BILL TOWNSEND

Our New Voice in Congress

POLICY OVERVIEW

AFFORDABLE HEALTH CARE

The Affordable Care Act was passed by the Democrats with most Members of Congress never having read the bill. The Republicans tried—and failed—54 times to repeal the Affordable Care Act, aka, Obamacare. Both Parties have failed to deliver reductions in the cost of health care. Here's how we do it.

Healthcare in America is exceedingly expensive. According to OECD data released in 2018, among 34 advanced industrialized countries, the U.S. spends $10,348 per person, which is more than twice the OECD average.

The next highest per capita spender on healthcare is Switzerland at $7,919 and then there is a sharp drop-off to #3 Germany at $5,550. Since 1980 the gap between what America spends on healthcare and what other countries spend has widened and our private sector spending is triple that of comparable countries. As a nation, are we sicker? No. We are simply paying too much for uncessary care and tests, non-emergency hospital visits, insurance, and drugs.

In 1995, the US spent about 13% of its gross domestic product (GDP) on healthcare. Today that number is 17.9% and tops $3.3 trillion.

Despite all that spending, America's health system does not perform particularly well. The US ranks 27th for life expectancy at birth. This comparatively low ranking is not merely a consequence of higher infant mortality, where the US ranks a dismal 53rd in deaths per 1,000 live births. Even considering life expectancy for men aged 65 places the U.S. in 23rd place.

The US ranks poorly on health outcomes partly because we are the only advanced industrialized economy that has not provided health care to everyone. Not having health insurance adversely affects access to health care, which in turn affects mortality and morbidity. A study published in the American Journal of Public Health calculated that there were approximately 45,000 excess deaths because of the absence of universal health coverage.

Numerous research studies have analyzed some of the pathways that lead to these excess deaths, including reduced use of preventive screenings among the uninsured, which means that disease is detected later when it is more difficult and expensive to treat.

When I was the Republican nominee for Congress in 1992, over 35 million Americans lacked health insurance. For all its problems, the Affordable Care Act (ACA) increased access to health insurance for Americans with 13 million people gaining insurance. The problem is that in the 26 years since 1992, we still have 29 million Americans who don't have insurance. Twenty-six years and still 29 million people without inurance.Why? Cost and availability.

The primary focus must be on containing and reducing costs.

We need to look at the health insurance industry to see why costs keep rising. The largest health insurance companies in the United States reaped historically large profits in the first quarter of 2017, despite all the noise surrounding the Affordable Care Act's individual marketplaces. Aetna, Anthem, Cigna, Humana and UnitedHealth Group — the big five for-profit insurers — cumulatively collected $4.5 billion in net earnings in the first three months of 2017. That was by far the biggest first-quarter haul for the group since the ACA exchanges went live in 2014.

The nation's top health insurers reported $6 billion in adjusted profits for the second quarter. That's up more about 29 percent from the same quarter in 2016 — far outpacing the overall S&P 500 health care sector's growth of 8.5 percent

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for the quarter.

Consider UnitedHealth, the nation's largest health insurer announced record-breaking profits in 2015, followed by an even better year in 2016, and this is after the ACA was in effect and supposed to reduce costs. In July 2016, UnitedHealth celebrated revenues that quarter totaling $46.5 billion, an increase of $10 billion since the same time last year.

UnitedHealth's CEO Stephen J. Hemsley made over $20 million in 2015. To be fair, that is a pay cut. The previous year Hemsley took home $66 million in compensation.

Aetna, whose CEO Mark Bertolini reported to the Securities and Exchange Commission a $27.9 million compensation in 2015, has sky-high profits. "In 2015, we reported annual operating revenue of over $60.3 billion, a record for the Company," Aetna told investors.

America doesn't have a healthcare problem; it has an insurance problem coupled with a prescription drug cost problem.

Some would say the only long-term fix to our health coverage problems are to move to a single-payer "Medicare for all" system. Others believe a federally run insurance system, which would eliminate the profit of healthcare insurance companies, is the right approach. Still others believe the free markets provide the best approach, although this has been largely debunked in most countries and in the history of the United States.

