



NATIONAL HEALTH COUNCIL

## **Policy Recommendations for Reducing Health Care Costs**

Updated September 2021

### **Introduction**

The National Health Council (NHC) is committed to promoting a society in which all people have equitable access to high-quality health care designed around the health outcomes most important to patients. One of the biggest barriers to access and health equity is the rising cost of care, especially for the more than 160 million American with at least one chronic disease and/or disability.

The NHC's Reducing Health Care Costs (HCC) Initiative, which began in 2016, critically screens a range of policy proposals designed to curb health care costs and establish policy recommendations. The HCC Initiative prioritizes patient-centered policies that contribute to equitable health care access. This document reflects the most recent update, completed in September 2021, to the policy recommendations produced under the NHC's five-year HCC Initiative.

Under our most recent analysis, the NHC screened a diverse set of policy proposals against a patient-centered framework with four driving principles. To guide recommendations, the policies must:

- Promote high-value care;
- Stimulate research and competition for health care products and services;
- Curb costs responsibly; and
- Ensure health equity.

Once screened, the NHC focused on a set of policy recommendations that: 1) align with the above principles, 2) demonstrate the potential to result in cost savings for patients and/or the health care system, and 3) have a reasonable likelihood of gaining sufficient political support.

Across its various programs and policy priorities, the NHC is committed to increasing access to sustainable, affordable, high-value care. As such, for each policy we recommend, we uphold that savings achieved through policy reforms must be directly reinvested to benefit patients and the systems that support them. While many of our recommendations would include upfront costs to the government or health care system, we feel these investments are crucial to ultimately reduce costs patients pay to manage their chronic conditions.

The NHC strongly opposes policies that achieve savings if they negatively impact patient safety, quality, or access to existing or future care. Additionally, it is important that any efforts designed to reduce health care costs must be predicated on promotion of value as defined by the patient. The NHC actively supports efforts to better incorporate patients into the ongoing debate on defining value in health care.

The 2021 list of NHC HCC policy recommendations comes at a critical time when policymakers in Congress and the new Administration are debating efforts to improve health care access and reduce Federal expenditures, with discussions focused on coverage expansion, drug pricing reform, and health equity. As the health care reform debate progresses, it is essential policymakers understand the impact of various proposals on patients and prioritize ones that best limit patient financial barriers to accessing care, including the policies described below.

## **2021 NHC HCC Priority Policy Areas and Recommendations**

The NHC and its Board of Directors, with input from its members, identified four main policy priority areas that have the potential to reduce costs for patients and the health care system:

### **1. Reduce barriers for the development of generic and biosimilar products, and expedite approval of certain generic applications<sup>1</sup>.**

- Curb patent settlements or other patent-based strategies that delay patient access to lower-cost medications (e.g., pay-for-delay).
- Require the Food and Drug Administration (FDA) to further prioritize review of applications, including applications for generic products, where there are no or few generic options available or in instances of a drug shortage.
- Support the development and coverage of biosimilars to promote competition and drive access to lower-cost products while ensuring appropriate prescribing through patient and provider education and removal of disincentives in the current rebate system that may create scenarios where higher-priced, higher-rebate products are preferred over lower-cost biosimilars.

### **2. Improve coverage and reimbursement requirements to expand patient access and promote value.**

- Update the Part D benefit structure to include the lowest possible out-of-pocket (OOP) limit in order to benefit the greatest number of patients, allow for certain patients facing high cost sharing to pay these amounts over the course of the year (instead of all at once), eliminate the coverage gap, and lower government liability by increasing plan and manufacturer liability throughout the Part D benefit.
- Build on the Center for Medicare and Medicaid's (CMS) Medicaid Value-Based Purchasing Final Rule ([CMS-2482-F](#)) and encourage outcome-based contracting/value-based arrangements by allowing new flexibilities

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<sup>1</sup> Any policy that requires additional FDA staff must include additional agency funding.

related to the anti-kickback statute, Stark law, and pricing metric calculations (e.g., Best Price). In advancing these flexibilities, CMS must engage patients and encourage the engagement of patients by eligible entities to ensure that any outcome-based measures reflect the needs and priorities of patients.

- Leverage the Patient Centered Outcomes Research Institutes (PCORI)'s "new mandate" ([PCORI 2019 Reauthorization](#)) to consider the full range of patient outcomes to create new methods and evidence for evaluating the wide range of impacts patients report as important to them beyond typical health outcomes, such as economic burdens on patients and families. These patient-centered impacts should be the focus of activities such as research, clinical trials, and/or value assessments.
- Experiment with greater use of Medicare, Medicaid, and private health-insurance funding for services that are not traditional medical interventions but support better health outcomes that are identified as a priority by patients. Funds could be used for, among other purposes, addressing food insecurity, providing transportation for health-related activities, and making housing accessible and healthier.
- Require states to allow for Medicare beneficiaries below age 65 to be eligible for Medigap supplemental insurance with coverage equivalent to that available for age-eligible Medicare beneficiaries.
- Require manufacturers to pay rebates to CMS if Part B or Part D net prices exceed the rate of inflation and ensure that CMS reinvests paid rebates to directly benefit patients' ability to access and afford their care. While current proposals focus only on list-price growth, policymakers should consider how growth in net prices should be integrated into any policy that looks to reduce drug spending.

### **3. Support chronic disease management and prevention.**

- Expand access to home and community-based services (HCBS) in Medicaid, for example, by enhancing the Federal matching funds available to states to provide HBCS services, as proposed in the [Better Care Better Jobs Act \(S. 2210\)](#) and by rebalancing home and community based services under Medicaid by making permanent the Money Follows the Person Demonstration Program, as proposed in [H.R. 1880](#).
- Break down financial barriers for patients to receive coordinated care by requiring or incentivizing adequate coverage for patient-centered services and supports that are proven to reduce costs and manage chronic diseases. Examples include removing the cost-sharing currently required for chronic-care management services under Medicare and improving coverage of tobacco cessation products and services.
- Invest in the Federal public health system and prioritize public health programs through the Centers for Disease Control and other Federal entities that address disease prevention and management

#### **4. Promote meaningful transparency on price and cost sharing.**

- Provide enhanced tools for patients to understand insurance coverage of products and services (including cost sharing) to drive informed action at crucial points of decision making, such as at the time of plan selection (through improvements to Medicare Plan Finder and/or HealthCare.gov), at the time of prescribing, and/or at the time of treatment decisions (such as by building on changes made by Congress and CMS to advance real-time benefit tools).
- Require manufacturers to report meaningful information and disclose supporting documentation needed to justify price increases for drugs, biologicals, and biosimilars. Reported information includes but is not limited to:
  - A narrative of factors contributing to the drug's pricing;
  - Information demonstrating comparative patient value;
  - Acquisition information if the drug was not developed by the current manufacturer;
  - Aggregate research & development expenditures; and
  - Aggregate rebates, discounts, and other concessions that reduce the effective price.
- Expand CMS' reporting on drug costs and spending, including price concessions and rebates, to help inform cost-containment strategies and drive informed action by health care stakeholders.
- Create a mechanism to ensure some or all cost savings to a plan/pharmacy benefit manager resulting from rebates, fees, and/or any other negotiations and price concessions are passed through to the patient, such that patients have lower OOP costs for drugs that have greater rebates.

The NHC looks forward to working with patients, health care stakeholders, and policymakers to advance the policy recommendations listed above to ensure better health care access and lower costs for patients.