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Subcommittee on Health, Employment, Labor, and Pensions

Competition and Transparency: The Pathway Forward for a Stronger Health Care Market

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Chairs Good and Foxx, Ranking Members DeSaulnier and Scott, members of the Subcommittee, thank you for the opportunity to testify today at this critical hearing focused on health care affordability, transparency, and competition. It is an honor to be with you this afternoon. My name is Sophia Tripoli, and I am the Senior Director of Health Policy at Families USA and the Director of our Center on Affordable Whole Person Care. For more than 40 years, Families USA has been a leading national, non-partisan voice for health care consumers working to achieve our vision of a nation where the best health and health care are equally accessible and affordable to all. In October 2022, we launched the Center for Affordable Whole Person Care in affirmation of our commitment to revolutionize America's health care system to hold the health care industry accountable for delivering affordable, equitable, high-quality health care.

The U.S. Health System in Crisis

Today's hearing is urgently needed. Our health care system is in crisis, evidenced by a lack of affordability and poor quality.[1] And it is going to take all of us working together, across political party and health policy philosophy, from rural and urban communities alike, to fix it.

At its core, our nation's affordability crisis is driven by a fundamental misalignment between the business interests of the health care sector and the health and financial security of our nation's families – a business model that allows industry to set prices that have little to do with the quality of the care they offer. These high and irrational prices are largely due to trends in health care industry consolidation that have eliminated competition and allowed monopolistic pricing to push our nation's families to the brink of financial ruin.[2]

The good news is that you and your colleagues in Congress have the support of the American people in making needed changes. Ninety-three percent of Americans agree that our country is paying too much for the quality of health care we receive, and more than half of adults in that same poll said that their most recent health care experience was not worth the cost.[3] Brand new polling shows that almost 90% of voters say it is important for this Congress to take action to reduce hospital prices, including 95% of Biden voters and 85% of Trump voters.[4]

It is not surprising that Americans are united around the urgent need to address these issues. Almost half of all Americans have reported having to forgo medical care due to the cost, and almost a third have indicated that the high cost of medical care is interfering with their ability to secure basic needs like food and housing,[5] and over 40 percent of American adults – 100 million people – face medical debt.[6] High and rising health care costs are a critical problem for national and state governments, and affect the economic vitality of middle-class and working families – crippling the ability of working people to earn a living wage. Today's real wages – wages after accounting for inflation – are roughly the same as four decades ago, while employer health insurance premiums have risen dramatically.[7] At the same time, nearly 90% of large employers say that rising health care costs will threaten their ability to provide health care benefits to employees over the next five to 10 years if costs are not lowered.[8]

Notably, the excessive cost of health care does not generally buy Americans higher-quality care or even higher volumes of care. In fact, the opposite is true. Despite spending two to three times

more on health care than other industrialized countries, the United States has some of the worst health outcomes, including some of the lowest life expectancy and highest infant mortality rates.[9,10,11] These health outcomes are even worse for people of color who experience higher rates of illness and death across a range of health conditions compared with their white counterparts.[12]

These abysmal health outcomes and extraordinarily high prices are the product of broken financial incentives within the U.S. health care system. Our current system rewards building local monopolies and price gouging instead of rewarding success in promoting the health, well-being and financial security of the community.[13] And hospital prices in particular have become highly problematic as the role of hospitals in our economy has shifted over the last 60 years from charitable institutions to corporate entities, resulting in a fundamental misalignment between the business interests of the hospital sector and the interests of the patients they serve.[14] These higher prices result in $240 billion annually coming out of workers' paychecks and instead becoming profits for large health care corporations.[15,16,17]

Health Industry Consolidation Driving High Prices

America's health care affordability crisis stems from high, rising, and variable prices across a wide range of health care goods and services, including prescription drugs and diagnostic tools such as MRIs and CT scans. For example, the price of Humira — a drug used to treat arthritis — is more than four times as expensive in our country as in the United Kingdom and almost twice as expensive as in Germany.[18] The average price of a hospital-based MRI in the United States is $1,475.[19] That same scan costs $503 in Switzerland and $215 in Australia.[20] These higher prices for an identical service are the main driver of the dramatic increase in per capita health care spending in our country, where health care accounted for nearly 20% of the nation's GDP in 2020, far exceeding health care spending by any other industrialized country.[21]

