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HEALTH CARE TRANSPARENCY: LOWERING COSTS AND EMPOWERING PATIENTS

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C O N T E N T S

HEALTH CARE TRANSPARENCY: LOWERING COSTS AND EMPOWERING PATIENTS

U.S. SENATE
SPECIAL COMMITTEE ON AGING
Washington, DC.

The Committee met, pursuant to notice, at 10:00 a.m., Room 138, Dirksen Senate Office Building, Hon. Robert P. Casey, Jr., Chairman of the Committee, presiding.

Present: Senators Casey, Blumenthal, Warren, Warnock, Braun, Vance, and Ricketts.

OPENING STATEMENT OF SENATOR ROBERT P. CASEY, JR., CHAIRMAN

Chairman CASEY. Good morning. The Senate Special Committee on Aging will come to order. Today's hearing will examine transparency in health care, and how it affects the ability of patients to access affordable health care. This is a very important topic as the cost of health care continues to rise, and it is clear we must do more, here in the Senate and throughout the Congress, to bring down costs for the American people.

I am proud to say we have made some progress, though we have more ground to cover, much more to do. Over the last several years, Democrats have passed several health packages to lower health care costs for Americans. Through the American Rescue Plan Act, Democrats reduced health care costs by bringing down the cost of premiums and expanding eligibility for health care coverage savings. I was proud to support the Inflation Reduction Act, so called IRA, which is actively bringing down health care costs for Medicare beneficiaries. It is also increasing transparency and affordability as the federal government, through Medicare, can now negotiate prescription drug prices under the Medicare program.

The IRA capped insulin costs at $35 a month for seniors, and then we saw insulin manufacturers extend those savings to all patients who pay out-of-pocket for insulin.

The IRA also includes a provision that caps prescription drug costs at $2,000 out-of-pocket each year for Medicare beneficiaries. This provision, which goes into effect this coming January 1st, will save Medicare beneficiaries an estimated $7.4 billion in 2025 alone. This is a lifeline for older Americans and shows us the opportunity to help Americans without Medicare who are still subject to high out-of-pocket drug costs.

That is why I am introducing the Capping Prescription Drug Costs Act with nine of my Senate colleagues. This legislation expands on the success of the IRA and extends prescription drug cost savings to the commercial health care market by capping out-of-pocket costs at $2,000 annually for individuals and $4,000 annually for families. Nationwide, 173 million people under the age of 65 have private health insurance either from an employer plan or in the non-group market. This legislation, the Capping Prescription Drug Costs Act will ensure that prescription drugs are more affordable for these tens of millions of Americans.

While we have come a long way to make health care more affordable and accessible, I look forward to hearing from our witnesses today and discussing how transparency can shine a light on high health care costs and ways to decrease those costs for every American.

I turn next to Ranking Member Braun.

OPENING STATEMENT OF SENATOR MIKE BRAUN, RANKING MEMBER

Senator BRAUN. Thank you, Mr. Chairman.

Health care costs have risen astronomically from where they were just a few decades ago, to now approaching 18 percent of our GDP, and it has all occurred very simply, because the health care industry has disguised itself as being part of free enterprise, which embraces transparency, competition, no barriers to entry, and most importantly, an engaged consumer. You know that none of that really applies to our current industry. You heard the Chairman talk about when you do operate like an unregulated utility you are going to have government getting involved, so the key is do we go there, when this place is going broke systematically over the last decade or two, and in a place that is running $2 trillion deficits, or do we reform the industry?

For anyone that is a CEO within the industry, I would suggest that you do what all the rest of us have done that run businesses—embrace competition. Deal with an engaged consumer in full transparency.

I mean, if we keep going down this trail, we are going to end up not only exacerbating the $2 trillion deficits we currently have, it is going to get even worse.

I was able to keep costs low in my own business. It can be done. I was so sick and tired of hearing how lucky I was that it was only going up five to ten percent every year. I found out how much the insurance companies were making on then what was a 300-employee plan that hardly had any claims, but they were making a fortune on it, and that is because even we did not have the full breath of options, and when I found out how lucrative it was to be in the insurance business, we self-insured, and then threw everything and the kitchen sink at prevention and wellness, and actually on the user side only, controlled costs. My employees got every wellness and prevention tool, and they became health care consumers, and in that method, we cut costs by over 50 percent, and have not had premium increases in 16 years.

Industry, wake up. It can be done. We need more tools, and we need you to get with it.

President Trump put in place regulations requiring hospitals and insurers to disclose prices. President Biden has continued to support it. The hospitals have tried to skirt it, mostly from the time that happened.

Today I am releasing a report that highlights the need for Congress to enact additional transparency across the health care supply chain. This is not going to go away, and it is a single place in our Federal Government that if we get it right we can reduce our deficits, the government will have a bill to pay that his less, if the providers shrink themselves down to where it is in most other economies and maybe not do it from a command system from government but because entrepreneurism and the markets are working.

The House passed the Lower Costs, More Transparency Act. That is a huge step to get us where we are needing to go.

I am on Health, Education, Labor, and Pensions. Another crazy thing about this place, they have got a hearing right now. It is at the same time this is, and we have never gotten that straight since I have been here. I will try to jump there.

Bernie Sanders and I introduced the Health Care PRICE Transparency Act 2.0, a landmark bill to reveal health care prices for Americans that mirrors the House bill in many ways. I want to thank Senators Warren and Fetterman, who are members of this Committee, for joining as cosponsors.

I want to cite someone in the audience here, Cynthia Fischer, who has been the most passionate individual I know. She has run a business over the years about keeping this in the limelight. It requires providers to publish actual prices, not estimates.

Another major component of the bill states that group health plans have the right to review and audit their claims data, and we cannot do that that has got to happen nationally, and states need to accommodate that. This will allow self-insured employers and unions to make changes to their plan and save money for their beneficiaries. Our bill puts the power back in the hands of Americans, it starts to make it consumer driven, and it starts to break up the oligopoly, the monopoly nearly, of how health care is provided currently.

I ask unanimous consent to enter into the record two statements, one from Power to the Patient and another from Patient Rights Advocate with 75 signatures in support of this legislation.

Chairman CASEY. Without objection.

Senator BRAUN. I look forward to continuing to work with my colleagues on both sides of the aisle to get the Health Care Price Transparency Act 2.0 to the President's desk.

It is time to deliver for our seniors, our families, and Americans all across the country.

I would now like to play a video telling just one of the thousands of stories about the impact price transparency can have on patients.

Thank you to Patient Rights Advocate for submitting this story and for their leadership in the fight to bring power to patients.

[Video plays.]

Chairman CASEY. Thank you, Ranking Member Braun.

I will now turn to our four witnesses. I will introduce our first witness, and Ranking Member Braun will introduce our second and third, and then I will introduce our fourth.

Our first witness is Dr. Christopher Whaley from Providence, Rhode Island. Dr. Whaley is Associate Director of the Center for Advancing Health Policy Through Research at Brown University. He also serves as Associate Professor in the Department of Health Services, Policy, and Practice at Brown University School of Public Health. His research is largely centered on health care price transparency and evolving market structure and the effect of such changes on overall health spending and quality of care for patients.

Doctor, thank you for being with us today and sharing your expertise with the Committee.

Dr. WHALEY. Thank you, Chairman Casey and Ranking Member Braun.

Chairman CASEY. Doctor, we will just introduce all the witnesses and then I will turn to you, if that is okay.

Senator BRAUN. It is my pleasure to introduce Chris Deacon. She is the founder of VerSan Consulting LLC. She advocates for cost-effective strategies that benefit both employers and employees. Ms. Deacon has held pivotal roles within the State of New Jersey, notably as a director of a state employee health benefits program, and school employee health benefit programs.

Her career in the public sector began with serving as Deputy Attorney General and then Special Counsel to Governor Chris Christie. She earned her Juris Doctor from Rutgers School of Law. Thank you for testifying today.

It is my pleasure also to introduce Cora Opsahl. She is the director of 32BJ Health Fund. She ensures that member and families of the union have affordable and high-quality health care. Under Ms. Opsahl's leadership, the 32BJ Health Fund has saved more than $35 million annually. That is impressive. She holds an MBA from St. Louis University. Thank you for being here today.

I yield back.

Chairman CASEY. Thank you, Ranking Member Braun. Our fourth and final witness is Sophia Tripoli. She is from Washington, DC. Sophia is the Senior Director of Health Policy at Families USA, an organization that seeks to achieve accessible and affordable health care for all Americans. Her work is largely focused on lowering costs of health care and improving health care delivery for Americans.

Thank you very much for being here today and for testifying and for sharing your knowledge with the Committee.

Now we will turn to you, Doctor, for your opening statement.

STATEMENT OF CHRIS WHALEY, PH.D, ASSOCIATE DIRECTOR OF THE CENTER FOR ADVANCING HEALTH POLICY THROUGH RESEARCH, ASSOCIATE PROFESSOR OF HEALTH SERVICES, POLICY, AND PRACTICE, BROWN UNIVERSITY SCHOOL OF PUBLIC HEALTH, PROVIDENCE, RHODE ISLAND

Dr. WHALEY. Thank you. Chairman Casey, Ranking Member Braun, and other members of the Committee, thank you for the opportunity to testify today.

My name is Christopher Whaley. I am an Associate Professor of Health Care Policy at the Brown University School of Public

Health, where I focus on health care price transparency and the evolving structure of U.S. health care markets.

The United States leads the world in health care spending in large part due to high and variable prices. Rising health care spending strains government finances and erodes worker wages, particularly for middle-and lower-income Americans. Prices are opaque, fueling consolidation and leading to patient frustration with the U.S. health care system.

These challenges have important implications for aging Americans. First, many elderly individuals receive private insurance, most commonly from their current or former employers, and thus are impacted by high and variable prices.

Second, high health care costs and patient financial burdens lead to reductions in high-value and necessary care. For the under–65 population to age healthily, it is critical that they have access to affordable health care.

Finally, high and differential prices drive health care consolidation, which erodes access to care and the quality of care for Medicare beneficiaries.

In response, policymakers have undertaken efforts to increase price transparency. However, many of these efforts are currently incomplete. Today I will discuss impacts of price transparency and ways to improve the use of price transparency data in the U.S. health care system.

First, it is important to recognize that price transparency is not a cure-all for the health care system but rather is critical to improve the efficiency and regulatory oversight of health care markets in the United States. While patients have an ethical recent to know prices, many do not actually shop for care. However, my research has shown how entrepreneurs and innovators can use price transparency to improve health insurance benefit designs and to create competition in health care markets.

In addition, price transparency is critical for enabling employers and other purchases to fulfill their fiduciary obligations to provide health insurance benefits to the workforce at fair prices. An appropriate use of price transparency is to serve as a hub that enables other benefit design innovation and inform policies that reduce spending and improve quality.

As a few examples, and as discussed in more detail in my written remarks, we have collected data from many employers in the State of Indiana and report what they are paying for hospital care. After seeing that they were paying some of the highest prices for hospital care in the country, these employers have used this type of price transparency data to both negotiate for lower prices on behalf of the workforce and also push for state policies to make Indiana health care markets more competitive.

In other examples, the State of Oregon public employees and schoolteacher have used price transparency data to implement a reference-based pricing program that caps prices at 200 percent of what Medicare pays. This program saved over $100 million in public funds in the program's first two years.

My co-panelist from 32BJ has used price transparency data to design a targeted insurance network that excludes inefficient pro-

viders. These savings from this type of program resulted in a $3,000 bonus for New York City service workers.

To allow for these types of innovations to occur nationwide, recent Federal policies seek to increase price transparency through two main requirements. First, hospitals are required to post prices for 300 shoppable services, and second, insurers are required to post their full set of negotiated rates.

The insurer-posted coverage and transparency data represents probably the most complete view into health care prices in the United States. While these data have certainly had a rollout process, researchers such as myself are now using these data to more completely understand health care markets in the United States and entrepreneurs are using these data to drive health care market competition.

While a terrific resource, these data can certainly be improved by reducing duplicate entries and posting of prices among providers who do not actually perform services. Requiring insurers to limit posted prices to providers who actually perform service or potentially include the number of services billed would greatly improve data quality and accessibility. These data could also be centrally hosted by CMS using modern data base technologies.

Additionally, despite the 2021 Consolidated Appropriations Act provisions, many employers and purchasers do not have access to their own plan claims data. Proposed bipartisan legislation codifies access to self-funded plans' claim data, and these data are necessary for employers to be responsible fiduciaries and purchasers of health care services on behalf of their workforce.

In conclusion, the large variation in health care prices and opaque nature of prices in the United States drives frustration with the U.S. health care system. Federal policies to improve transparency are important first steps, and I believe that building on these efforts will improve the U.S. health care system and lower spending, particularly for aging Americans.

Thank you, and I look forward to your questions.

Chairman CASEY. Dr. Whaley, thanks so much for your testimony.

We will now continue testimony with Ms. Deacon.

STATEMENT OF CHRIS DEACON, JD, PRINCIPAL OWNER, VERSAN CONSULTING, LLC, MOORESTOWN, NEW JERSEY

Ms. DEACON. Chairman, Ranking Member, and distinguished members of the Committee, thank you for the opportunity to testify today on the critical issue of transparency in health care.

Imagine, if you will, that you are the CFO of a company where you give the company credit card to your suppliers and vendors. Instead of receiving an itemized statement at the end of the month you receive one paper with one number—no receipts, no details, just the total amount owed. No business would ever allow such a practice.

Yet this is exactly what happens in our health care system today. Employers are forced to hand over the company credit card to Blue Cross Blue Shield, Cigna, Aetna, United, allowing them to pledge company dollars and member dollars to a health care system that can charge whatever they want, however they want, with little to

no accountability or oversight. That is why we are here today. Transparency, or rather lack of transparency, facing employers and unions that are responsible for purchasing health care for almost 160 million Americans.

You likely know the statistics and the alarming rate at which health care costs are growing, but I know the people behind these statistics. As the former administrator for the State of New Jersey's public sector health plans, I know firsthand how the lack of transparency impacts our teachers, firemen, police officers, and public sector workers.

Sadly, this year in New Jersey, over 200 school positions will be eliminated due to budget constraints, constraints largely driven by health benefit costs, and public safety workers are facing a 16 percent premium hike, eroding years of wage growth and further stretching scarce public safety resources.

ERISA, which governs most employer sponsored health plans in the country, is intended to protect plan participants and beneficiaries by mandating that plan sponsors act as fiduciaries. When employers lack access to meaningful claims data and transparent information on the cost and quality of care, the promise of ERISA remains unfulfilled.

Let me share three examples that illustrate the magnitude of this issue.

At the Mayo Clinic in Jacksonville, Florida, if you were to use your Federal Employee Health Benefits Blue Cross Blue Shield card for an arthrocentesis procedure it would cost you and the Federal Government approximately $2,500, but if you were to not use your card and pay cash, you would pay just $392. That is six times more.