What is a health insurance company other than an intermediary that adds costs to a system? Health insurers receive payments from employers, individuals, and governments and then send that money to health care providers such as pharmacy benefits managers, doctors, and hospitals, of course keeping some for themselves to cover overhead and, in some instances, profit. As an example, Stanford University, which has its own medical school, hospital, and doctors, sends money to Blue Shield on behalf of those employees who use Stanford Medical Center services (and others). And then Blue Shield sends that money back to Stanford for the services Stanford renders to its own employees. The obvious questions are: how much does this intermediation cost and what valuable purpose does it serve? I can't be the only person who thinks this is crazy.

Let's consider evidence on the cost issue first.

In 1991, Steffie Woolhandler and David Himmelstein, two Harvard doctors with an interest in health policy, published a paper in The New England Journal of Medicine in which they estimated that health care administration constituted somewhere between 19% and 24% of total spending on health care, an amount that was 117% higher than what it was in Canada and much more than in the U.K. What a waste of money!

It may be time for single nationwide insurance system to take back control of health insurance. As your voice in Congress, I will investigate this. The idea behind a single nationwide insurance system is akin to Medicare, but would offer more options. It gives every American a lower insurance plan because it would include coverage in all 50 states, would provide for a massive reduction in duplicative paperwork and administrative costs, would allow you to see any doctor you wish, and would strip billions of profits and overhead out of commercial insurance companies. It would need to provide at least six key benefits in two categories: long and short term care. The Long-term benefits are: Wellness & Sickness, Invalidity (non-employment disability) and Survivors (minor children who are survivors of a deceased parent). Short-term benefits are: Wellness & Sickness, Maternity, Funeral and Employment Injury. Under a single nationwide insurance plan, contributions to the plan are paid by employees and employers on earnings, and by employers on certain benefits-in-kind provided to employees. We already pay FICA taxes and most people who obtain insurance through an employer have the costs of the insurance taken out of their paycheck automatically, so nothing would change from that perspective, but the costs should go down. The self-employed would contribute the same way they pay FICA. Individuals who are not employed, are disabled, or have some other incapacity, would pay into the system in order to access it. These payments could be based on a percentage of their disability payments or as a set fee each month that would give them access to basic health care needs and also carry a higher deducible long-term care insurance plan.

As long as there is profit for someone being sick nothing will change. People often conflate medical care with the payer system. Insurance companies are multiple payers. Hospitals, doctors and other health care providers have to endure the paperwork of each and every insurance plan they bill. This is a huge waste of time and money that adds to the cost of healthcare: about 9% annually. By going to a national insurance system, the paperwork is reduced to one standardized set. This has nothing to do with sitting in the ER for three hours or more, which occurred pre-ACA, during the ACA and will continue to occur as long as other imperfections, like physician and nursing shortage in rural areas, primary care physicians who are underpaid relative to highly paid surgeons, lack of clinics, and overpriced drugs. Single payer insurance is a solid first step to begin to save time and money like the other western industrialized countries already do and to put that time to reducing the wait time, and then use that money to implement incentives for a healthy lifestyle, func-

tional medicine training for providers, and increase clinics.

What's the downside? Many health insurance companies will go out of business, although the smart ones will offer supplemental health plans for those with the financial means to purchase. Many insurance company employees will lose their jobs, although many will find opportunities to work in the national insurance program.

Let's look at the healthcare market as if having a single nationwide insurance plan is not an option.

Health care costs are like a runaway train. It keeps rolling and rolling, faster and faster, and nobody wants to stand on the tracks to try to slow it down...especially elected officials who have taken money from hospitals, insurance companies, pharmaceutical companies, and medical groups.

There are many ways to lower costs of care and make it more affordable and better for America's citizens. While the Republicans have tried multiple times to repeal the ACA, they never succeeded. **Now is the time to fix what doesn't work and increase those areas of the ACA that are most beneficial.** To do so we must first step back and look at what an effective national healthcare reform program must include:

1. Retain the provision forbidding discrimination based on pre-existing conditions as this is a vital part of ensuring people obtain and remain on insurance.

2. Allow those under 25 years old, living at home, to remain on their parents' healthcare plans.

3. Allow portability of employer-sponsored plans, if they are not part of a national insurance program, enabling someone who leaves an employer to continue on the employer's plan indefinitely; essentially converting it from an employer plan to a personal/family plan. This isn't Cobra, but the conversion of a plan from employer-based to private. Of course, if the person moves to another company that offers healthcare, they would convert to that company's plan.