These irrational and unjustifiable prices are largely due to trends in health care industry consolidation that have eliminated competition and allowed monopolistic pricing to flourish.[22] This consolidation has taken place without meaningful regulatory oversight or intervention, and is becoming more acute.[23] In fact, there are few truly competitive health care markets left, with 95% of metropolitan statistical areas (MSAs) having highly concentrated hospital markets, nearly 80% of MSAs having highly concentrated specialist physician markets, and 58% of MSAs having highly concentrated insurer markets.[24]

- **Hospital consolidation:** Hospital mergers are occurring more frequently both within and across health care markets, leading to higher prices in both cases. According to the American Hospital Association, there were 1,577 hospital mergers from 1998 to 2017.[25,26] An estimated 40% of those mergers took place from 2010 to 2015.[27]

- **Insurance consolidation:** Insurance markets are not as highly concentrated as providers, but there is evidence of markets with little competition between insurers. Between 2006 and 2014, the four-firm concentration ratio — the extent of market control held by the four largest firms, Aetna, Blue Cross Blue Shield, United and Anthem — for the sale of private insurance increased from 74% to 83%.[28]

- **Vertical Integration:** The number of hospital-acquired physician practices grew from 35,700 in 2012 to more than 80,000 in 2018.[29] Over this same time period, the percentage of physicians employed by a hospital or health system nearly doubled, from 25% to 44%.[30] Recent research found that over 55% of physicians are now employed in hospital-owned practices.[31] This trend was accelerated by the COVID-19 pandemic, which exacerbated the financial vulnerabilities of independent and smaller physician practices and threatened the near collapse of entire sectors of the health care system — particularly primary care.[32] Nearly 23,000 physicians left independent practice to work for a hospital or other corporate entity after the onset of the COVID-19 pandemic, while hospitals and other corporate entities acquired nearly 21,000 additional physician practices from 2019 to 2020, representing a 25% increase in corporate-owned practices.[33]

- **Mergers and Vertical Integration of Pharmacy Benefit Managers (PBMs), Insurers, and Pharmacies:** Though big drug companies bear the lion's share of the responsibility for our high and rising drug costs, other industry players also contribute.[34] Just as consolidation in hospitals and large health care corporations causes price increases, similar trends in consolidation among PBMs, insurers, and pharmacies can lead to increased costs for patients who are trying to access and afford their medications.[35] The top three PBMs, all of which are affiliated with major insurers and/or pharmacies, control 80% of the market: CVS, including Caremark and Aetna; Express Scripts owned by Cigna; and Optum owned by UnitedHealth Group.[36] As PBMs buy up more and more of the market, they have increased negotiating power with drug manufacturers, which results in pricing structures that serve PBM financial interests at the expense of the financial security of our nation's families. For example, a Delaware state auditor report found Express Scripts overcharged the state employee prescription drug plan by $24.5 million.[37] Or, take the Ohio Department of Health which found that CVS Caremark and Optum Rx pocketed the nearly 9% difference between what they billed managed care plans and what they paid pharmacies instead of passing those savings on to families.[38] Consolidation in the PBM market also allows PBMs to prioritize the pharmacies they own, which reduces patient choice and access to some drugs by "steering" patients to specific pharmacies.[39] As of 2017, PBM-owned pharmacies represented 46% of the industry's revenue growth.[40] This is a major threat to the ability of independent pharmacies to operate and threatens access to pharmaceuticals for millions of families living in rural and underserved communities.

Hospital Pricing Abuses

Nowhere is the negative impact of consolidation more evident than the rising cost of hospital stays and services, which have increased dramatically in the last decade and make up a large portion of increasing health care costs overall.[41,42,43] These cost increases have occurred despite lower hospital utilization and are largely due to escalating prices, which are the result of hospitals buying other hospitals and community doctors to eliminate competition and form big health care corporations and medical monopolies.[44,45]

Americans in many communities have watched as their local hospitals became health systems, and those health systems were bought by large health care corporations. What most in the public and

policymaking community have not realized is how much this has destroyed any real competition in our health care sector, allowing hospitals to dramatically increase their prices every year.[46,47] Between 1990 and 2023, hospital prices have increased 600% – and just since 2015, hospital prices have increased as much as 31% nationally, now accounting for nearly one-third of U.S. health care spending, and growing more than four times faster than workers' paychecks.[48,49,50,51]

These high prices, combined with intentionally opaque billing practices, often hit consumers at their most vulnerable moments. Consider the story of Nicki Pogue:

> *In August 2018, Pogue ran a high-altitude trail race with a chest cold. After returning home she started having difficulty breathing, rapid pulse, tingling in her extremities, dizziness, and had difficulty walking. Her neighbor rushed her to the closest hospital where they ran multiple tests – an EKG, chest X-rays, and blood tests – but they could not pinpoint what was wrong with her. Luckily after four hours she stabilized and was sent home. A month later, a $13,000 bill arrived. When she reviewed her bill, she noticed that the biggest charge was a mysterious line item for "ER EX/TX RM LEVEL V," which came with a fee of more than $11,000. She had no idea what this charge was and did not get any transparency or explanation from the hospital. She spent the next five months working to decipher the bill on her own, only to discover the hospital had miscoded her Emergency Severity Index and severely over-charged her.*[52]

High and Irrational Prices Fueled by a Lack of Transparency

Importantly, hospital prices are not only high, but have become essentially irrational:

- In 2020, across all hospital inpatient and outpatient services, employers and private insurers paid on average 224% of what Medicare pays for the same services.[53]
- Prices at hospitals in concentrated markets are 12% higher than those in markets with four or more rivals without any demonstrated improvement in the quality or access to care.[54,55,56] All the while, the workforce in these concentrated markets suffers – wages for nurses and other health care workers decrease significantly after mergers and acquisitions.[57]
- Prices for the exact same service vary widely, sometimes even within a single hospital system:
    - A colonoscopy at a single medical center in Mississippi can range from $782 to $2,144 depending on insurance.[58]
    - At one health system in Wisconsin, an MRI costs between $1,093 and $4,029 depending on level of insurance.[59]
    - Across the country, the average price for a knee replacement ranges from $21,976 in Tucson, Arizona to $60,000 in Sacramento California.[60]
    - The price of an MRI at Mass General Hospital in Boston Massachusetts ranged from $830 to $4,200 depending on the insurance carrier.[61]

What's more, consumers and employers, who are the ultimate purchasers of health care, have limited insight into what the prices of health care services are until after they've received a bill. For the majority of Americans – 66% – who receive health care through private insurance,[62] health

care prices are established in closed-door negotiations between large hospital corporations and health plans based on who has more market power.[63] These health care prices, often referred to as the negotiated rate, are buried in proprietary contracts without allowing for insight into or oversight over the price of health care services by the public and policymakers.[64] Health care is one of the only markets in the U.S. economy in which consumers are blinded to the price of a service until they receive a bill after the services is delivered.[65] It is the epitome of a broken market that threatens the financial security of American families and fails to serve their needs.

Congress has the Power to Fix our Broken System

It does not have to be this way. We know what the major drivers of high and irrational health prices are, and we know how to fix them. As federal lawmakers, you have an obligation to carefully steward our national health care resources and taxpayer dollars. We urge the Committee to consider well-vetted, bipartisan, and commonsense legislation that would remedy some of the most obvious health system failings, and to take on rising health industry consolidation among hospitals, insurers, and other health care organizations that enables anticompetitive behaviors, prevents healthy competition in markets and results in monopolies that set outrageous and unjustifiable prices. Policymakers should also ensure there is a great deal more transparency around both the cost of care and health care outcomes, including for vulnerable populations living in rural America, people of color and people living with disabilities.

<u>Price Transparency</u>

One crucial way this Committee can address provider consolidation and encourage competition in the health care system is through price transparency. Unveiling prices is a critical step towards achieving truly affordable health care, improved health, and more competitive health care markets across the U.S. health care system. Price transparency pulls back the curtain on prices so that policymakers, researchers, employers, and consumers can see how irrational health care prices have become and take action to rein in pricing abuses.[66] Further, unveiling prices can specifically inform where the highest and most irrational prices are occurring in the health care system, so policymakers can implement more targeted policy solutions to bring down the cost of health care.[67]

Consumer advocates have long sought transparency in health care prices. Following years of consumer advocacy, the Center for Medicare and Medicaid Services (CMS) finalized the Hospital Price Transparency Rule and Transparency in Coverage Rule, which require hospitals and insurers respectively to disclose health pricing information, including their negotiated rates and to provide consumer-friendly online tools to allow consumers to compare prices and estimate out-of-pocket costs.[68]

Taken together, these two regulations mark a critical step forward in driving towards higher value health care across the US health care system. While this rulemaking represents progress, more work is needed to achieve meaningful transparency of health care price and quality data. To achieve this goal, Transparency in Coverage regulations should be strengthened and codified to improve the quality and usability of the data files to ensure the data is actionable. This can be

achieved by enacting at least one of several policy options including establishing a national data format and file standard, reducing the redundancy of the data files, and regularly assessing the data quality to address poor data quality and make needed corrective actions.[69]