At the University of Pennsylvania Hospital in Philadelphia, the cash price for an ACL repair is approximately $9,500, but if you are a servicemember and you use your TRICARE coverage your price, and the Federal Government's price, is $37,489. That is almost a 300 percent markup.

Or consider when a third-party administrator, or TPA, overpays for a claim or pays a claim in error with a self-funded employer or union's money. If—and I emphasize ″if″—the TPA seeks to correct their error and recover the employer's funds, it will cost them. TPA's regularly charge employers 25 to 50 percent of the recovered payment. This is the ultimate fox guarding the henhouse.

Finally, there are the misaligned financial incentives that play out when a TPA is able to pay providers one price and then charge the employer or the union many times more for the exact same claim. In several recently unsealed court documents out of a case in the Central District of California, it was revealed that a group health plan paid over $4 million for one claim, but the provider only received approximately $876,000 of that $4 million. What accounted for the difference? Cigna kept over $2.5 million in fees, and their subcontractor, Multiplan, kept another $678,000. The fees were over three times higher than what the provider was actually paid.

These examples are just the tip of the iceberg in terms of the waste, abuse, and inefficiencies in the current market, driven, in

large part, by the lack of transparency and meaningful access to data for employers.

If we expect employers and unions to exert any type of market forces to rein in health care costs we must empower them with actionable data and transparent pricing. The company credit card has been abused for too long by the PBMs and TPAs. It should not be unreasonable to demand receipts for payment, itemized statements, and the ability to protect our businesses and plan members, and that is what S. 3548 uniquely accomplishes, in a superior manner, in my opinion, to the Lower Cost More Transparency Act with respect to access to claims data. Federal lawmakers must rebalance the information asymmetry to empower employer purchasers and unions to push back against egregious pricing, gross overreach, and profiteering. This will help protect the American workers' paychecks and ensure a fair, more accountable health care system for all.

Thank you.

Chairman CASEY. Ms. Deacon, thanks very much for your testimony.

Ms. Opsahl.

STATEMENT OF CORA OPSAHL, MBA, HEALTH FUND DIRECTOR, 32BJ HEALTH FUND, NEW YORK, NEW YORK

Ms. OPSAHL. Good morning. Thank you Chairman Casey,

Ranking Member Braun, and the rest of the Committee on Aging for inviting me to speak today.

My name is Cora Opsahl, and I am the Director of the 32BJ Health Fund. The 32BJ Health Fund is a self-insured, Taft-Hartley benefit fund that provides health benefits to over 200,000 union members and their families. Our members are essential workers who work in the real estate industry, security officers, school workers, and airport workers. We are based primarily in the New York/New Jersey area, but we have families up and down the East Coast including Pennsylvania and Massachusetts.

The fund is jointly governed by a board of trustees appointed by the Union and the Employers, and we provide high-quality benefits with no premium sharing, $0 in-network deductibles, and low in-network copays. We believe the fund has an important role in tackling the problem of health care affordability, and we have spent years doing just that by leveraging our data, challenging the status quo, and finding innovative ways to manage our benefit.

Having access to our claims data is foundational to our work, and we have been fortunate to have access to our medical, pharmacy, and ancillary claims data. We use this data to understand our health care spend, make benefit decisions, and ensure we are a good steward of the fund's resources, because of our data, we know the following:

In 2023, we spent $1.4 billion in health care. Of the $1.4 billion, 55 percent is spent on inpatient and outpatient care. In 2021, we paid 271 percent over Medicare prices for the same care, which is up from 219 percent of Medicare in 2016, and in the past 10 years, health care has risen from 17 percent of total compensation to 37 percent of total compensation. Wages have gone up 54 percent but health care costs have gone up a whopping 230 percent, and to put

that into a dollar amount, our members could have had $5,000 more in annual wages had health care spend risen at just the same rate of inflation.

While having your data and being able to see how your benefit is being spent is important, as a plan we know this is only the first step. The next step is taking action on the data.

In 2018, after spending 10 years looking at our claims data, it became abundantly clear to us that we needed to address the prices we were paying. The data showed we were paying wildly different prices for the same procedures, depending on what hospitals our members went to. For example, we were paying approximately $10,000 for a colonoscopy at New York Presbyterian system versus approximately $4,000 at Mount Sinai Hospital system. The same pattern was true at other high-priced systems. Based on our data, we tiered our network on price beginning in 2019. Members could still access the higher-priced hospitals, but they would have to pay higher copays to do so.

While we had won the right to tier our plan in 2019, in 2021, New York Presbyterian told Anthem, Blue Cross Blue Shield, that they would have to be preferred in all networks, leveraging a clause in their contract. In 2022, the fund won permission to remove them from our network. This change has saved the plan approximately $35 million every year by members receiving care from lower-priced facilities and providers.

In the most recent contract negotiations, the union and employers leveraged the savings in our benefits to give union members a one-time bonus, the largest wage increase in contract history, and a pension increase, and they were able to limit employer premium contribution increases to no more than three percent every year through 2027.

While these benefit changes showcased our ability to leverage our data, both changes also illuminated the contract terms between providers and carriers that obstruct, hinder, and limit the ability for us and other employers to take action on their data.

Recently, the Health Fund led a procurement for a medical and hospital benefit third party administrator, or carrier. We were adversely affected by anti-competitive contract provisions between providers and carriers, such as requirements to be in network, anti-steering and anti-tiering provisions, limitations in how claims are allowed to be paid, and even limitation in access to claims data. Due to these contract provisions, every TPA bidder, except one, was unable to meet our network requirements, including that New York Presbyterian remain out of network.

Other provisions routinely demanded by hospitals include restrictions on retroactive claim reviews, exclusion of ″lesser-of″ provisions, and limits on payment recoupment. None of those contract provisions are beneficial to the employer-sponsored plans or their membership. The experience showcased how difficult it is for employers and self-funded plans, even of our size, to have a highly competitive bid process.

We would not be where we are today without access to our data, allowing the union and employers to give raises and limit premium increases, ensuing our members can continue to have access to high-quality and affordable care. Employers having access to their

claims data and the terms in which their benefits are being managed are essential for them to be able to do the same thing. That is why we need the Braun-Sanders bill, and Section seven in particular.

Thank you for having me.

Chairman CASEY. Ms. Opsahl, thank you for your testimony. We will turn to our final witness, Ms. Tripoli.

STATEMENT OF SOPHIA TRIPOLI, MPH, SENIOR DIRECTOR OF HEALTH POLICY, FAMILIES USA, WASHINGTON, D.C.

Ms. TRIPOLI. Chairman Casey, Ranking Member Braun, and members of the Committee, thank you for the opportunity to testify today. It is an honor to be with you. On behalf of Families USA, a leading national nonpartisan voice for health care consumers, I want to thank you for this critical discussion.

No one in America could have to choose between going to see their doctor and buying groceries to feed their family. Yet almost half of all Americans do not get needed medical care because of the cost, and 48 million older Americans fear they will not be able to afford lifesaving care.

Every American knows that we pay too much for the health care we get, but many Americans do not know why—because health care consolidation, particularly among hospitals, has eliminated competition and allowed monopolistic pricing to push our Nation's families to the brink of financial ruin.

Particularly concerning is that health care is one of the only sectors in the U.S. economy where consumers are blinded to health care prices until after they have received a service and a subsequent bill. This lack of transparency is a major barrier to the health care sector competing based on fair prices and high-quality care, and there is no question that our Nation's families are suffering the consequences.

Take the story of Kyunghee Lee from Mentor, Ohio. Once a year she goes to a rheumatologist for a steroid injection in her hand to relieve pain associated with her arthritis. Each round of injections costs her $30, but in 2021, when she arrived at her usual office for her usual treatment she found they had moved up one floor in the building. She thought nothing of it until weeks later she received a bill for nearly $1,400. Ms. Lee's infusion clinic was moved from an office-based practice to a hospital-based setting, resulting in a price increase of almost 4500 percent for the exact same service, from the exact same provider, or take the story of Ben Los and his then 5-year-old son from Monument, Colorado. In 2022, Ben and his wife rushed their son to the doctor after he began experiencing seizures. They were referred to a specialist and received confirmation that their son's EEG scan would be covered. Weeks later the Los family received a bill for $2,500. When they called the hospital about the bill they were told it was a facility fee, that the physician service was covered, but now they had to pay the hospital.

Frustrated with a bill he could not pay and grappling with his son's health, Ben wanted answers about why this happened, but found it nearly impossible to determine who actually owned the hospital. It was a giant black box. Ultimately, Ben discovered that this hospital system raked in billions of dollars in profits just in

the first nine months of 2022, all while he was struggling to pay his medical bill.

These stories are far too common in the U.S. health care system, particularly since the role of hospitals in our economy has shifted drastically over the last 60 years. What were once local charitable institutions built to serve the community have now become large corporate entities, focused on maximizing revenue rather than improving health. Fundamentally, the business interests of the sector are no longer aligned with the health and financial security of the patients they serve.

Study after study shows that privately insured consumers and employers are paying two to three times what Medicare pays for the same hospital services. Commercial insurance prices for hospitals and physician services in more monopolistic markets like Florida, South Carolina, and Tennessee, cost at least twice as much as the same services in competitive markets.

Take the average price of a knee replacement, which costs three times more in Sacramento, California, than in Tucson, Arizona, or the price of an MRI at Mass General Hospital in Boston, that costs five times more just depending on the insurance carrier. These higher prices result in higher premiums, lower take-home pay, and higher cost-sharing for the more than 176 million Americans who get health insurance through their employer or directly from a health plan.

Medical monopolies are forming in nearly every state, whether it is a private equity-backed firm buying up hospitals and then cutting service lines and laying off workers, as we see is the case of Steward Health System in Massachusetts, or price gouging and suppressing wages in the case of UPMC in Pennsylvania, or the giant medical monopoly that is HCA Healthcare, which has facilities in 20 states, including Indiana, Georgia, Florida, and South Carolina. Notably, HCA Healthcare ended 2023 with more than $5 billion in profits, on $65 billion in revenues, allowing their CEO to take home a salary of more than $21 million. These billions of dollars of profits are made on the backs of people like Ben Kyunghee Lee, and the one-third of Americans who cannot afford to buy groceries or pay their rent because of rising health care costs.

Congress has used its power to rein in the corporate abuses of Big Oil, Big Tobacco, Big Banks, and Big Tech. Last year, the Senate examined how to protect people from price gouging for concert tickets. It is past time to scrutinize big health care corporations and protect families in America from the greed of medical monopolies.

We urge this Committee to support well-vetted, bipartisan solutions, including strengthening and codifying price transparency rules, implementing site-neutral payment, and addressing dishonest billing, increasing transparency of ownership data, limiting harmful contracting terms, and strengthening FTC and DOJ enforcement of anti-competitive practices.

This Committee has a responsibility to put the needs of our Nation's families ahead of the greed of big health care corporations. Our health is not a game, and no one should be allowed to play Monopoly with it.

I thank the Committee for your time and look forward to answering any questions.

Chairman CASEY. Ms. Tripoli, thank you for your testimony. I will start our round of questions.

Dr. Whaley, I will start with you, and I am grateful for your testimony today. We all know health care costs in the country are continuing to rise. Hospital costs have risen faster than health care costs overall. These increasing costs directly impact Americans' access to health care, and before we get to solutions, which we are, of course, trying to arrive at today, we need to understand the underlying causes of these high prices.

What are the major—and if you can just, and I know this is part of your testimony, if you can itemize again for us the major drivers of rising hospital costs, in particular.

Dr. WHALEY. We know that in particular hospital costs are driven by provider consolidation, and are actually not driven by differences in quality of care, and I think this is particularly relevant because over the last two decades we have seen over 2,000 hospital mergers in the United States, which have resulted in a hospital market that is incredibly concentrated.

Chairman CASEY. 2,000 mergers, in what time period?

Dr. WHALEY. Over the last two decades.

Chairman CASEY. That is an alarming number.

I wanted to turn next to Ms. Tripoli. As we know, the cost of health care has implications at all levels of our economy. Health care spending affects both government and employers. It affects, obviously, patients and families. As costs rise and patients continue to struggle to afford care, which often results in delayed care or care that is actually foregone, in 2022, more than a quarter of adults reported delaying or foregoing health care due to the costs, so it is a disincentive to seek out the care they need. Others may still receive needed care but go into medical debt when they do so.

Here are kind of two questions in one. How do high hospital costs impact the lives of patients. That is one, and the second question is what might an unexpected surgery or other medical expense mean for a family's budget?

Ms. TRIPOLI. Thank you very much for the question. I think high hospital costs, what it means is an increasing impact on our premiums, for example, increasing cost sharing, and what many folks do not actually realize is that for people in the commercial market for employees that more of their take-home pay is going to rising health care costs instead of being able to come home with them to afford things like buying groceries.

At the same time, premiums are increasing much faster than workers' wages, so we are creating a real crisis, from workers who are showing up every single day, doing exactly what they should be doing, and yet they are continuing to struggle to afford the skyrocketing costs of health care.

Chairman CASEY. Any examples you have, or walk me through, if you can, the scenario of an unexpected surgery or other medical expense in terms of a family budget.

Ms. TRIPOLI. Absolutely. I think data suggests that more than half of Americans have no emergency savings on hand, and of the ones that do, they have less than $1,000 on hand at any given mo-

ment, so you are talking about an emergency surgery or any type of unexpected health care need, that would literally bankrupt the American family that more than half of Americans would not be able to afford the care. That is why we are seeing 100 million Americans, and growing, with medical debt.

Chairman CASEY. Thank you. I wanted to move to another question before my time runs out. We have discussed hospital costs, obviously. I also wanted to focus, as well, on prescription drugs. We know those costs account for a high percentage of health care spending. I mentioned my legislation, Capping Prescription Drug Costs Act. Senator Warnock and I have introduced that together. That would expand on the success of the IRA provision on extending prescription drug costs to patients.

What can high prescription drug costs mean for a family that is already struggling to make ends meet?

Ms. TRIPOLI. Absolutely. I mean, we know that 30 percent of adults do not actually take their prescription drug medication, either rationing the drug, skipping it, or foregoing it altogether because they cannot afford it, and that actually results in 125,000 deaths a year. For most people, not being able to afford their drugs, not being able to afford their medical care, is literally a decision between life or death.

Chairman CASEY. Give me that number again. You said 125,000——

Ms. TRIPOLI [continuing]. deaths per year.

Chairman CASEY. Caused by——

Ms. TRIPOLI. Adults not being able to afford their prescription drugs, either from delaying care, rationing their medication, or foregoing taking the drug altogether.

Chairman CASEY. Mr. Tripoli, thanks for your testimony and answers to those questions.

I will turn to the Ranking Member.