4. Most physicians believe that good oral and vision health leads to better overall health, so any health plan that is comprehensive in nature should include dental and vision coverage. The idea that we have to purchase separate plans for these two important coverages is dated and needs to be eliminated. It's the equivalent of telling women they have to purchase pregnancy insurance—something that used to occur prior to ACA and rightfully was resolved in ACA. Vision and dental must be included in any new healthcare program.

5**. We must examine costs at a granular level at which clinical outcomes are matched with the business and administrative processes.** Demand-side options, such as consumer-directed health plans, to supply-side options, such as alternative methods to pay care providers, can reduce costs significantly. For example, a standardized insurance claim form, available via digital submission, used across all physicians and insurers, will lower administrative costs significantly, by millions of dollars in man-hours, paper costs, and other administrative expenses. It will also cut down on errors. Harvard Business Review reported that administrative complexity eats up 9% of the nation's health care expenditures.

6. For coverage of uninsured the approach should be that every American needs to be covered by a plan whether it is private, employer-based, public (Medicare/ Medicaid), association-based, or a new single source nationwide insurance system. Instead of the "fine" that Obamacare enacted, anyone not enrolling in a plan should be auto-enrolled in a single payer major medical plan that kicks in when emergencies or catastrophe occurs and carries a very high deductible—perhaps $15,000 or $20,000, but a very low monthly subscription rate that is affordable for these enrollees and is billed monthly until the individual enrolls in a formal plan such as available through an employer or the ACA. This solves the fear of "people dying in the street" which most Americans do not want. We are a caring nation and we want those who cannot afford health care to be able to get care.

Since many of the people who do not buy health insurance are under the age of 30, creating a "*Comprehensive Coverage"* program that costs only $59-$99 a month is a safe insurance policy against disaster and would result in almost $34 billion a year paid into the program by those not currently insured.

Even with ACA, millions of Americans still do not have health insurance. Many uninsured people cite the high cost of insurance as the main reason they lack coverage. In 2015, 46% of uninsured adults said that they tried to get coverage but did not because it was too expensive. Many people do not have access to coverage through a job, and some people, particularly poor adults in states that did not expand Medicaid, remain ineligible for financial assistance for coverage. Some people who are eligible for financial assistance under the ACA may not know they can get help, and others may still find the cost of coverage prohibitive.

Most uninsured people are in low-income families and have at least one worker in the family. Reflecting the more limited availability of public coverage in some states, adults are more likely to be uninsured than children. People of color are at higher risk of being uninsured than non-Hispanic Whites.

7. We must enact reforms on pharmaceutical drug pric-

ing. As the President & CEO of a pharmaceutical and nutraceutical company, I can tell you the average cost to bring a prescription drug to market through the FDA process takes about 12 years and costs an average of $1.4 billion. Surely pharmaceutical companies must recoup their investment, but currently, they rely mostly on the US consumer to do that. These costs need to be spread across the global market which will lower costs for American's in need of prescription medications.

The United States spends almost $1,000 per person per year on pharmaceutical drugs. That's around 40 percent more than the next highest spender, Canada, and more than twice as much as than countries like France and Germany spend.

As your voice in Congress I will write legislation to create a Median Pricing Program. This is a program I designed that provides pharmaceutical companies a solid return on their investment, reduces costs to consumers, and would reduce by 40% of the cost of prescription drugs.

Under a Median Pricing Program, n**o drug provider who obtains FDA approval to market a drug in the United States can charge American consumers more than 110% of the average price of their drug worldwide.** This will upset Wall Street and the pharmaceutical companies, but it is only fair that Americans not be gouged by drug companies. If drug companies want access to the most lucrative market in the world, they can play by our rules.

The pharmaceutical companies will adapt to earn more revenue overseas which will force them to raise their prices worldwide and not stick Americans with the biggest drug bills. If they want to sell in our market, they have to adhere to this law.

Under our plan, Celebrex, a popular pain and inflammation drug, would not cost $330, but $115.24 ($120.73 global average cost plus 10%). Cymbalta, which millions of Americans take to battle depression and fibromyalgia, would not cost $240, but $76.45 ($69.50 global average cost plus 10%).

