeking or delivering medical care. Consequently, by more than one measure of efficiency, the provision of medical services has deteriorated.

Some view “EHR interoperability” as the only solution to the issues of the EHR. But, given the experience of patients and physicians in recent years, “EHR interoperability,” in the existing environment, will only add to the burdens of an encumbered system, and put patient data at further risk.

The security and privacy of the information regarding patients and physicians have simply not been adequately addressed in discussions of EHR. Patients and their chosen physician stewards, must be in control of all patient private data, not insurance companies, third parties, their designees or government entities.

PPA recommends serious consideration of deactivating or repealing outright the MIPS component of MACRA.

The primary determinant of healthcare record system quality should be returned to those it rightfully serves: the patient and the physician. We recommend an end to the current status of government choosing systems that qualify as acceptable.

Instead, the free market should be permitted to create multiple solutions that compete on the basis of quality, efficiency, and price. All options for healthcare information should be “on the table” for physicians and their patients.

Government entities and profiteering third parties will never be in a position to create solutions for the troubled healthcare sector of the American economy that would support the overarching objectives of lowering costs while simultaneously maintaining the quality of care and the freedom of individual choice.

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PPA believes that the solutions we have recommended herein will help not only prevent surprise medical billing and drive the costs of healthcare and insurance down, but also to foster enhanced quality, efficiencies, and a healthy competitiveness that would truly serve the American people.