Senator BRAUN. Thank you, Mr. Chairman. I am going to start with Ms. Deacon and Ms. Opsahl. This whole idea of claims data, for the benefit of the Committee and other listening, on self-insured plans why has that not been the default that you will get it? What has the industry done to keep the one thing, when you do have, like when I formed my own plan we finally got rid of the profit margin that the insurance company was making. Give us a little background on why they have been so begrudging in terms of giving that basic information.

Ms. Deacon, I will start with you, and then Ms. Opsahl will go next. Go ahead.

Ms. DEACON. I think the example I gave in my opening remarks is probably the best example of why a carrier or a TPA would not want a self-funded employer to have access to their data. What you will see in the data is that you are often paying above billed charges. You might also see that the rate you are paying under their negotiated discounts can be six times, ten times higher than the cash rate, and what they have done to sort of block access to this data over the years, anything from draconian NDA provisions, proprietary data formats, claiming that the data is proprietary and confidential, limited data sharing provisions, implementing prohibitive cybersecurity policies in order to access your own data, and

even so far as limiting what data warehouses are able to share with employers and third-party——

Senator BRAUN. That is the ultimately behavior of a monopoly, and remember, they are the supplier, and this is going against their own customers, and that, to me, is indicative of why we are in the pickle we are in.

Has this been the general dynamic across all states? Have some places been able to fix that? Has it just happened recently, where plans have been able to sue to get the information? Give me a little kind of background on how long we have been dealing with this and what has kind of cracked the ice at this point.

Ms. DEACON. It has been a long time that self-funded employers are dealing with a lack of access to data, but with the Consolidated Appropriations Act of 21, we had hoped that some of the provisions in that act would lead to more access to claims data. Employers were restricted from entering into contracts that would limit their access to claims data. However, in practice, that has not necessarily played out how we had hoped it would, and employers are still facing these roadblocks and barriers in getting access to their claims data, but the sort of crack that you mentioned is we now have this law so that employers are litigating. They are filing suit to say this is my——

Senator BRAUN. Are they winning mostly, or are they losing?

Ms. DEACON. We have not really had a case that has come all the way to decision. We are at the outset of some of those cases, and some of them have settled outside of the public domain, so we do not necessarily know what——

Senator BRAUN. All insurance companies basically do this.

Ms. DEACON. All of the big ones, yes.

Senator BRAUN. All of the big ones, so maybe it needs to be where employers start looking at other than the big guys that seem to not want to bargain fairly, with information that should not be theirs in the first place.

Ms. Opsahl, can you kind of explain how you finally cracked through, how long it took, and are you still wrestling with it?

Ms. OPSAHL. Thank you so much for the question. I will start with, yes, we are still wrestling with it. We just recently went through a procurement, and still had to reassert our agreement and right to this claims data.

I look at claims data as receipt for payment. You do not pay your credit card bill without an itemized list. You should not be paying claims. As a self-funded employer, it is our responsibility to pay these claims.

We won the right to get our claims data a little over 15 years ago, but had to do that through leaving a big carrier and coming back. It should not take employers having to go through a comprehensive procurement process to have to win enough power to get access to their claims data, but again, we still fight that today. If we want to add a new field—we were just talking about this this morning—add a new field, well, that is in System A, and we are actually pulling this from System B, and so it is going to take nine months to add this flag that says whether or not, you know, which hospital systems and things of that nature.

It is not simple. It is not easy, and I have eight people on my staff who look at the data every day to even see how good it looks.

Senator BRAUN. Thank you. I am out of time but I do have another round of questions, but I would like to point out to the public, I do not know of one other industry where we have had to bring, at the federal government level, a transparency bill. Every other industry out there engages with an informed consumer, and you have got that information on the Web, you have got it so many places. In my own business I remember it was so competitive, your customers would put you on speed dial to see who was going to give the best price, and you could have accomplished that all within about four or five minutes. We are so far from that. The industry better take note that it is not normal to operate the way they do.

I will yield back for now.

Chairman CASEY. Ranking Member Braun, thank you for your questions, and as you all know, on a Thursday we have got Senators that are in and out, competing demands, especially competing hearings, as Senator Braun mentioned. He and I are both members of the HELP Committee, so we cannot transport ourselves quite yet, but we are going to be in and out. People will be in and out today, but I wanted to thank Senator Ricketts for being here. He might have close to 100 percent attendance record. There is some prize for him somewhere, but I will turn next to Senator Ricketts.

Senator RICKETTS. Thank you, Mr. Chairman. Thank you, Ranking Member, and thank you to all of our witnesses for being here today to provide testimony.

As the population of the United States ages it is vital that we take a closer look at the institutions and programs that we trust to take care of them. It is our job to protect America's most vulnerable citizens and ensure that they are equipped with the tools to make the best decisions for their own care. In addition, we must ensure that programs like Medicare and Medicare Advantage have accurate and easily understandable information that is accessible for those who rely on it.

This past February I held an Aging Committee hearing in my home State of Nebraska, and we focused on educating older Americans on health plans through Medicare. While there are resources through Medicare and state health insurance assistance programs, SHIPS, many older Americans fail to become properly educated on the wide variety of health plans.

For 2024, it is estimated that there are a total of 8,676 different Medicare Advantage plans. According to a recent report, one of the biggest challenges with Medicare Advantage plans is poor patient education. If a person enrolls in Medicare Advantage when they first become eligible for Medicare they can switch to original Medicare and Medigap within the first 12 months of their plan. However, if an enrollee fails to switch their plan within that first 12 months, there are additional requirements to switch back to Medicare and a Medigap plan that can be very challenging.

Ms. Tripoli, it is often the case that older Americans sign up for plans that do not cover many of their needs and cover their out-of-pocket costs. Do you have recommendations for addressing this issue, and maybe education gaps? What can we do to be able to

help folks who are getting ready to make this decision to be able to make the right plan choice for them?

Ms. TRIPOLI. I mean, absolutely. I think in general we need a lot more transparency of information across the health care system. Medicare Advantage is no different. One of the things that we often see in Medicare Advantage is a very aggressive marketing of supplemental benefits, for example, and plans are using it as a hook to get seniors to sign up for the plan and then they are enrolled and they actually find out, oh, that is not exactly the benefit that was marketed to me.

I think one of the solutions both around supplemental benefit and just in general is we need much more transparency. We need more data that is accessible for researchers, for the public, and for policymakers to understand what is actually happening underneath the hood of the health care system, so we can have more targeted decisions to make sure that consumers, the end user of the health care system, are actually getting the care they need, that is affordable, and it is meeting their health needs.

Senator RICKETTS. As we were talking about this transparency, is this something where we would be able to require, like these plans, to be able to provide—I don't know, we were talking about some of the cost differences in different procedures. Certainly, there are common things that our seniors need or get requirements. Is that something that maybe the plans should have to be able to talk to seniors about and say, hey, for a typical thing that our seniors are going to need this is what it may cost you?

Ms. TRIPOLI. Absolutely. Seniors and older Americans and just the general public needs much more data about the cost of care and the quality of care that is associated with that cost, so they can understand what is the value of what I am getting, and then they can make more informed choices about plan selection, whether they need a service, whether they want to shop for one MRI at this hospital versus another hospital, but yes, absolutely.

Senator RICKETTS. Actually, you bring up a great point there, because we have talked a lot about costs and transparency on costs. How do we go about tackling the quality aspect of it? Some of the folks have mentioned the quality as an aside, but how do we educate consumers on that quality aspect of it too, because there is always a cost-quality tradeoff. How do we measure the providers on that quality?

Ms. TRIPOLI. I think you are asking probably the million-dollar question right now. Obviously, we have a lot of quality reporting requirements, but there are a lot of requirements, and there is not necessarily a harmonized set of quality measures that we can pull down and assign to a specific service, so we actually need quite a bit of work on the quality side, and CMS, as well as multiple stakeholders from a lot of different sectors have been working to address this issue, but it takes time, and much more work is needed.

Senator RICKETTS. Great. Thank you.

Ms. Deacon, in 2020, Congress passed legislation to stop third-party administrators of self-insured employer and union health care plans from writing contracts that denied plans access to their data on prices and health services, but it sounds like, from earlier

legislation, this legislation has it stopped the gag clauses from being implemented?

Ms. DEACON. Thank you for the question. In my experience, no, it has not. I have worked with multiple employers and unions that continue to face these roadblocks, and again, some of the examples that I gave earlier, draconian NDA clauses that even if they are getting access to the data they cannot do anything with it. They cannot audit their own claims. They cannot look for retrospective payment reviews, so it is very limited even when they are getting access to the data, but that is when, and I would say that, by and large, we have not had the sea change that we were hoping for after that law.

Senator RICKETTS. Thank you. Mr. Chairman, if I could just have another minute or so.

Chairman CASEY. Sure.

Senator RICKETTS. I would like you, Ms. Deacon, to comment on the quality question, as well.

Ms. DEACON. The quality question?

Senator RICKETTS. Yes, because again, there is cost-quality. How do we tackle that part of it?

Ms. DEACON. Yes. To sort of echo Ms. Tripoli's point, there is a lot of work that needs to be done on the quality side, as well. CMS obviously has some star ratings on hospitals. We have different associations and stakeholders that are also issuing quality ratings, but what I will say is that the consumer today, unfortunately, is left with sort of improperly correlating brand name and high cost with quality, but as Dr. Whaley would probably attest, there is no direct correlation between increased price and higher quality. In fact, oftentimes it is the inverse.

Again, we need to provide consumers and purchasers with more information on quality so they are not left to make that decision, an improper correlation on their own.

Senator RICKETTS. Yes, and just to be clear, when you are talking about the star ratings on hospitals, that is the hospital, in general. It is not about a particular procedure that hospital may be doing, right?

Ms. DEACON. That is right.

Senator RICKETTS. Even that data does not really mean that much to an individual who is getting a procedure in one hospital versus another because the hospital may have a high star rating but it may do this procedure particularly poorly versus another provider.

Ms. DEACON. Right.

Senator RICKETTS. Fair?

Ms. DEACON. Yes, absolutely, and they might be great at transplants, but, you know, not necessarily cardiac, so we definitely need more information on the quality side.

Senator RICKETTS. Great. Thank you, Ms. Deacon. Thank you, Mr. Chairman.

Chairman CASEY. Thank you, Senator Ricketts. Senator Warren.

Senator WARREN. Thank you, Mr. Chairman, and thank you and Ranking Member Braun for holding this hearing on price transparency. For almost every other type of service you can look up the price before deciding whether or not to purchase, but when it

comes to health care it is virtually impossible, even though Americans are paying more for health care than any other country in the world, so when patients need health care they should be able to easily find out the price of those services.

Here is something else they should be able to find out easily—who owns the hospital or the physician practice that you or a loved one may visit to receive that care? Today nearly 80 percent of doctors are employed by corporate entities, including private equity firms, and once in control, these firms raise their prices and cut corners to line their own pockets while the quality of care suffers.

Let me start with you, Dr. Whaley. You are an expert on private equity in health care. If a patient wanted to find out whether a neighborhood hospital or a primary care practice was owned by private equity, how hard would that be to do?

Dr. WHALEY. Senator Warren, I think it is virtually impossible for a patient to know whether or not their doctor's office is owned by a private equity company.

Senator WARREN. Yes, so virtually impossible, because private equity firms do not have to report ownership, it is nearly impossible to find out if the doctor's office you visit is owned by one of these corporate vultures.

Well, let's ask about the workers. How hard is it for the workers to find out? Ms. Opsahl, you lead the health fund at labor union 32BJ. If one of your members wanted to find out if a potential employer of any kind was owned by a private equity company, how simple would that be to do?

Ms. OPSAHL. Similar to what Dr. Whaley said, next to impossible, and I would even say as the employer or as the sponsor of the plan, I do not know who I am writing my self-funded checks to, as well.

Senator WARREN. Okay, so next to impossible, virtually impossible. I am sensing a trend here. Patients cannot find this information. Workers cannot find this information. Even antitrust regulators have a hard time finding this information. These are the agencies that are responsible for cracking down on anti-competitive behavior, and they cannot get their hands on these data, and it matters because private equity ownership has real consequences for the families and the workers who need help here.

Dr. Whaley, once private equity firms take over health care companies what happens to health care costs and quality?

Dr. WHALEY. Several studies have shown that when a private equity company acquires a health care practice, whether it be a physician or a hospital or other type of health care provider, prices increase quite substantially. We have also seen evidence, particularly in nursing homes, that quality goes down, again quite substantially.

Senator WARREN. I just want to relate this to the earlier line of questions, where you said people are using higher price as a signal that they are going to get better care, and yet the data show us that when private equity takes over, price goes up and quality of care actually goes down. Is that right, Dr. Whaley?

Dr. WHALEY. That is what the host of studies that have examined the question have said.

Senator WARREN. So not just one study. You see it across the board in all of the studies that have looked at this.

You know, I saw this firsthand in Massachusetts after private equity drove Steward Healthcare into bankruptcy, and that is why I introduced the Corporate Crimes Against Healthcare Act, which, among other things, would require private equity-owned health care companies to publicly report mergers, acquisitions, changes in ownership and control, and financial data, so at least the information would be out there.

Let me ask, Dr. Whaley, would these data help state and federal regulators prevent crises like the Steward failure in the future?

Dr. WHALEY. I think having accurate and transparent data on ownership is incredibly important and can help both state and federal regulators monitor health care markets and get ahead of what is happening in many cases.

Senator WARREN. Yes. It is shameful that these firms can hide in the shadows while patients and workers suffer. My Corporate Crimes Against Healthcare Act would shine a light on private equity's most parasitic practices. I would also claw back compensation from private equity executives that drive portfolio companies into bankruptcy. It would impose criminal penalties on executives when their failure result in patient deaths, and it would empower regulators to prevent crises like Steward from ever happening again.

There is a lot of work we need to do here, Mr. Chairman. Thank you.

Chairman CASEY. Senator Warren, thanks for your questions. I will turn to Senator Vance.

Senator VANCE. Thank you, Mr. Chairman, and thanks to you and the Ranking Member for your work on this, and thanks to the four of you for being here with us.

I have to sort of give special credit to both the Ranking Member and also to President Trump's administration for, I think, working a lot and getting a lot done on the question of price transparency, and obviously there is a lot more to do. I know Senator Braun has a bill that has done a lot on this space, and hopefully we can get some work on it.

I wanted to direct my questions to you, Ms. Deacon, and ask a little bit about just the connection between price transparency and actual price, because it is something that, you know, as somebody who has never worked in the health care space, at least not directly, I do not fully understand this entirely.

The basic argument, as I get it, is that if you provide more price transparency it gives people more information to negotiate better prices for certain services and so forth, but then obviously if you are an individual, self-insured, maybe small group insurance, it is going not be a little harder for you to negotiate a price than if you are part of a large group plan where effectively the insurance company is negotiating the price for you, so I am just very curious. Walk me through the interaction here between, especially for smaller consumers, between price transparency and hopefully lowering health care prices.