Imagine what this would do for someone spending $200 a month on medications? They'd see about an $80 discount to today's pricing, resulting in approximately $1,440 a year savings. Most Americans can do a lot of good things with an extra $1,440 a year.

Enacting and enforcing a Median Pricing Program requirement would dramatically lower the costs of drugs for the Medicare/Medicaid program and would likely reduce total drug expenditures by more than 40% nationwide.

8. If a Median Market Pricing law cannot be passed, we must allow Medicare to negotiate to lower drug prices. Authorizing Medicare to negotiate directly with drug companies to set prescription drug prices will lower costs—the challenge is the people most against allowing Medicare to do this are Republicans. The Medicare Modernization Act of 2003 (MMA), which established Medicare Part D, included a ban on such negotiation. In theory, if the Centers for Medicare and Medicaid Services (CMS) could negotiate with pharmaceutical companies, the agency could leverage its purchasing power to pay less for drugs. The idea has broad public support, reflected in a recent poll showing 87 percent of Americans have a favorable view of the idea.

CMS's proposed a pilot on value-based drug purchasing in Medicare Part B. (While most prescription drugs covered by Medicare are managed in Part D, certain drugs, such as those administered via infusion by physicians, are managed in Part B.) I believe this pilot program could generate useful data and could be initiated without Congressional action.

The Part B pilot continues to receive significant backlash funded by the pharmaceutical industry and has resulted in increased Congressional scrutiny of CMMI's activities. House Republicans even introduced a bill (H.R. 5122) to prohibit further action on the proposed Part B pilot, even though CBO estimates that blocking the project would cost $395 million in direct spending over the next 10 years. The pilots should proceed and then pilots on Part D should follow a similar pattern to build evidence for value-based drug pricing or other reforms that will finally bust the gridlock, prove to elected officials that negotiating drug prices is the best thing for our country, and results in lower drug costs for Americans.

9. Earmark all settlements with drugmakers and device makers to be applied to help offset costs of the Medicare program.

A report by Public Citizen, the Washington DC-based health care advocacy group, ranks the largest settlements by drugmakers, and shows these companies paid out 74 settlements to the tune of $10.2 billion from Nov. 2010 to July 2012. The report does not include J&J's $5+ billion settlements. Where does this money go? The public doesn't know because we're never told where these fines end up. Let's pass legislation to earmark all settlements with drugmakers and device makers to be applied to help offset costs of the Medicare program.

10. As citizens we must take better care of ourselves and a simple rule requiring every insurance plan to cover one yearly healthcare screening, with no copay by the individual, to detect and prevent health issues should be

mandated. If you want insurance, you need to see a doctor at least once a year, have a blood test, perform a cardio/stress test, receive advice on healthy diet and exercise, etc. **In the long run, because of early detection of illnesses, this will save lives and money.** If you don't make your yearly physical screening, you should face a fine of $75 with the proceeds going into the general insurance fund. Consumers need to start taking their health care decisions seriously and this would help accomplish that goal.

Create jobs. In addition, if 328 million people require annual screenings, the demand growth for doctors, registered nurses, clinics and testing laboratories would boom, creating hundreds of thousands, if not millions of new jobs.

Clinical waste (spending that could be reduced with better prevention and high-quality initial care) is estimated to consumer 14% of our nation's health care expenditures. Annual screening may even be able to be accomplished by nursing professionals—registered nurses—with doctors reviewing the test results and having a consultation with the patient, after the results are returned. And as a preventive measure annual screenings can do much to lower costs.

11. Many members of Congress like to talk about eliminating the artificial boundaries that separate health insurance providers, the so-called "letting insurers sell across state line". This is what I call *"political do-nothing talk"*.

Sabrina Corlette, the director of the Georgetown University Health Policy Institute and co-authors completed a study of a number of states that passed laws to allow out-of-state insurance sales. Not a single out-of-state insurer had taken them up on the offer. As the study found, there is no federal impediment to across-state-lines arrangements. The main difficulty is that most states want to regulate local products themselves. The ACA includes provisions to encourage more regional and national sales of insurance, but they have not proved popular. The challenge is cost: plans simply don't have incentives to create doctor networks in other states without first having a large base of policy holders. Let's stop kidding ourselves with thoughts that this is an approach that will lower costs. It won't.