And while not the primary focus of this Committee, compliance with and usability of data from the Hospital Price Transparency Rule remains poor[70] and we encourage you to work with the other committees of jurisdiction to push back on industry gaming to skirt the rule's conditions by sharpening data requirements and establishing standard formats, eliminating loopholes, and further increasing penalties to encourage greater compliance by hospitals. Ultimately, policymakers must pass legislation that creates a national database such as a national All-Payer Claims Database (APCD) to house health care cost and quality data, claims data and clinical data that would allow policymakers, researchers, employers and consumers to analyze health care costs and quality data in order to drive higher value care into the health care system and lower costs for America's families. Because the Employee Retirement Income Security Act of 1974 (ERISA) preempts states from enforcing regulations on self-funded employer-sponsored health plans, which accounts for 65% of the data in the employer-sponsored insurance market, these self-insured plans are exempt from any state laws that attempt to collect health care cost and quality information. As a result, Congressional action is needed to access this data. This committee is the only committee that has the jurisdiction to make ERISA data available so that researchers and policymakers can analyze data across all payers in the health care system to drive towards higher value care for all consumers who rely on private insurance. Ultimately, the data collected through the Transparency in Coverage and Hospital Price Transparency should be collected into a national database such as an APCD.

<u>Site of Service Payment Differentials and Dishonest Billing</u>

We also encourage the Committee to crack down on industry practices that take advantage of market inefficiencies that come from site-specific payment rates. This broken financial incentive that pays hospitals higher reimbursement rates for outpatient services than for the exact same services provided at independent physician offices are a significant problem, a major driver of unaffordable care for America's families, and if addressed comprehensively could save American families and payers billions of dollars.[71]

These payment differentials across sites of service drive care delivery from physician offices to higher-cost hospital outpatient departments[72] and incentivize further consolidation – encouraging health systems to buy physician practices and rebrand them as outpatient facilities in order to generate higher reimbursement and charge consumers and payers higher prices. This type of consolidation – vertical integration between hospitals and physicians – leads to a growingly anticompetitive market where hospitals increase market power to demand even higher prices from commercial payers.[73] These higher commercial prices are then passed on to American families and come directly out of workers' paychecks, typically as monthly health insurance premiums.[74]

In some cases, hospitals intentionally reclassify a doctor's office they own as a hospital-based setting in order to charge consumers and insurers higher prices – this is "dishonest billing".

Currently, hospitals are able to purchase off-campus doctors' offices and use their hospital national provider number to charge Medicare and private insurance plans at hospital rates. An analysis by Northwestern University found the price of physician services increases 14 percent[75] after a hospital purchases a physician practice. Site of service payment differentials and dishonest billing result in higher premiums, higher copays, and higher deductibles for families and individuals. This broken incentive is ripe for this Committee's oversight and action.

These practices negatively impact real people every day, all across our country.

Kyunghee Lee, a then 72-year-old retiree who lives in Mentor, Ohio:

> *Kyunghee Lee has arthritis and once a year she would go to a rheumatologist for a steroid injection in her hand to relieve pain in her knuckles. For a few years, each round of injections cost her $30. In 2021, she arrived at her usual office and the rheumatologist she regularly saw had moved to a new floor of the building - just one floor up. She didn't think anything of it, as the rest of the appointment went as usual, until she received a bill for $1,394. The infusion clinic that Lee went to had been moved from an office-based practice to a hospital-based setting, and as a result the price of the same service she had been relying upon increased a staggering 4,546%. Lee's bill had a $1,262 facility fee attached, making up the majority of the increase in cost, even though she saw the same doctor and received the same treatment as the years prior. Lee and her family didn't know what they would do about the shot in the following year when the story was reported.*[76]

Brittany Tesso and her then 3-year-old son Roman from Aurora, Colorado:

> *In 2021, Roman's pediatrician referred him to Children's Hospital Colorado to receive an evaluation for speech therapy. With in-person visits on hold due to the Covid-19 pandemic, the Tessos met with a panel of specialists via videoconference. The specialists, who appeared to be calling from their homes, observed Roman speaking, playing, and eating. Later, Mrs. Tesso received a $700 bill for the one-hour video appointment. Then, she received another bill for nearly $1000. Thinking it was a mistake, Mrs. Tesso called to question the second bill. Despite the fact that the Tessos never set foot inside the hospital, she was told the bill was a "facility fee" designed to cover the costs of being seen in a hospital-based setting.*[77]