Ms. DEACON. Great. I think for a small business that provides health insurance for their members, whether self-funded or fully insured, they have an incentive and a financial reason to ensure

that their members are going to the most cost-effective hospitals or providers in their area, and so that does not just mean the cheapest or lowest price but that is price and quality.

If a small employer, that might not be able to have the weight of negotiation power with a big hospital or with a carrier, has this information they might be able to direct their members to the high-value provider that is in their community. Perhaps they have to drive an additional five miles or maybe even 10, but if they are able to send their members to high-value providers that they have access to they can dramatically lower their costs, without having to have the might of hundreds of thousands of lives behind them.

Senator VANCE. Got it, and so part of this, effectively, is employers, especially small employers, effectively using their claims data effectively, right. What are some of the barriers to using that claims data? Why don't we already just have the system? Why can't they do it already?

Ms. DEACON. I mean, I believe that most of the carriers today do not have an incentive. In fact, they have a disincentive to provide access to that information to employers, because they know what employers will see and they know what employers can do with that.

Senator VANCE. When you say carriers, do you mean insurers?

Ms. DEACON. Yes, third-party administrators in the case of a self-insured employer, or a carrier in a fully insured product, but absolutely, you know, especially for small employers, one of the reasons that the Braun-Sanders bill is so important is because it makes this data available in a standardized format that we know every carrier and/or TPA has access to, and it has the capability of providing that information in specifically standardized formats that they are using today, so small employers will really benefit from access to tools and technology that can leverage that standardized formatting in the claims data to really do a good job managing their health care costs for their businesses and their employees.

Senator VANCE. Got it. Well, thank you, Ms. Deacon. It sounds like a good endorsement of the Braun-Sanders bill, and apologies to the other three for not getting to you. Thank you all for being here. Thanks.

Chairman CASEY. Thank you, Senator Vance. I will turn next to the Ranking Member.

Senator BRAUN. Thank you, Mr. Chairman. Ms. Tripoli, I would like you to talk about another aberration in the hospital system—site neutrality, in this whole business of when hospitals buy clinics. Explain to the American public, to the Committee what that is about.

Ms. TRIPOLI. Absolutely. Site-of-service payment differentials really originate in Medicare payment, where Medicare pays more for services performed in an outpatient department than it does for the same service and the same quality if it is performed in a physician's office, and what this does is it does two things. First, it creates this incentive to push patients to higher costs of care settings, which, of course, increases the cost for everybody, and second, it creates a financial incentive, an economic incentive, for hospital systems to actually buy up physician practices, rebrand them as

outpatient department, and all that is really happening is they change the sign on the door to name it a hospital outpatient clinic.

Senator BRAUN. That average jack in price is about 40 percent?

Ms. TRIPOLI. Yes.

Senator BRAUN. That is why hospitals now comprise about 45 percent of the health care dollar because they have bought up so many clinics, and as soon as they buy the clinics the prices go up. That is another ripoff that happens nowhere else. Thank you for explaining it.

I want to expose this part of what was really essentially when I fixed it in my own business. The consumer is really disengaged, and then complains about the bill, holds his or her breath, three to four months later when you get it, and hope that the plan was right, and I have never seen a business either, for the folks that can afford it, and when the insurance companies told me that it is minor health care, and the overutilization of it, and the fact that there is no skin in the game among consumers, that that has driven costs high.

I mentioned earlier, insurance should be for indemnifying against critical illness or accident. I would like your opinion, Dr. Whaley and Ms. Deacon, on how do we get what drives most markets would be unfettered competition, no barriers to entry, price transparency, but an engaged consumer? How important is that part of the equation on the people that can afford it to be shopping around for their primary health care and to where we take insurance out of it completely?

That is what I did. That was a key element that actually brought it into line, because my employees became health care consumers and they exercised their power in doing it. Dr. Whaley?

Dr. WHALEY. I think that aspect is critical. I think one really good example actually comes from the California Public Employees Retirement System, or CalPERS, which recognized the huge variation in price that was not tied to quality and the exact same site-of-care differentials that we just discussed, and so what they did is they decided to give consumers skin in the game and said to patients, ″We know that there are low-priced providers and we are going to fully cover those providers. If you want to go to a higher-priced, inefficient provider then you are going to have to pay that difference.″

What we have seen in several studies with CalPERS is that over 90 percent of patients chose the lower-priced provider, and there is a huge reduction in prices, an improvement in quality, and substantial savings.

Senator BRAUN. Ms. Deacon?

Ms. DEACON. Yes. I definitely believe that there is a greater role that the consumer can play if and when they get access to good information and actual price. Again, this is one of the reasons that real prices, as opposed to estimates, are so important. When you get access to real prices, as opposed to estimates, you are much more likely to rely on those for your financial well-being and making decisions, so there is a set of what we will call shoppable services that you are able to do, that engage in that consumerism, but then there is the other sort of set of services, and more have to do with inpatient stays and sort of unplanned services, and that is

really when the employer or plan sponsor has to step in and take a role in terms of making better decisions and choices in who are they letting into their network, what they are paying for that network rate, and the value that they are getting for their members and for their business.

Senator BRAUN. By the way, before my time runs out, back in 2008, the insurance companies told me that if you can create a market and an engaged consumer you will save so much money. By then dealing with the slim amount of information—that was 16 years ago—it happened every time. When you had to pick up the phone, get on the Web, you were experiencing 30 to 70 percent savings.

They also told me you would save so much money you can protect your employee with not having to engage in the coinsurance, which is when you have a significant illness or accident you blow outside the deductible and that is what takes you to bankruptcy court. We got rid of that, and also got rid of copayments, and that has held everything flat since then, so they became health care consumers. People love it, because sooner or later you have a critical illness or a bad accident, and when you never have to pay outside your deductible and you help save money by shopping within a broken system, imagine if providers would make that easy what we could do to lower health care costs.

Thank you.

Chairman CASEY. Thank you, Ranking Member Braun. I knew that Senator Warnock was on his way, and he appeared exactly at the right time. Senator Warnock.

Senator WARNOCK. Thank you very much, Chair Casey and Ranking Member Braun. Great to work with both of you on so many important things. Chair Casey, I am especially grateful to be working with you on the Capping Prescription Costs Act, so we can finish the job of the Inflation Reduction Act when it comes to lowering drug costs. That means so much for the populations that we are discussing in this hearing.

Nearly 15 years after the passage of the Affordable Care Act, 10 states have not extended access to affordable Medicaid coverage for nearly three million Americans, in my own State of Georgia more than 600,000 Georgians. Ms. Tripoli, there is a lot of mischaracterizations about who is left in the coverage gap. Can you paint a picture for us about those who are left behind? Who are these people?

Ms. TRIPOLI. Absolutely. These are people who are very poor, who do not currently meet the eligibility or category requirements to qualify for Medicaid in states that have not expanded, in the 10 states, but they also fall underneath the Federal poverty level, so they do not qualify for subsidies in the marketplace either, and these are disproportionately people of color, disproportionately people with disabilities, and without access to health care it is very difficult road. They essentially have to forego or delay care, and we know that that often exacerbates their health conditions and can be often a life-or-death situation.

Senator WARNOCK. Disproportionately people of color.

Ms. TRIPOLI. That is right.

Senator WARNOCK. Disproportionately the working poor.

Ms. TRIPOLI. That is right.

Senator WARNOCK. Working people, and I underscore that because we hear a lot of moralizing in this space, in so many of our government spaces, about people needing to work, but often our policy literally gets in the way of people who are quite literally dying to get to work, and I say that, and I am thinking about Heather Payne, a traveling nurse in Dalton, Georgia. I have gotten to know Heather. She was my guest at the State of the Union address. I talked to her this morning. She is a relatively young woman who has had a series of strokes that literally changed her life. She was a traveling nurse, and sometimes she had health care and sometimes she did not, so she has found herself in a terrible situation, and the tragic irony that here she is a traveling nurse who has dedicated her whole career to caring for people, and she has had to put off essential medical procedures because she simply cannot afford to pay out-of-pocket costs and cannot afford plans on the Marketplace because she does not qualify for subsidies.

I literally talked to her about this this morning. I could both hear and feel her stress around these issues, even as she is trying to get her life together. She wants to go on and get another nursing degree and hopefully get her health back I order, but she cannot see the specialist she needs, so that is why today I am introducing the Bridge to Medicaid Act, with Chair Casey's support, which would temporarily extend subsidies to people in the coverage gap to buy private insurance.

Ms. Tripoli, how does access to affordable health care benefit people like Heather who are in the coverage gap?

Ms. TRIPOLI. I mean, simply it is a lifeline. It allows them to have access to the preventive services—cancer screening, prescription drug medication, diabetes management——

Senator WARNOCK. They want to get back to work.

Ms. TRIPOLI. Exactly

Senator WARNOCK. I am encouraged by recent developments, and I believe we are closer than ever to closing the coverage gap in all 50 states, for those who want to make this a red/blue issue. Most of the states have expanded, blue states and red states, but as those conversations continue, people like Heather are caught in the crosshairs, so my legislation would give vulnerable Americans access to affordable health care while state politicians, I hope, move closer to making the right decision for their constituents.

I am a pastor, but those who are not moved by the moral argument, you know, that would be sad.

Let me underscore the economic argument. A report from the Georgia Health Initiative, in March 2024, found that closing the coverage gap would create 51,264 jobs statewide, and boost economic output by $9.3 billion during the first three years of full expansion. That is just in the State of Georgia. Not to mention that we saw $3 billion of uncompensated care that our hospitals had to carry in Georgia in 2021 alone, while politicians play this game.

Can you talk about how states have benefited economically from Medicaid expansion?

Ms. TRIPOLI. Absolutely. I think that is exactly right, and I think the other economic benefit for states who have expanded, particularly states with a lot of rural hospitals, is that we have seen, in

states that have expanded Medicaid, we have seen a reduction in the amount of rural hospitals that have had to close their doors, so Medicaid expansion is very important, obviously important for people to get access to care, and important for the economy, as well.

Senator WARNOCK. Thank you so very much, Ms. Tripoli, and thanks to all of our witnesses. Georgians and Americans in nine other states cannot afford to wait around for state leaders to make the right choice, and that is why today I am proud to introduce, along with Chair Casey, the Bridge to Medicaid, which temporarily extends subsidies to the millions of Americans in the coverage gap. This legislation is not a replacement for full Medicaid expansion, but we are doing it because people like Heather Payne cannot wait.

Georgia still, by the way, has the option to fully expand, and $1.2 billion in additional Federal funding will be waiting for Georgia when it finally does the right thing.

Thank you so very much.

Chairman CASEY. Thank you, Senator Warnock, and thank you for your work on these issues, especially Medicaid, all these years.

Senator Braun, the Ranking Member, just went to the HELP hearing, so I want to make sure that we have time to close so I can get to the same hearing. We are juggling today.

I want to note for the record, as well, that Senator Blumenthal joined us earlier, and as I said today, it is a busy Thursday, but we are grateful for those who attended the hearing. We are certainly grateful for the expertise and experience brought to this Committee by the witnesses.

As we heard today, rising health care costs are a terribly significant problem for so many Americans, and this issue has to be addressed. As hospital prices rise, individuals are increasingly faced with the unacceptable decision, the awful decision to delay or forego necessary care or go into medical debt to receive lifesaving health services. Improving transparency is one of the many policy proposals that has the potential to help lower costs for patients.

As we heard today, especially from Ms. Tripoli, a broader rethinking of economic incentives in the health care sector is necessary to better meet the goal that we all share to improve health for both patients and families. Along with transparency measures we must continue efforts to address all factors impacting health care costs.

We have heard from our witnesses today about the various factors driving up hospital costs, and we know that patients also struggle with costs associated with prescription drugs, costs associated with doctor visits, and health insurance premiums.

I look forward to working with my colleagues to address rising health care costs and ensure that all Americans can afford quality care.

I will have Ranking Member Braun submit his closing remarks for the record, and I want to thank again all of our witnesses for being here, for taking the time to be with us, and to provide your expertise to the Committee.

If any Senator has additional questions for the witnesses or statements to be added to the hearing record, the record will be

open for seven days, until next Tuesday, July 18th. Thank you all for participating today. We are adjourned.

[Whereupon, at 11:20 a.m., the hearing was adjourned.]

CLOSING STATEMENT OF SENATOR MIKE BRAUN, RANKING MEMBER

Thank you, Chairman Casey. Thank you to our witnesses for sharing your testimonies and personal experiences.

Today, we heard about the importance of health care price transparency and how access to this information will lower costs for Americans. We need policies that empower patients and provide employers with the information necessary to create the best health care benefit for their employees. With transparency throughout the health care supply chain, Americans will be able to see the cost of health care services before they receive them. This will increase competition and lower prices as patients have the ability to shop around for the best price and highest quality.

I hope today we recognized that there are bipartisan solutions that thoughtfully address this issue.

I am encouraged by the work being done by all of our witnesses here today, and I appreciate our Committee's focus on this issue.

I yield back.

APPENDIX

Prepared Witness Statements

U.S. SENATE SPECIAL COMMITTEE ON AGING

"HEALTH CARE TRANSPARENCY: LOWERING COST AND EMPOWERING PATIENTS"

JULY 11, 2024

PREPARED WITNESS TESTIMONY

Dr. Chris Whaley

Chairman Casey, Ranking Member Braun, and members of the Committee, thank you for the opportunity to testify today. My name is Christopher Whaley. I am an associate professor of Health Policy at the Brown University School of Public Health and Associate Director of the Center for Advancing Health Policy through Research (CAHPR). My research focuses on health care price transparency, the impacts of evolving health care markets, and studying employer and purchaser innovations that are enabled by price transparency information.

In the United States, employers and purchasers of health care play a significant role in shaping the U.S. healthcare system. Employers provide health insurance for over 160 million Americans the largest source of health insurance in the United States.[1] In most cases, employers select employee plan offerings and thus determine the types of health plans available to their employees and their families. Employers also play a critical role in financing the U.S. healthcare system. Collectively, employer-sponsored insurance accounts for approximately $1.4 trillion in health care spending.[2]The average premium for an employer-sponsored family health insurance plan is now nearly $24,000. As health care spending has increased over the last two decades, employers have reduced wages for workers.[3] [4] [5] [6]

Particularly for lower-income households, rising health care costs for employer-sponsored insurance create financial burdens when receiving care, which can limit access to care, because health benefits are financed from wages, employers have both a legal and moral obligation to be responsible fiduciaries when they purchase health benefits on behalf of their employees.

Unfortunately, many employers face challenges purchasing affordable health care coverage that provides real value for their workers, as more often than not they are having to make decisions while blind to prices for services in the marketplace. Many employers cannot access plan claims data, limiting their ability to monitor prices negotiated on their behalf and prudently design plan offerings. Furthermore, even when employers can access comparative cost information, they far too often face consolidated provider markets with limited access to lower-price, high-quality providers. The combination of a lack of price transparency and health care consolidation has made fulfilling their fiduciary obligations challenging for even the most engaged employers and purchasers.