12. Any health care program should allow our Armed Forces and Veterans to see the doctor, clinic, or hospital of their choice. This is a plan both Republicans and Democrats should be able to get behind.

13. Fifty percent of Americans take multivitamins. 1 in 5 U.S. adults takes herbal supplements. Most people do not need to take any supplements as they get enough vitamins from their food. The U.S. Preventive Services Task Force doesn't recommend regular use of any multivitamins or herbs. The FDA only spot tests 1% of the 65,000 dietary supplements on the market. All these are reasons the FDA should require truth in labeling and testing of all dietary supplements to prove the ingredients being touted are actually in the supplements being sold.

There are an estimated 85,000 dietary supplements sold in America generating over $30 billion in annual revenue, but the producers are largely unregulated and stories of false ingredient labels are rampant. It is time that dietary supplements (diet, vitamins, muscle building, etc.) be required to have their ingredients and doses confirmed by the Food & Drug Administration prior to being sold to the public.

How bad are many of these supplements? This is a transcript from a recent ***PBS Frontline*** series where a hospital addresses the difficulty in obtaining accurate data—if at all—related to supplements that patients bring into the hospital. It's shocking.

SARAH ERUSH, Pharm.D., Pharmacy Clinical Manager:

"Families are showing up literally with shopping bags full of dietary supplements. The regulatory issues in the United States are that you have to— if a patient brings a medication into a hospital, we have to, as pharmacists, verify that this is a quality product, it is what it says it is, it's labeled appropriately, it's being dosed appropriately, and so on."

PAUL OFFIT, M.D., The Children's Hospital of Philadelphia:

"We got fed up. We took a step back and we said, "OK, we're going to ask these companies to at least meet a labeling standard." They have to send us something called a certificate of analysis, which means they've had their product analyzed by an independent party that says that what's on the label is what's in the bottle."

"Ninety percent of the companies never responded. And of the 10 percent that responded— of that 10 percent, often they would send us certificates of analysis where what was on the label wasn't even close to what was in the bottle. And these were the ones who responded to us, which made us fearful of an industry that we couldn't trust."

SARAH ERUSH:

"For example, this is an aqueous Vitamin D drop. So we use Vitamin D in premature infants. It says it should have 400 International Units per one ml of solution. However, it tells us that the results are that it's 213 percent of the legal value. So it's more than double what it says that it is."

"So if we're dosing premature infants who need very tiny doses if this drug, we're now potentially giving them double what they should get, and could really put them at risk for toxicity."

GILLIAN FINDLAY (Journalist):

In the end, only 35 supplements met the hospital's standards.

Not only is this shocking, it is also dangerous.

Dietary supplements represent a hidden danger to the American public and can lead to illness or death. The FDA's charter is to set regulations is to ensure that the system best protects and promotes the public health and the well-being of patients. We cannot meet this goal if supplements are not put under FDA oversight. Fees from these approvals should be applied to operating the FDA and supporting both public and *"Comprehensive Coverage"* insurance programs. I believe any health care program for Americans must include the FDA oversight of dietary supplements---even if it is simply to prove that what is in a supplement is what is reflected on the label.

[In the interest of openness, my company, TRICCAR, ormulates dietary supplements and pharmaceutical medications that will require FDA approval to bring to consumers. While we conduct double-blind studies on our products' efficacy and only work with trustworthy bottling and packaging companies, this proposal would negatively impact our bottom line. However, if this leads to better control over the supplements market, providing consumers with safer products and telling them exactly what is in each product, then it's worth it to have more safety in the market.]

14. For years some elected officials have rallied against the abortion industry while also not requiring health plans to cover contraceptives. Meanwhile, single motherhood, babies born out of wedlock, and fatherless families have increased. 26 of the last 27 mass shooters came from fatherless families? Coincidence?

As a nation, we can't have it both ways. Contraceptives for men and women should be part of every health insurance plan offered in America. If you have a moral objection to a man using a condom, then don't buy condoms. If you morally object to your health insurance paying for the birth control pill for a single mother of three on welfare, then don't complain when welfare expenses have to be increased to pay for a fourth baby. I also believe that any woman receiving CHIP or welfare benefits should be offered free birth control as part of her benefits.