This is patently ridiculous, and this kind of abusive pricing should not be allowed to continue. In addition to cracking down on "dishonest billing" practices by requiring hospitals to accurately report their site of service, we urge the Committee to work with the other committees of jurisdiction to consider implementing comprehensive site-neutral payment policies as recommended by MedPAC in 2022,[78] and to eliminate site-dependent reimbursement distortions that indirectly incentivize acquisition of non-hospital patient access points.[79]

<u>Anticompetitive Contracting Practices</u>

We also urge the Committee to take a close look at anticompetitive practices and clauses in health care contracting agreements, which when occurring between providers and insurers give large

entities in highly consolidated markets the upper hand in contract negotiations to build networks and set prices. As a result, many of these contracts include terms that limit access to higher-quality, lower-cost care. Congress made important progress by banning gag clauses in executed contracts between insurance plan issuers and providers or provider networks as part of the Consolidated Appropriations Act of 2021. This policy has the potential to enable consumers and employers to be more informed purchasers of health care and to unveil fundamental information that policymakers, employers, researchers and other stakeholders need to identify health care markets with the highest prices and then build policy that encourage competition. With the first set of attestations due at the end of 2023, we encourage this committee to continue monitoring the implementation of the gag clause prohibition, and to work with the other committees of jurisdiction to go further by prohibiting additional anti-competitive contracting practices by providers including hospitals, health plans and issuers that are used to gain market power, raise prices and limit access to higher-quality, lower-cost care.

Drug Pricing and PBM Transparency

This Committee can also play a role in building on last year's historic reforms to address high drug costs. While the unscrupulous business models of big drug corporations are most squarely to blame for our drug costs crisis, PBMs also have played an important role in driving unaffordable drug prices.[80] As third party administrators designed to serve as intermediaries between health insurance providers and drug manufacturers, the key function of a PBM is to negotiate drug price concessions from pharmacies and drug manufacturers to lower prescription drug costs for health plans and employers.[81] To be clear, some drug costs are lower than they otherwise would be because of PBMs – and pharmaceutical corporations have taken particular aim at PBMs because of their role in negotiating a better price.

However, there is far too much opaqueness in the functioning of PBMs and certain business practices that are good for PBMs are bad for consumers. PBMs receive rebates and discounts from drug companies in exchange for formulary placement, or a place of the list of drugs a PBM has agreed to cover.[82] Importantly, although PBMs negotiate rebates, their revenue is based on a percentage of the drug's list price.[83] The result is that PBMs have a strong financial incentive to prioritize higher cost drugs. In many plan designs, PBMs pocket a percent of the rebate they get for consumers, making it advantageous for them to negotiate a higher rebate for a higher priced drug than a lower overall list price.[84] Pharmaceutical companies, then, raise both the list price and the rebate year after year making the overall cost of the drug higher.[85] A 2020 study showed that for every $1 increase in drug rebates there is a $1.17 correlating increase in the drug list price.[86] As result, PBMs are able to substantially increase their profits from rebates in addition to their normal revenue cycle, which relies on administrative fees, and in some cases they are not actually lowering the costs of drugs for consumers.[87]

We support the Committee's work to investigate the role of PBMs and urge you to continue to take action on abusive and anti-competitive business practices by increasing transparency into PBM negotiations and contracting including ensuring PBMs report on revenue, price and utilization data, and allowing plans and employers to receive data on negotiated rates, gross PBM profits, cost effectiveness of the PBM's drug list and spending patterns; increasing oversight and regulation of vertical and horizontal PBM consolidation; and ensuring 100% pass-through of

rebates and cost-sharing based on the actual price paid, and that 100% of rebates are passed on to consumers. Additionally, we urge you to work with your colleagues to continue to pursue reforms that take on the systemic abuses from big drug companies that are the main drivers of high drug prices.

Beyond these immediate steps, policymakers should focus on a broader redesign of the economic incentives of the health care sector to align with consumers and families. Ultimately, policy solutions should reorient health care payment and delivery to the goal that we all have — improved health for ourselves and our families that is affordable and economically sustainable.

Once again, the American people want action. Large majorities of voters support a range of policies to lower prices. Voters from both sides of the aisle broadly support:[88,89]

- Requiring all health care organizations to publicly disclose their prices (87%)
- Limiting outpatient fees to the same price charged by doctors in the community (85%)
- Preventing hospitals from engaging in business tactics that reduce competition (75%)
- Limiting mergers and acquisitions (74%)

Thank you again for holding this hearing today. Congress should seize this momentum to immediately implement commonsense policies that rein in abusive health care prices and make health care more affordable for everyone. The journey to fully transform our health care system is long, but Congress holds the power to take the next critical steps. Families USA stands ready to support you in this essential and urgently needed work.

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