My testimony today will focus on why making price information transparent is critical for addressing health care affordability and ensuring efficient health care markets. I will make three main points:

1. Health care prices in the United States are high and variable and are driven by provider consolidation and market power, and those high prices are not linked to increases in quality.

2. Rather than placing the responsibility of navigating the US healthcare system on patients, effective price transparency can be a hub that enables impactful programs and policies developed by employers and policymakers that improve access to lower-priced, high-quality providers and ensure health market competition.

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[1] Employer Health Benefits Survey. KFF. Published October 18, 2023. Accessed July 8, 2024. https://www.kff.org/health-costs/report/2023-employer-health-benefits-survey

[2] Centers for Medicare & Medicaid Services. Historical/CMS. https://www.cms.gov. Published December 13, 2023. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical

[3] Arnold D, Whaley CM. Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages. RAND Corporation; 2020. https://www.rand.org/pubs/working—papers/WRA621-2.html

[4] Baicker K, Chandra A. The Labor Market Effects of Rising Health Insurance Premiums. Journal of Labor Economics. 2006;24(3):609-634. doi:10.1086/505049

[5] Brot-Goldberg Z, Cooper Z, Craig SV, Klarnet LR, Lurie I, Miller CL. Who Pays for Rising Health Care Prices? Evidence from Hospital Mergers. Published online June 2024. doi:10.3386/w32613

[6] Anand, Priyanka. 2017. Health insurance costs and employee compensation: Evidencefrom the national compensation survey. Health Economics, 26(12): 1601 1616.

3. There are potential steps Congress and the federal government could consider to increase both transparency on prices and ownership structure in health care markets and enable price transparency to reach its cost-containment potential.

U.S. Health Care Prices are High and Variable

The United States leads the world in health care spending, largely due to high prices.[7] Prices also vary considerably, both within and across markets. Several studies document substantial variation in U.S. health care prices. My recent research shows employer and private insurance prices for hospital care average 254 percent of Medicare. However, prices are below 200 percent of Medicare in states like Arkansas, Iowa, and Michigan, but over 300 percent of Medicare in states of West Virginia, Florida, and Georgia.[8] In addition, both Medicare and commercial insurers pay roughly twice as much for common services, such as laboratory tests, diagnostic imaging services, and outpatient surgeries, performed in hospital-based settings than non-hospital sites of care.[9]

High and variable health care prices are often not linked to quality and are driven by provider consolidation and market power. Over the last two decades, U.S. health care provider markets have experienced three main types of consolidation. The first involves horizontal consolidation, primarily driven by hospital and health system acquisition of other hospitals. U.S. health care markets have seen over 2,000 hospital mergers. Hospital mergers lead to meaningful increases in prices, without improvements in quality.[10] [11] The second form of consolidation involves vertical consolidation, where large entities, primarily hospitals and health systems, acquire intermediaries, primarily physician practices. Over the last decade, the share of U.S. physicians employed by a hospital or health system has approximately doubled. Currently, over half of U.S. physicians are employed by a hospital or health system. Driven by site-of-care payment differentials in both Medicare and commercial payment rates, this form of consolidation changes referral patterns for many downstream services, thereby increasing both Medicare and commercial spending.[12] [13] A more recent form of vertical integration involves insurers directly acquiring both physician practices and other types of providers.[14] Particularly for Medicare Advantage populations, this form of consolidation raises concerns about access to care and payment gaming.[15] Finally, the latest wave of health care consolidation is driven by private equity, which owns a growing share of U.S. physician practices. Studies show private equity acquisition leads to price increases without commensurate gains in access or quality. Importantly, these models of consolidation disadvantage the

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[7] Anderson GF, Reinhardt UE, Hussey PS, Petrosyan V. It s The Prices, Stupid: Why The United States Is So Different From Other Countries. Health Affairs. 2003;22(3):89-105. doi: doi. https://www.org/10.1377/hlthaff.22.3.89

[8] Whaley CM, Kerber R, Wang D, Kofner A, Briscombe B. Prices Paid to Hospitals by Private Health Plans: Findings from Round 5 of an Employer-Led Transparency Initiative. RAND Corporation; 2024. Accessed July 8, 2024. https://www.rand.org/pubs/research—reports/RRA1144-2.html

[9] Robinson J, Whaley C, Dhruva S. Prices and Complications in Hospital-Based and Freestanding Surgery Centers. The American Journal of Managed Care. 2024;30:179-184. Accessed July 8, 2024. https://www.ajmc.com/view/prices-and-complications-in-hospital-based-and-freestanding-surgery-centers

[10] Cooper Z, Craig SV, Gaynor M, Van Reenen J. The Price Ain t Right? Hospital Prices and Health Spending on the Privately Insured. Q J Econ. Published online 2018. doi:10.1093/qje/qjy020

[11] Liu JL, Levinson ZM, Zhou A, Zhao X, Nguyen P, Qureshi N. Environmental Scan on Consolidation Trends and Impacts in Health Care Markets. RAND Corporation; 2022. Accessed January 19, 2024. https://www.rand.org/pubs/research—reports/RRA1820-1.html

[12] Whaley C, Paul DRL, Perkins J. Addressing Site-of-Care Payment Differentials in the United States Health Care System. Brown University School of Public Health 2024.Accessed July 8, 2024. https://www.cahpr.sph.brown.edu/sites/default/files/documents/Site%20Neutral%20Payment%20Policy%20Brief-2.pdf

[13] Richards MR, Seward JA, Whaley CM. Treatment consolidation after vertical integration: Evidence from outpatient procedure markets. Journal of Health Economics. 2022;81:102569. doi:https://www.doi.org/10.1016/j.jhealeco.2021.102569

[14] Zhao X, Richards MR, Damberg CL, Whaley CM. Market Landscape and Insurer-Provider Integration: The Case of Ambulatory Surgery Centers. Health affairs scholar. 2024;2(6). doi:https://www.doi.org/10.1093/haschl/qxae081

[15] Rooke-Ley H, Shah S, Fuse EC. Medicare Advantage and Consolidation s New FrontierThe Danger of UnitedHealthcare for All. New England Journal of Medicine. Published online July 6, 2024. doi:https://www.doi.org/10.1056/nejmp2405438

healthcare workforce, with physicians and nurses receiving lower pay following consolidation.[16] [17]

While high and variable prices directly impact those with commercial insurance, they also have important implications for aging Americans. First, many over-65 individuals receive private insurance, most commonly from current or former employers, and are thus impacted by high and variable prices. Second, numerous studies show the health impacts of high healthcare costs for patients in the form of reductions in high-value and necessary care. For the under-65 population to age healthily, it is critical that they have access to affordable health care. Finally, high and differential prices drive health care consolidation, which erodes access to and quality of care for Medicare beneficiaries.[18] [19] [20]

What is the role of price transparency in addressing rising health care costs?

Due to the high and variable nature of U.S. health care prices, improving price transparency has been a potential policy option for several years. Early price transparency models relied on patient-driven use through apps and online tools.[21] Despite initial promise, these models had little success.[22] [23] Relying on patients to navigate the complexities of the U.S. healthcare system with even the best price transparency tools is a challenging task.[24] However, the lack of usable price transparency limits the ability of researchers to understand health care markets, entrepreneurs from adding competition to healthcare markets, and regulators from monitoring market conduct and competition. Rather than placing the responsibility of navigating the US healthcare system on patients, effective price transparency can be a hub that enables impactful programs and policies. Several employers and purchasers have used price transparency to redesign benefits.

Example 1: California Public Employees Retirement Systems (CalPERS)

The California Public Employees Retirement System (CalPERS), which provides health benefits to approximately 1.4 million individuals, recognized the wide variation in prices within their network that was not tied to clinical outcomes. Rather than implementing a punitive high-deductible plan, they worked in conjunction with their labor representatives to design a steerage program that uses financial incentives to encourage the use of lower-priced providers and non-hospital providers.

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[16] Prager E, Schmitt M. Employer Consolidation and Wages: Evidence from Hospitals. American Economic Review. 2021;111(2):397-427. doi:https://www.doi.org/10.1257/aer.20190690

[17] Whaley CM, Arnold DR, Gross N, Jena AB. Physician Compensation In Physician-Owned And Hospital-Owned Practices. Health Affairs. 2021;40(12):1865-1874. doi:https://www.doi.org/10.1377/hlthaff.2021.01007

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[19] Levin JS, Komanduri S, Whaley C. Association Between Hospital, Physician Vertical Integration and Medication Adherence Rates. Health Services Research. Published online October 22, 2022. doi:https://www.doi.org/10.1111/1475-6773.14090

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[24] Chernew M, Cooper Z, Hallock EL, Scott Morton F. Physician agency, consumerism, and the consumption of lower-limb MRI scans. J Health Econ. 2021;76:102427. doi:10.1016/j.jhealeco.2021.102427

Across several services, this program reduced spending by approximately 20 percent and improved care quality.[25] [26] [27]

Example 2: State of Oregon Hospital Reimbursement Caps and All-Payer Claims Database

A similar example comes from the State of Oregon. Recognizing the wide variation in hospital prices, Oregon passed legislation that caps the prices of hospital care at 200 percent of the Medicare rates for Oregon's public employees and educators. My colleagues have demonstrated that this program led to over $100 million in savings in the first two years of the program, without impacts on the quality of care or the provider workforce.[28] If adopted among other states, we estimate that this model could reduce public employee spending by approximately $7 billion, which could be used to increase public employee pay or returned to taxpayers, and nearly $90 billion if expanded to the broader commercial market. Oregon also invested in an all-payer claims database, which allows state authorities to monitor price and spending trends.

Example 3: 32BJ Health Fund - Private-Sector Adoption of Innovations

These innovations are also being adopted by private-sector organizations. In one notable example, the 32BJ Health Fund, which provides health benefits to approximately 200,000 service workers, reviewed its claims data and realized some providers had exceptionally high prices. After several attempts at negotiation, 32BJ excluded a single hospital from its network. This decision saved the Health Fund approximately $100 million per year, which it returned to its workers in the form of the largest worker pay increase in its history and a $3,000 bonus for each member.[29]

Example 4: Indiana employers using data to push for policy changes

Another example comes from employers in the state of Indiana. Through the Employer s Forum of Indiana, we worked with Indiana employers to analyze their claims data and found they were paying some of the highest prices in the country.[30] In addition to using price transparency data to monitor prices negotiated on their behalf and to inform both benefit design and purchasing decisions, Indiana employers pushed for legislation that limits facility fees and adds additional transparency to Indiana health care markets.[31] These efforts use price transparency data to add oversight into an opaque market and inform policies that improve market competition.

These are notable examples and there are many more entrepreneurs and innovators that are using price transparency data to develop similar programs that steer patients to lower-priced providers,[32] modernize payment methods in ways that align incentives between patients, providers, and payers,[33] and add competition to health care markets.

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[25] Robinson JC, Brown TT. Increases In Consumer Cost Sharing Redirect Patient Volumes And Reduce Hospital Prices For Orthopedic Surgery. Health Affairs. 2013;32(8):1392-1397. doi:https://www.doi.org/10.1377/hlthaff.2013.0188

[26] Robinson JC, Brown TT, Whaley C, Finlayson E. Association of Reference Payment for Colonoscopy With Consumer Choices, Insurer Spending, and Procedural Complications. JAMA Internal Medicine. 2015;175(11):1783. doi:https://www.doi.org/10.1001/jamainternmed.2015.4588

[27] Robinson JC, Brown TT, Whaley C. Reference Pricing Changes The Choice Architecture Of Health Care For Consumers. Health Affairs. 2017;36(3):524-530. doi:https://www.doi.org/10.1377/hlthaff.2016.1256

[28] Murray RC, Brown ZY, Miller S, Norton EC, Ryan AM. Hospital Facility PricesDeclined As A Result Of Oregon s Hospital Payment Cap. Health Affairs. 2024;43(3):424-432. doi:https://www.doi.org/10.1377/hlthaff.2023.01021

[29] SEIU 32BJ Healthcare Savings Case Study. PatientRightsAdvocate.org. Accessed July 8, 2024. https://www.patientrightsadvocate.org/seiu-32bj-healthcare-savings-case-study

[30] Abelson R. Many Hospitals Charge Double or Even Triple What Medicare Would Pay. The New York Times. https://www.nytimes.com/2019/05/09/health/hospitals-prices-medicare.html. Published May 9, 2019.

[31] Mathews AW. These Employers Took On Healthcare Costs, and the Fight Got Nasty. WSJ. Published September 28, 2023. https://www.wsj.com/health/healthcare/these-employers-took-on-healthcare-costs-and-the-fight-got-nasty-54674114

[32] Whaley CM, Vu L, Sood N, Chernew ME, Metcalfe L, Mehrotra A. Paying Patients To Switch: Impact Of A Rewards Program On Choice Of Providers, Prices, And Utilization. Health Affairs. 2019;38(3):440-447. doi:https://www.doi.org/10.1377/hlthaff.2018.05068

[33] Whaley CM, Dankert C, Richards M, Bravata D. An Employer-Provider Direct Payment Program Is Associated With Lower Episode Costs. Health Affairs. 2021;40(3):445-452. doi:https://www.doi.org/10.1377/hlthaff.2020.01488

While these policies and programs are designed to fit the needs of each group's market and population, a common theme is that each group relied on price and network data, most commonly from medical claims data, to innovate. These organizations also take seriously their responsibilities as health care purchasing fiduciaries. These types of models are critical to ensure affordable access to high-quality providers across the aging lifecycle.

What more can be done to enable price transparency to reach its cost containment potential?

In recognition of the importance of price transparency, recent federal policies have sought to expand access to price transparency information. On January 1, 2021, requirements for hospitals to negotiate their prices for all items and services went into effect.[34] Following that, on July 1, 2022, a federal rule went into effect that requires health plans to disclose the negotiated prices they pay physicians and facilities for each item they provide, known as Transparency-in-Coverage (TiC) data.[35] Both of these policies greatly expand health care price transparency.

While there have been some concerns with the implementation of the rules, there have been significant positives to each. The insurer-posted (TiC) data provides the most comprehensive view of U.S. health care prices currently available. There were initial concerns about the TiC data usability, but researchers, including myself, have been able to use data to measure price variation. Entrepreneurs are also using these data to improve benefit design innovations.

While these data are important, they, like most things, can also be improved. There are several steps Congress and the federal government could consider to increase price transparency in health care markets and enable price transparency to reach its full cost-containment potential.

Increase compliance enforcement and standardization of hospital-posted price transparency data

The hospital-posted price transparency data represent an initial step into expanding access to price transparency. However, compliance with requirements to post negotiated rates for 300 shoppable services could have been better, largely due to more enforcement. While recent enforcement has increased, compliance still needs to improve, with estimates suggesting that only 16 to 35 percent of hospitals are fully compliant.[36] [37] Other studies find strategic non-compliance is related to a hospital s market environment.[38] Even among complying hospitals, data formats, reported services, and price measurements vary widely. To ensure that these data are useful for informing policy decisions, it is important for CMS to enforce compliance and standardize data submission.