When you look deeper—*beyond the rhetoric, shouting, name calling, and rancor*—you realize the abortion issue is not about pregnant women wanting abortions: *it is about unwanted pregnancies.*

There are many reasons a woman chooses to have an abortion. Maybe they can't afford a pregnancy and a child. Maybe they have health problems. Maybe they are not in a place in their lives where they can properly care for a child. Maybe they are minors. Or maybe, they just don't want to have the baby.

Regardless of their reasons, the core cause of abortion is an unwanted pregnancy. Naturally, the way to end abortion is to stop unwanted pregnancies from occurring in the first place. If a woman never becomes pregnant without wanting to be pregnant, there would be no need for abortion, and the divisive debate could finally end. In my policy statements on Women's Issues, I write about the need to make contraception more readily available and affordable and the requirement that we better educate young women about what birth control does and doesn't do. Why do I do this? Because it is a means to and end; a chance to reduce abortion rates and help women who are under-educated about sex, diseases, and pregnancy.

Abortion is already difficult to obtain in 90% of the United States and for most women, it is a last resort that comes with complex emotional and moral dilemmas. The Supreme Court has ruled that it is legal and continued efforts to limit its access without understanding what leads women to seek abortions and how to prevent pregnancies in the first place is not helpful. The real problem is America has an access to birth control, personal responsibility, and education problem.

Many staunch conservatives believe that birth control should not be offered to women. But being too frugal by opting for a "free" but relatively ineffective method, such as abstinence, fertility awareness or withdrawal, can easily lead to accidental pregnancy. Add in the transmission of diseases, including HIV, and it's a recipe for long-term higher costs to taxpayers.

A couple using no birth control has an 85% chance of becoming pregnant in one year, and yet, many simply don't understand the likelihood of pregnancy. Thirty-eight percent of all women of reproductive age are not currently using a contraceptive method.

All of the contraceptive methods, from the Pill to shots, to sterilization, are cheaper than the cost of carrying a baby to birth which is estimated to average between $12,000 and $18,000. They are certainly cheaper than raising a child to age 18.

This begs the question of why so many people and elected officials—*mostly men*—want to prevent government spending on contraception, at $300 a year for prevention, as a means to prevent unwanted births and abortions. From a financial standpoint to our country, providing birth control for free, at cost, or even reduced retail rates, is much better than

not. The average yearly payment to a woman on WIC with one child is $2,504. If one-third of women who are on or may end up on WIC were to accept free contraception, the American taxpayer would save over $1.1 billion a year. That's money that could be better spent in education or providing more safety in every school in America.

Plus, regardless of the financial benefits, this will decrease the number of abortions, which is what the pro-life side wants, and, in speaking with the 312 women who took my survey regarding contraception and abortion, the pro-choice side wants as well. Ahhh…compromise. Could it be that because both sides have been battling over the medical procedure of abortion that they've failed to realize a common ground is possible?

Abortion rates are already trending downward. Offering low-cost or no-cost contracteptive options could bring it down dramatically more. The Center for Disease Control states there are about 650,000 legal abortions performed each year. This is a drop of about 21% since 2008. That's a positive trend.

The highest percentage of abortions occurred in the Washington, DC/District of Columbia (38%), New York (33%), and New Jersey (30%). California and Florida reported about 222,000 abortions, with the majority—53%—being performed on women who are Black or Hispanic and predominantly poor. Nevada's abortion rate has steadily dropped the past ten years: the state reported 7,294 abortions in 2016, a large reduction of 32.4% over 2008.

Summary

Ours is a health system of unbelievable heights, offering innovations and levels of care many nations do not. But we are also a nation of catastrophic lows: vast underserved areas, inaccessible medical records, tens of millions of uninsured and opioid addicts dying in the street.

We can do better. We can have our outstanding medical inventions, lower the costs of insurance and medications, improve the safety of nutraceuticals and dietary supplements, provide a dignified social safety net, and still staff the Mayo Clinic. We can no longer pretend health care is a zero sum game that risks our collective prosperity. Rather, productivity surrounding the care we provide to one another represents almost 18% of our economy. Healthier people equals a more prosperous economy.

We must fix the problems of the Affordable Care Act in a way that protects and treats all Americans and the only way to do that is through reducing or eliminating insurance company profits, providing Americans the choice of choosing their own physician, covering all maladies from head to toe, including vision and dental, and working to streamline the paperwork costs that eat up 9% of our healthcare expenditures.

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