Reduce the duplicative prices and prices for providers that do not perform listed services from the TiC data and centralize data posting

The TiC data include many duplicative prices and prices for providers that do not perform listed services. These features greatly inflate the size of the TiC data, reducing its applicability and accuracy. Second, the TiC data are completely updated on a monthly basis, which further adds barriers to data use. To further improve this innovative resource, CMS could require insurers to only post prices for providers with submitted claims for a given procedure. CMS could also limit monthly updates to new or changed prices, rather than a complete data refresh.

Additionally, the TiC data are currently hosted individually by plans and insurers. CMS could centralize TiC data by acting as a central hub for hosting these data. The data are also currently posted in non-standard data formats, which contributes to inflated data size. CMS could use common modern database technologies

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[34] Department of Health and Human Services. 45 CFR Part 180. Published November 27, 2019. https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-E/part-180#180.40

[35] FAQS about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49.; 2021. https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf

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[37] Patient Rights Advocate. Sixth Semi-Annual Hospital Price Transparency Report February 2024. Patient Rights Advocate; 2024. https://www.patientrightsadvocate.org/semi-annual-report-feb2024

[38] Mittler JN, Abraham JM, Robbins J, Song PH. To be or not to be compliant? Hospitals initial strategic responses to the federal price transparency rule. Health Services Research. Published online November 6, 2023. doi:https://www.doi.org/10.1111/1475-6773.14252

to allow a broad set of users to access the data and substantially reduce data size and complexity without losing any valuable data.

Require a centralized national database to enhance transparency of provider ownership and control

While existing transparency efforts primarily focus on prices, provider ownership and affiliation arrangements are often complex and opaque. Existing data resources do not adequately track ownership structure, limiting appropriate measurement of consolidation activities and policies to guard against adverse impacts of consolidation.[39] Researchers, and importantly, policymakers, lack comprehensive data on who owns or controls health care entities and physician practices. Many provider organizations are organized through complex corporate structures that obscure the identity of the owner or control entity and prevent accountability.[40] Patients often have little information on their physician s actual employer. As a result, estimates of both the extent and impacts of consolidation are limited and incomplete. Ownership transparency could be improved by requiring provider organizations to report not just direct ownership but also management, joint venture, and related arrangements. Developing a centralized national database to enhance the transparency of provider ownership and control will allow for a more complete understanding of the true extent and effects of consolidation in US health care markets, including changes in prices, utilization, and quality of care.

Ensure that self-funded purchasers have access to data on price, utilization, and quality

While these efforts have been primarily focused on expanding access to publicly-available price transparency data, many employers and self-funded purchasers rely on medical claims data to measure prices, track quality, and ensure access to efficient providers. Yet, many employers and purchasers face barriers in accessing their medical and pharmacy claims data. The 2021 Consolidated Appropriations Act (CAA) removes many restrictive and anti-competitive clauses from plan contracts, but does not ensure that self-funded purchasers have access to their claims data.[41] As a result, many employers have had to sue to get access to their own data.[42] It is important that purchasers have access to data on price, utilization, and quality that these data provide. Proposed bipartisan legislation codifies access to these data, which are necessary for self-funded plans to be responsible fiduciaries and monitor prices negotiated on their behalf.[43]

Conclusion

Health care prices in the United States are high, variable, and opaque. High prices are both a cause and a consequence of health care consolidation, which has left many communities with a single provider system and worsened access to high-quality care. Arguably, the most significant bipartisan federal agreement in recent years has centered on enhancing transparency in healthcare pricing. In combination with expanded insight into provider ownership and management, broadened transparency can help employers and health care purchasers fulfill their fiduciary obliga-

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[39] The Perils Of PECOS: Using Medicare Administrative Data To Answer Important Policy Questions About Health Care Markets. Forefront Group. Published online January 7, 2021. doi:https://www.doi.org/10.1377/forefront.20201222.615286

[40] Hearing on Strengthening U.S. Economic Leadership: The Role of Competition in Enhancing Economic Resiliency. Published online 2024. https://www.judiciary.senate.gov/committee-activity/hearings/strengthening-us-economic-leadership-the-role-of-competition-in-enhancing-economic-resiliency

[41] Consolidated Appropriations Act, 2021 (CAA)/CMS. https://www.cms.gov. https://www.cms.gov/marketplace/about/oversight/other-insurance-protections/consolidated-appropriations-act-2021-caa

[42] Kraft Heinz Co. Employee Benefits Administration Board, et al., v. Aetna Life Insurance Company, 2:23-cv-00317, District Court, E.D. Texas, June 30, 2023, https://www.versanconsulting.com/post/kraft-heinz-co-employee-benefits-administration-board-et-al-v-aetna-life-insurance-company; Massachusetts Laborers Health & Welfare Fund v. Blue Cross Blue Shield of Massachusetts, 66 F.4th 307 (1st Cir. 2023), April 25,2023, https://www.casetext.com/case/mass-laborers-health-welfare-fund-v-blue-cross-blue-shield-of-mass-1; Owens & Minor, Inc. and Owens & Minor Flexible Benefits Plan v. Anthem Health Plans of Virginia, Inc., 3:23-cv-00115, February 13, 2023, https://www.millerchevalier.com/sites/default/files/resources/General—Alerts/2023-02-13—Owens-v-Anthem—Complaint.pdf; Bricklayers, Craftworkers, Sheet Metal Workers Unions v. Elevance, 3:22-cv01541-VLB, December 5, 2022, https://www.documentcloud.org/documents/23378734-bricklayers-craftworkers-sheet-metal-workers-unions-v-elevance.

[43] 118th Congress S.3548 - Health Care Prices Revealed and Information to Consumers Explained Transparency Act. https://www.congress.gov/bill/118th-congress/senate-bill/3548/all-info

tions to provide access to high-quality and affordable care. It also aids regulators and policymakers in overseeing healthcare market competitiveness and ensuring patient access to high-quality, cost-effective care. While not a cure-all for the U.S. healthcare system, given the widespread impact on all individuals navigating the healthcare system, these initiatives enjoy substantial public backing. To accomplish these goals, Congress can improve the existing Transparency-in-Coverage policies that provide substantial insight into US health care prices, ensure transparent reporting of provider ownership and management, and codify self-funded employer and purchaser access to their claims data.

U.S. SENATE SPECIAL COMMITTEE ON AGING

"HEALTH CARE TRANSPARENCY: LOWERING COST AND EMPOWERING PATIENTS"

JULY 11, 2024

PREPARED WITNESS TESTIMONY

Chris Deacon

Chairman, Ranking Member, and distinguished members of the Committee,

Thank you for the opportunity to testify today on the critical issue of transparency in healthcare. Imagine, if you will, you are the CFO of a company where you give the company credit card to your vendors and suppliers. Instead of receiving an itemized statement at the end of the month, you are handed a sheet of paper with one number-no receipts, no details, just the total amount owed. No employer would ever allow such a practice. Yet, this is exactly what happens in our healthcare system today. Employers hand over the company credit card to Blue Cross Blue Shield, Aetna, United, Cigna, Optum and CVS, allowing them to pledge company dollars to a healthcare system that can charge whatever they want, however they want, simply because they can.

Where are the checks and balances in healthcare? Balance necessarily requires equal access to information, and that is why we are here today.

Transparency. Or rather, the lack of transparency facing employers and unions that are responsible for purchasing healthcare for over 160 million Americans.

You likely know the statistics and the alarming rate at which healthcare costs are growing, but I know the people behind these statistics. As former administrator for the State of New Jersey employee health plan I know first-hand how the lack of transparency impacts our teachers, firemen, police officers, and public sector workers. Sadly, this year in New Jersey over 200 school positions will be eliminated due to budget constraints, driven in large part by the cost of health benefits.[1]

ERISA, which governs most employer sponsored health plans in the country, is intended to protect plan participants and beneficiaries by mandating that plan sponsors act as fiduciaries. When employers lack access to their own data and transparent information about the cost and quality of care, they are unable to fulfill ERISA's promise.

Let me share three examples to illustrate the magnitude of this issue:

–At Mayo Clinic in Jacksonville, if you were to use your Federal Employee Health Benefit BCBS card for an arthrocentesis procedure it would cost you and the federal government $2,516.[2] If you were to pay cash for the same procedure, you would pay just $392.60. That is six times more than the cash rate. At University of Pennsylvania Hospital, the cash price for an ACL repair is $9,523.36,[3] but if you are a service member covered by TRICARE, your price is $37,489.74, that is 294% more than the cash rate.

–Or consider when a third-party administrator, or TPA, pays twice for a claim in error, or pays for an improperly upcoded claim, because TPAs act as middlemen, similar to a PBM, and uses the employer's funds to pay claims, they bear none of the risk. And when a TPA pays the inflated or improper bill with the employer or unions' funds, there is no obligation for the TPA to recover those payments. If, and I emphasize IF, the employer is lucky enough to benefit from an attempted recovery, it will be less the TPA's savings fee, ranging anywhere from 25-50%. This is the ultimate fox guarding the hen house.

–But TPA's are not always "overpaying;" in fact, quite often they are paying providers one sum, and then charging the employer many times more for the same claim. In several recently unsealed court documents it was revealed that an employer sponsored health plan paid $4,078,652.42 on a claim, but the provider only received $875,809.76.[4] What accounted for the difference? Cigna took $2,524,898.98 in fees, and their subcontractor Multiplan took $677,943.68. The fees were 2.9 times the provider's payment.

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[1] https://www.nj.com/education/2024/07/nj-schools-are-cutting-hundreds-of-jobs-this-summer-heres-why.html

[2] https://https://www.turquoise.health/health—systems/mayo-clinic/services/?q=Arthrocentesis+%28drainage%29+of+joint&service—name=arthrocentesis-drainage-of-joint

[3] https://https://www.turquoise.health/health—systems/university-of-pennsylvania-health-system/service—category/musculoskeletal/

[4] htttps://https://www.dockets.justia.com/docket/california/cacdce/8:2020cv00269/772742 See attached TML Recovery Services, Ltd. unsealed exhibit

These examples are the tip of the iceberg in terms of the waste, abuse and inefficiencies in the current market, driven in large part by lack of transparency and meaningful access to data. Though we may increasingly be able to pull up the hospital prices, and carrier negotiated rates, unless and until employers are able to have access to run their own numbers, identifying this type of conduct will remain elusive to employers and unions.

If we expect employers and unions to exert any type of market forces to reign in healthcare costs, we must empower them with actional data and transparent pricing. The company credit card has been abused for too long by the PBMs, TPAs and other industry players. It should not be unreasonable to demand for receipts of payment, itemized statements, and the ability to protect their members. This is what S3548 uniquely accomplishes, in a superior manner, in my opinion to the Lower Cost More Transparency Act. Federal lawmakers must rebalance the information asymmetry to empower employer purchasers and unions to push back against egregious pricing, unfair billing practices, gross overreach, and profiteering. This will help protect the American workers' paychecks and ensure a fairer, more accountable healthcare system.

Thank you.

U.S. SENATE SPECIAL COMMITTEE ON AGING

"HEALTH CARE TRANSPARENCY: LOWERING COST AND EMPOWERING PATIENTS"

JULY 11, 2024

PREPARED WITNESS TESTIMONY

Cora Opsahl

Good morning. Thank you Chairman Casey, Ranking Member Braun, and the rest of the Committee on Aging for inviting me to speak this morning.

My name is Cora Opsahl, and I am the Director of the 32BJ Health Fund. The 32BJ Health Fund is a self-insured, Taft-Hartley benefit fund that provides health benefits to over 200,000 union members and their families. Our members are essential workers who work in the real estate industry, security officers, school workers, and airport workers. We are based primarily in the New York/New Jersey area, but we have families up and down the East Coast including Pennsylvania and Massachusetts. The Fund is jointly governed by a board of trustees appointed by the Union and the Employers, and we provide high-quality health benefits with no premium sharing, $0 in-network deductibles, and low in-network copays. We believe the fund has an important role in tackling the problem of healthcare affordability, and we have spent over a decade doing just that by leveraging our data, challenging the status quo, and finding innovative ways to manage our benefit.

Having access to our claims data is foundational to our work. For almost 20 years, we have been fortunate to have access to our medical, pharmacy, and ancillary claims data. We use this data to understand our healthcare spend, make benefit decisions, and ensure we are a good steward of the Fund's resources, because of our data, we know the following:

–In 2023, we spent $1.4 billion in healthcare.

–Of the $1.4B we spend in healthcare, 55% is spent on inpatient and outpatient care

–In 2021, we paid 271% over Medicare prices for the same care, which is up from 219% of Medicare in 2016

–In the past 10 years, healthcare has risen from 17% of total compensation to 37% of total compensation; wages have gone up 54% but healthcare costs have increased 230%; and to put that into a dollar amount, our members could have had $5,000 more in annual wages had healthcare spend risen at the same rate of inflation

While having your data and being able to see how your benefit is being spent is important, as a plan we know this is only the first step. The next step is taking action on this data.

In 2018, after spending over 10 years looking at our claims data, it became abundantly clear to us that we needed to address the prices we were paying. The data showed we were paying wildly different prices for the same procedures, depending on what hospitals our members went to. For example, we were paying approximately $10,000 for a colonoscopy at NY Presbyterian system versus approximately $4,000 at Mount Sinai Hospital system. The same pattern was true at other high-priced hospitals. Based on our data, we tiered our network on price beginning in 2019. Members could still access the higher priced hospitals, but they would have to pay higher copays to do so.

While we had won the right to tier our plan in 2019, in 2021, NY Presbyterian and our carrier, Anthem, were up for their network renewal. During that renewal, NY Presbyterian told Anthem they would have to be preferred in all networks, leveraging a clause in their contract. Eventually, NY Presbyterian granted the Fund permission to remove them from our network only in 2022. This change has saved the plan approximately $30M every year by members receiving care from lower priced facilities and providers. Additionally, in the most recent contract negotiations, the union and employers leveraged the savings in our benefits to give union members a one-time bonus, the largest wage increase in contract history, a pension increase, and limit employer premium contribution increases to no more than 3% every year through 2027.

While these benefit changes showcased our ability to leverage our data, both changes also illuminated the contract terms between providers and carriers that obstruct, hinder, and limit the ability for us or any employers to take action on their data.

Recently, the Health Fund led a procurement for a medical and hospital benefit third party administer, or carrier. We were adversely affected by anti-competitive

contract provisions between providers and carriers. The provider contracts included items such as requirements to be in network, anti-steering and anti-tiering provisions, limitations in how claims are allowed to be paid, and even limitation in access to claims data. For us, the network inclusion and other contracting demands of hospitals limited participation of TPA bidders in our procurement process. Every TPA bidder, except one, was unable to meet our network requirements, including that NY Presbyterian remain out of network. Other network provider contract provisions routinely demanded by hospitals include restrictions on retroactive claim reviews, exclusion of lesser-of provisions, and limitations on overpayment recoupment. None of those contract provisions are beneficial for employer sponsored plans or their membership. This is just one example of how difficult it is for employers and self-funded plans, even of our size, to have a highly competitive bid process.

While our bidding process faced limitations by the anti-competitive contracting provisions in provider and carrier contracts, we would not be where we are without access to our data, allowing the Union and Employers to give raises and limit premium increases ensuing our members can continue to have access to high quality and affordable care. Employers having access to their claims data and the terms in which their benefits are being managed are essential for them to be able to do the same thing. That s why we need the Braun Sanders bill, and section seven in particular.

Thank you for having me.

U.S. SENATE SPECIAL COMMITTEE ON AGING

"HEALTH CARE TRANSPARENCY: LOWERING COST AND EMPOWERING PATIENTS"

JULY 11, 2024

PREPARED WITNESS TESTIMONY

Sophia Tripoli

Chairman Casey, Ranking Member Braun, members of the Committee, thank you for the opportunity to testify at this critical hearing focused on health care affordability and the harmful impact of medical monopolies that flourish under our health care system's lack of transparency and healthy competition. It is an honor to be with you today.

My name is Sophia Tripoli, and I am the Senior Director of Health Policy at Families USA. For more than 40 years, Families USA has been a leading national, nonpartisan 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 to affirm and enhance our commitment to revolutionize America's health care system to hold the health care industry accountable for delivering affordable, equitable, high-quality and person-centered health care.

We greatly appreciate the work of this Committee to examine and advance bipartisan solutions to lower costs and improve health system transparency for aging Americans and families across the country. This work is urgently needed: Our health care system is in crisis, evidenced by a severe lack of affordability and poor quality. 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.

You have the support of the American public as you work to address these issues. 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.[2] The majority of Americans now rate the quality of health care as subpar, including 31% saying it is 'only fair' and 21% calling it 'poor.'[3] Recent polling shows that almost 90% of voters say it is important for this Congress to take action to reduce high health care prices, particularly hospital prices, including 95% of Biden voters and 85% of Trump voters.[4]

The U.S. Health System in Crisis: Harming Families, Workers, Employers, and Taxpayers

The United States is in the midst of a health care affordability and quality crisis. High and rising health care prices, particularly for hospital stays and prescription drugs, are a direct threat to the health and wellbeing of every American, negatively impacting our access to health care, our ability to earn a living wage, and the health of our national and local economies. At its core, this 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.

Broken incentives within our current system reward building local monopolies and price gouging instead of rewarding success in promoting the health, wellbeing and financial security of families and communities.[5] This is particularly acute when looking at the shifting role of hospitals in our economy over the last 60 years.[6] What were once local charitable institutions built to serve the community have now become large corporate entities focused on maximizing revenue rather than improving health.[7] Americans in far too many communities have watched as their local hospitals became health systems, and those health systems were bought by large health care corporations. What many in the public and policymaking community are beginning to realize is how much this has destroyed any real competition in our health care sector, allowing hospitals to dramatically increase their prices every year with little to no transparency into the true costs associated with delivering care.[8] And health care consumers have been left holding the bag.

Impact on Families and Workers

More than 100 million Americans face medical debt; a quarter of all Americans forgo needed medical care due to the cost; and a third of Americans indicate that the cost of medical services interferes with their ability to secure basic needs like

buying groceries and paying rent.[9] In addition, more than a quarter of older Americans, who spend more on health care than any other age group, report being very concerned they will be unable to pay for lifesaving health care in the future.[10]

Not only do consumers and patients experience high health care prices in the form of expensive medical bills, but high health care costs also affect the economic vitality of middle-class and working families by crippling the ability of working people to earn a living wage. Rising prices are a major contributor to skyrocketing health insurance costs, which come directly out of workers' paychecks as annual increases in premiums and cost sharing.[11] This results in stagnating wages, rising income inequality, and ultimately leaves workers with less in take home pay over time, making it more difficult for them to afford housing, pay their regular expenses, send their children to school, and retire.[12]

Today's real wages - wages after accounting for inflation - are roughly the same as four decades ago, yet employer health insurance premiums have risen dramatically.[13] The total cost of a family employer-sponsored insurance (ESI) plan increased an astounding 272% in the past two decades, rising from $6,438 annually in 2000 to $23,968 in 2023.[14] As a result, a U.S. family of four with a median income of roughly $95,000 annually is estimated to have lost more than $125,000 in wages over roughly the same time period.[15] A recent analysis by Families USA found that if policymakers do not take action to rein in high and rising hospital prices and the harmful business practices of large heath care corporations, low- and middle-income workers - a group that disproportionately includes people of color - could lose another $20,000 in wages by 2030.[16] 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.[17] The rising costs of health care have already contributed to record numbers of businesses no longer providing critical worker benefits, including retiree health benefits, disproportionately harming older adults who rely on these benefits during retirement. As a result, older Americans are increasingly exposed to high and rising health care costs. In fact, out-of-pocket health care spending for older Americans grew a staggering 41% between 2009 and 2019.[18]

To make matters worse, workers are increasingly subjected to health insurance plans with larger cost-sharing requirements, including higher-deductible health plans, in an effort to contain rising health care spending and costs. Deductible-related costs for workers have grown significantly, with the average annual deductible for an individual employee's coverage nearly doubling in just a decade, from $1,025 in 2010 to $2,004 in 2021.[19] Importantly, the 153 million Americans who rely on ESI for health insurance cannot always access the care they need, with more than a quarter putting off or postponing needed medical care due to the high cost.[20]

Impact on Taxpayers and Our Economy

High and rising health care costs not only threaten the health and financial security of American individuals and families but are also a critical problem for the federal government, state governments, and taxpayers. National health expenditures (NHE), which includes both public and private spending on health care, have grown from $27.1 billion in 1960 to nearly $4.5 trillion in 2022.[21] Relative to the size of the economy, NHE grew from 5% of gross domestic product (GDP) in 1960 to 17.4% in 2022.[22] The largest proportion of this spending is on hospital care, which accounts for a 30 percent share at a whopping $1.4 trillion annually.[23]

The situation is expected to get much worse, with NHE projected to climb to $7.2 trillion by 2031, and high and rising health care costs projected to continue to grow faster than the economy, hitting nearly 20% of GDP by 2031.[24] That means a fifth of our economy will be spent on health care. This far outpaces what similarly situated countries spend on health care: On a per capita basis, the U.S. spent $12,555 in 2022 - over $4,000 more per person than any other peer nation.[25]

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 peer countries, the United States has some of the worst health outcomes, including some of the lowest life expectancy and highest infant mortality rates.[26] 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.[27] And the vast majority of our nation's seniors have at least one chronic health condition, with many dealing with multiple health issues.[28]

Lack of Transparency Provides Cover to Medical Monopolies and their Unjustifiably High Prices

Importantly, America's health care affordability crisis stems from high, rising, and variable prices across a wide range of health care goods and services, particularly for hospital care and prescription drugs. 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.[29] The average price of a hospital-based MRI in the United States is $1,475,[30] while that same scan costs $503 in Switzerland and $215 in Australia.[31]

What's more, 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 are delivered.[32] Consumers and employers, who are the ultimate purchasers of health care, have limited insight into what the prices of health care goods and services are. For the majority of Americans (66%) who receive health care through private insurance, health care prices are established in closed-door negotiations between large hospital corporations and health plans based on who has more market power.[33] These health care prices, often referred to as the negotiated rate, are buried in proprietary contracts without insight into or oversight over the price of health care services by the public and policymakers.[34]

These exorbitant, opaque, and unjustifiable prices are largely due to trends in health care industry consolidation across the U.S. that have eliminated healthy competition and allowed monopolistic pricing to flourish.[35] This consolidation has taken place without meaningful regulatory oversight or intervention, and is becoming more acute.[36]

The end result is a system with few truly competitive health care markets left: 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.[37] Consolidation has been particularly pronounced among hospitals, drug companies, and pharmacy benefit managers and is made worse by the increasingly harmful role of private equity firms in the U.S health care system:

–Hospitals, health systems and other providers have rapidly consolidated, via horizontal and vertical integration, into large health care corporations, amassing outsized market power in order to increase prices for hospital care year after year. In fact, over 1,500 hospital mergers have occurred between 1998 and 2017, with an estimated 40% of those mergers taking place from 2010 to 2015.[38] Moreover, between 2013 and 2021, the percentage of physician practices that were hospital-owned rose from 15% to 53%, and the percentage of physicians employed by a hospital rose from 27% to 52%.[39]

–Drug manufacturers have increasingly engaged in anti-competitive behavior and transactions to similarly amass significant market power, regularly buying up or paying off their competition in order to game the U.S. patent system and price gouge our nation's families for prescription medications. The vast majority (70%) of drug industry profits now go to only a small number (25) of the top prescription drug companies in the country.[40]

–Pharmacy benefit managers, as third-party administrators designed to serve as middlemen between health insurers and drug makers, have increasingly merged with insurers and pharmacies to increase their own market power to negotiate pricing structures that serve their financial interests, often to the detriment of securing more affordable prescription medicines for consumers. This has led to the top three PBMs controlling 80% of the PBM market.[41]

–Health insurers are increasingly consolidated. Between 2006 and 2014, the four-firm concentration ratio - the extent of market control held by the four largest firms, Aetna, Anthem Blue Cross Blue Shield, UnitedHealthcare and Cigna - for the sale of private insurance increased from 74% to 83%.[42] This results in monopolistic health care prices that lead to unaffordable health care and poorer quality.[43] There is also growing vertical integration between insurers and health care providers; UnitedHealthcare for instance now employs almost 50,000 physicians as of 2021, and their reported share of medical expenses that flow to employed providers or other related businesses increased nearly 250% between 2016 and 2019.[44]

Widespread consolidation across the health care system has been compounded by the growing role of private equity (PE) firms over the last decade. Once largely uninvolved in the U.S. health care system, PE firms are increasingly purchasing and reselling a variety of health care provider organizations in order to make short term profit, largely to the detriment of the financial wellbeing of those providers and ultimately to health care access and affordability in a community. In 2020, health care

became the second largest sector for private equity investment, accounting for 18 percent of all reported deals, up from 12 percent in 2010.[45] Private equity investors spent more than $750 billion on health care acquisitions between 2010 and 2019.[46]

The business model of private equity firms is fundamentally misaligned with ensuring that our nation's families have the high-quality, affordable, and equitable health care they need and deserve. PE firms often apply a very short-term profit driven business model (a three-to-seven- year period) to their investment strategy, characterized by buying a health care entity that is struggling financially or offers short-term growth potential, investing in it, saddling it with debt, and then selling their stake to generate profit.[47]

Further, recent studies show that PE ownership was associated with a number of harmful health care impacts, including but not limited to:

–Decreases in health care quality and patient safety: PE owned hospitals experience a 25% increase in hospital-acquired conditions, including a 27% increase in patient falls and an almost 38% increase in infections.[48] Researchers say that these outcomes may be partially due to ″decreased staffing, changes in operator technique, poorer clinician experience,″ among other potential causes;[49]

–Increases in health care prices and charge-to-cost ratios: PE owned hospitals charge $400 more per inpatient day on average compared to non-PE owned hospitals;[50] and

–Increased out-of-network costs due to PE firms buying up specialty physician staffing firms.[51]

Without question, widespread and largely unchecked health industry consolidation has led to the deterioration of healthy competition across and within U.S. health care markets and has had a significantly negative impact on the affordability and quality of American health care.[52] Importantly, most health care consolidation has not resulted in reduced costs through economies of scale, improved care coordination or quality oversight as industry proponents have argued.[53] In fact, the evidence overwhelming confirms that consolidation has produced exploitative markets that drive high prices and costs without improving the quality of care.[54]

In many cases, consolidation is actually associated with reductions in health care quality.[55] For instance, one study found that mortality risk among heart attack patients is significantly higher in more concentrated hospital markets.[56] On top of that, consolidation often leads to reduced geographic access to needed providers, which can contribute to longer travel times and serious health consequences, particularly for rural communities.[57] For example, rural hospitals that merge with larger hospital systems are more likely to eliminate key service lines in primary care, maternal and neonatal health, surgery, mental health, and substance use disorder services post-merger, significantly reducing access to critical health care services and threatening the health and wellbeing of rural communities.[58] Moreover, increasing the distance to the nearest site of health care can result in people living in all types of communities not getting the care they need due to a lack of transportation or the time needed to get there, disproportionally affecting older Americans, racially and ethnically marginalized groups, those with low incomes, and people with disabilities.[59]

A Closer Look at Hospital Consolidation

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.[60] 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.[61]

Between 1990 and 2023, hospital prices 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.[62] 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.[63]:

–Prices at hospitals in concentrated markets are 12% higher than those in markets with four or more rivals without any demonstrated improvement in quality or access to care.[64]

–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.[65]

–At one health system in Wisconsin, an MRI costs between $1,093 and $4,029 depending on level of insurance.[66]

–Across the country, the average price for a knee replacement ranges from $21,976 in Tucson, Arizona to $60,000 in Sacramento, California.[67]

–The price of an MRI at Mass General Hospital in Boston Massachusetts ranged from $830 to $4,200, depending on the insurance carrier.[68]

Importantly, America's health care workers are also suffering ill-effects of being trapped in this greed-driven system. Following hospital mergers, wages for nurses and skilled workers stagnate: Wage growth was found to be 1.7% below the average national wage growth for these workers following horizontal mergers.[69] Research on high-impact mergers shows that over the four years post-merger, wages might be 6.8% lower for nurses and pharmacy workers and 4% lower for other skilled workers, in comparison to what wages could have been without the merger.[70] This is compounded in rural areas: Research from 2015 showed that after a merger some rural hospitals decreased their spending on employee salaries by more than $1000 per full-time equivalent employee.[71] Hospital consolidation has also been shown to have negative impacts on staffing ratios. Following an acquisition in North Carolina by HCA Healthcare in 2019, nurses in that system experienced nurse-to-patient ratio changes and staffing cuts, in addition to closures of primary care offices and cutbacks of other services.[72] This left nurses and other health care workers caring for more patients with less time and fewer resources, which the Federal Trade Commission (FTC) cautioned would lead to patient harm in the form of ″higher health care costs, lower quality, reduced innovation and reduced access to care.″[73]

Congress Should Root Out Corporate Greed and Fix our Broken System

It does not have to be this way. We know what the major drivers of high and irrational health care prices are, and we know how to fix them. This Committee has previously examined potential abuses in health care and taken steps to conduct oversight over the quality of care delivered in nursing homes and explore root causes of high prescription drug prices. Since the late 1800's Congress has leveraged its power to break up harmful monopolies, rein in corporate abuses and drive improved transparency across a wide array of other industries and sectors, ranging from big oil to big tobacco to big banks to big tech.[74] Last year the Senate even examined how to promote healthy competition in entertainment and protect consumers from the monopolistic pricing practices exhibited by Ticketmaster.[75] Now is the time to turn full attention to the health care industry and ask the hard and necessary questions about the impacts of medical monopolies on health care affordability that pose a direct threat to the health and wellbeing of every American.

The House of Representatives has already advanced well-vetted, bipartisan, and commonsense legislation that would remedy some of the most obvious health system failings. The Lower Costs, More Transparency Act, which passed the House in an overwhelming bipartisan vote in December 2023, would make crucial progress by codifying and strengthening price transparency rules, expanding site neutral payments, and advancing billing transparency, among other reforms. Several Members of Congress have introduced other meaningful solutions, including Ranking Member Braun's legislation: S. 3548, the Health Care PRICE Transparency Act 2.0 and S. 1869, the Site-based Invoicing and Transparency Enhancement (SITE) Act. Some of these provisions, in addition to other important policy solutions, are discussed in further detail below.

Strengthen 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.[76] Further, unveiling prices can specifically inform where the highest and most irrational prices are occurring in the health care system, so policymakers can implement targeted policy solutions to bring down the cost of health care.[77] All Americans, and particularly older Americans who heavily rely on the health care system, should be able to easily access the price of health care services at a hospital or health care facility before they receive care.

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 the 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.[78] But many large hospital corporations have bucked the federal requirements and are actively working to keep their prices hidden.[79]

The Lower Costs, More Transparency Act makes clear, without any exception, that all hospitals and insurers are required to post the underlying price of health care services, in a machine readable and consumer-friendly format. The Health Care PRICE Transparency Act 2.0 would advance transparency by taking bold steps to:[80]

–Impose data sharing standards.

–Require machine-readable files of all negotiated rates and cash prices between plans and providers, not estimates.

–Expand price transparency quirements to clinical diagnostic labs, imaging centers, and ambulatory surgical centers.

–Require pricing data standards including all billing codes for services.

–Require actual prices for 300 shoppable services with all services by 2025.

–Require attestation by executives that all ices are accurate and complete.

–Increase maximum annual penalties to $10,000,000 (includes specific minimum and maximum penalties according to number of hospital beds in the facility).

–Prevent pre-emption of state price transparency laws, except for ERISA group health plans.

–Codify the Transparency in Coverage (TIC) rule.

–Provide group health plans the right to access, audit, and review claims encounter data.

The American public is in broad agreement about the need for action on price transparency, with polling showing that a large majority (95%) of the public say it is important for Congress to pass a law to make health care costs more transparent to patients, including 60% who call this a top priority.[81]

Enact Site Neutral Payment and Billing Transparency

Market inefficiencies that stem from site-specific payment rates in Medicare are a significant problem which, if addressed, could save American families and health care payers billions of dollars.[82] Since commercial insurance and Medicaid often adopt Medicare payment policies, the broken payment incentives in Medicare are amplified across payers. These site-of-service payment differentials drive care delivery from physician offices to higher-cost hospital outpatient departments.[83] This shift is a major driver of higher spending on health care services which require lower resources such as office visits and minor procedures.[84] Importantly, these payment differentials create a financial incentive for hospitals to consolidate by buying physician offices and rebranding them as off-campus outpatient hospital departments (HOPDs) and facilities in order to receive higher payments.[85] 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.[86] These higher commercial prices are then passed on to American families and come directly out of workers' paychecks, typically as monthly health insurance premiums.[87]

Currently, hospitals that own doctors' offices that have been rebranded as off-campus HOPDs are allowed to charge a ″facility fee″ in addition to the higher fees they bill for the physician services they provide.[88] The result is that consumers not only receive a bill for the visit with the physician but also for the use of the hospital facility where the visit occurred.[89] These bills together (the physician fee and the facility fee) amount to a higher total cost for the consumer than if the service was provided in the physician's office.[90]

We are encouraged that Members of Congress are working to address payment differentials across sites of service that incentivize further consolidation and are a major driver of unaffordable care for America's families. The Lower Costs, More Transparency Act takes important steps toward fostering healthier competition in health care markets by advancing billing transparency reforms and expanding site neutral payments for drug administration services to help ensure consumers pay the same price for the same service regardless of where that service is performed. It would enact billing transparency reforms so that off-campus hospital outpatient departments are required to use a separate identifier when billing to Medicare or commercial insurers to ensure large hospital systems do not overcharge for the care

they deliver in outpatient settings. It would also enact site neutral payments for physician-administered drugs in outpatient settings, which is estimated to save the highest-need chemotherapy patients more than $1,000 on cost sharing a year.[91] The Congressional Budget Office (CBO) estimates that site neutral payments for physician-administered drugs and billing transparency reforms would generate $3.74 billion and $403 million in savings, respectively, over ten years.[92] These policies are welcome first steps to addressing misaligned payment incentives that lead to higher costs for patients without meaningfully improving quality.

Bipartisan legislation introduced by Ranking Member Braun, S. 1869 Site-based Invoicing and Transparency Enhancement (SITE) Act, would go even further to expand site neutral payments for outpatient services, end exemptions in Medicare billing rules that keep many facilities from having to charge the same price for the same service, and require that health systems establish and bill using a unique National Provider Identifier number for each and every off-campus outpatient department.[93] The bill is projected to save the government as much as $40 billion based on previous CBO estimates.[94]

Ultimately, Congress could make significant strides in addressing medical monopolies by implementing comprehensive site-neutral payment policies as recommended by MedPAC in 2023, and eliminating site-dependent reimbursement distortions that indirectly incentivize acquisition of non-hospital patient access points.[95] CBO estimates that this policy could save Medicare approximately $140 billion over the next decade.[96] And the Committee for a Responsible Federal Budget projects that these policies could reduce health care spending by $153 billion over the next decade, including lowering premiums and cost-sharing for Medicare beneficiaries by $94 billion and for those in the commercial market by $140-466 billion.[97]

Ban Anticompetitive Contracting Practices

We also urge Congress to take a close look at anticompetitive practices and clauses in health care contracting agreements between providers and insurers that give large entities in highly consolidated markets the upper hand in contract negotiations to build networks and set prices. Many of these contracts include terms that limit patient access to alternative sources of 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 build policy that encourages healthier competition.

Congress should further prohibit large hospital systems from using their monopoly power to employ anti-competitive contracting practices when negotiating with insurers and other health care providers, as this is one of the primary ways medical monopolies are able to charge high and rising prices.[98] These prohibitions should include the use of ″all-or-nothing,″ ″anti-steering,″ and ″anti-tiering″ clauses in contracts between health care providers and insurers. ″Anti-tiering″ and ″anti-steering″ clauses restrict the plan from directing or incentivizing patients to use other providers and facilities with higher quality and lower prices; and ″all-or-nothing″ clauses require health insurance plans to contract with all providers in a particular system or none of them. ese contracting terms too often limit consumers from accessing higher-quality and lower-cost care.[99]

Bipartisan legislation led by Senate HELP Committee Chairman Sanders, S.2840, the Bipartisan Primary Care and Health Workforce Act,[100] includes provisions to ban anticompetitive terms in facility and insurance contracts, estimated by CBO to increase revenues by $3.2 billion over a 10-year window.[101]

Ensure Transparency in Ownership

Additionally, we urge the Committee to continue to explore opportunities to improve transparency around the ownership interest of health care corporations, particularly when it comes to private equity. We support legislative provisions considered by committees of jurisdiction in the U.S. House of Representatives that would require providers to annually report changes in ownership, and hope that Congress will consider integrating these or similar provisions back in to any final health care transparency legislation that is sent to the President's desk. Without insight into how profits from health systems are ultimately being funneled it is very difficult to identify potential abuses, leaving private equity firms free to purchase health systems in order to drive profits through upcoding, surprise billing, and other questionable business practices.

Strengthen FTC Oversight Authority

Policymakers should prevent future horizontal, vertical, and cross-market mergers that undermine healthy competition in health care markets and drive unaffordable care by ensuring the Federal Trade Commission (FTC) and the U.S. Department of Justice (DOJ) are fully applying federal antitrust laws to horizontal integration, such as mergers between hospitals and other health systems, pharmacy benefit managers and drug companies; and vertical integration, such as mergers between physician practices and hospitals, health plans and pharmacy benefit managers. Specifically, Congress should improve the infrastructure needed to monitor anti-competitive mergers and contracting practices among health care corporations by increasing FTC and DOJ funding for anti-trust enforcement, and by giving the FTC authority to investigate and rein in anti-competitive practices by non-profit health care entities, including non-profit hospitals. Special attention should be given to PE firms and the smaller transactions that may traditionally fall below existing thresholds of review. Congress should increase the number of health care transactions reported to FTC and DOJ and subject to anti-trust review and enforcement by reducing the Hart-Scott-Rodino Act reporting threshold.[102]

Congress has the Power to Fix our Broken System - And Families Can't Afford to Wait

Over the last year there has been growing bipartisan momentum in Congress to advance policies that improve health care system transparency, end pricing abuses, and deliver on promises to make health care more affordable. Congress has a clear and immediate opportunity to put the needs of families ahead of the demands of corporate greed, and people all across the country are desperately awaiting action.

Consider the story of Ben Los from Colorado, whose encounter with our health care system's lack of transparency came at the most vulnerable time for his young family:

In September of 2022, Ben Los's 5-year-old son began experiencing seizures. After rushing him to the doctor, Ben and his wife were referred to a specialist within their insurance network, an hour and a half away from their Colorado Springs home. They got the EEG scan for their son and were in and out of the specialist's office in 45 minutes where they were assured, "yes, absolutely this is covered." t two months later, the Los family received a bill for $2,518 for the appointment. After calling the hospital to find out why they were being charged for something they had confirmed multiple times was covered, the hospital claimed this was for "facility fees." The appointment itself was covered, but now the hospital was defending the charge stating, "Well, you paid the clinic staff, but now you also have to pay the hospital."

After extensive efforts, Ben was able to speak to somebody near the top of the hospital's administration, who negotiated the bill down to a 75% reduction under a classification of charity care. During this time Ben engaged with an investigative journalist in Denver and found out the hospital is owned by one company, which is owned by another company, and so on. When they finally identified the overarching owners of the health system, they discovered those owners profited billions of dollars in the first nine months of 2022 alone. "You can't tell me that there is no way for the hospitals to pay their employees when they're raking in the kinds of net profits that they're claiming every single year," said Ben.[103]

Patients experience egregious price hikes for the very same services they've previously received in the very same outpatient settings. For instance, 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 st 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.[104]

In some cases, patients receive bills for facility fees when they never even set foot inside a medical facility of any kind. Take the story of 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.[105]

In addition to jeopardizing financial security for individual patients and their families, widespread health system consolidation risks the health and economic security of entire communities:[106]

Hahnemann University Hospital opened in Philadelphia, Pennsylvania in 1885. For more than 130 years, it served primarily lower income residents, until 2018 when it was purchased by Paladin Healthcare, a private equity firm. Over the course of about 18 months, Paladin Healthcare laid off physicians, nurses, and other workers, while steering the hospital towards bankruptcy and closure.[107] *Questions and concerns were raised by local, state, and national officials as to whether the motivation for these decisions came from the value of the land on which the hospital sat being seen as more valuable to the private equity firm than the nearly 500-bed charity hospital itself.*[108] *Despite the local community's longstanding reliance on this centrally located hospital, Hahnemann University Hospital closed its doors in August 2019. Shortly thereafter, the land was put up for sale. addition to residents losing access to care, thousands of employees lost their jobs and 550 medical residents were displaced.*[109]

A broad range of stakeholders have endorsed and supported critical policy solutions to address consolidation and improve transparency, including organizations representing consumers, patients, workers, small and large employers, and primary care clinicians.[110] Large majorities of voters support a range of policies to lower prices. Voters from both sides of the aisle broadly support:[111]

–Requiring hospitals to provide real prices in advance, not estimates (93%)
–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%)

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.

Thank you again for holding this hearing today and for your leadership in addressing the challenges posed to older Americans and their families by our health care system's lack of transparency and affordability. 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: patients, workers, and taxpayers alike. 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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Questions for the Record

U.S. SENATE SPECIAL COMMITTEE ON AGING

"HEALTH CARE TRANSPARENCY: LOWERING COST AND EMPOWERING PATIENTS"

JULY 11, 2024

QUESTIONS FOR THE RECORD

Dr. Chris Whaley

Senator Kirsten Gillibrand

Question:

A recent report showed that less than 36 percent of hospitals were fully compliant with transparency requirements issued by the Centers for Medicare and Medicaid Services Hospital Price Transparency Rule. Dr. Whaley, what should the Federal government do to increase and enforce compliance?

Response:

Starting in 2021, hospitals have been required to post negotiated rates for 300 shoppable services. However, compliance with this policy has been low, in part due to lax enforcement. To date, fewer than 20 hospitals have been penalized for not posting prices.[1] To further increase compliance, an immediate step for CMS is to fully enforce penalties for non-compliance. Ensuring compliance through complete enforcement will provide a greater degree of transparency and accountability around U.S. healthcare prices.

Question:

How would increased transparency in healthcare pricing specifically benefit small employers who struggle the most to access their data? What impact could this have on their ability to provide competitive benefits?

Response:

Health care costs come directly from worker paychecks and other benefits, employers who provide health benefits to their workforce have a legal and moral fiduciary obligation to be responsible fiduciaries and purchasers. It is not possible to fulfill this fiduciary obligation without insight into prices and contracts negotiated on behalf of employers and purchasers. Access to both medical claims data and contract information is the clearest way for employers and purchasers to ensure prices align with received value.

With access to their data, employers and purchasers have innovated, including:

– The California Public Employees Retirement System (CalPERS), which uses targeted financial incentives to steer patients to lower-priced, high-quality providers. For a range of shoppable services, my work shows that this program reduces spending by approximately 20% and leads to quality improvements.[2]

– The of Oregon public employees and school teacher s plan, which limits hospital prices to 200 percent of Medicare. By limiting hospital prices, this program reduced annual spending by approximately four percent for the plan.[3]

Question:

The average drug price increase between January 2022 and 2023 was 15.2 percent. The Capping Prescription Costs Act of 2024 would cap individual cost-sharing for prescription drugs to help those with limited incomes and high costs. Dr. Whaley, which sector of the health care market has benefitted the most from higher drug prices? Which sector has suffered the most? Which sector would a patient out-of-pocket cap affect?

Response:

Many studies show high patient out-of-pocket costs for prescription drugs reduce adherence to medication management. Particularly for chronic conditions, reduc-

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tions in medication management due to cost leads to increases in hospitalizations, emergency department visits, and overall healthcare spending.[4] [5] Thus, policies, including limits on out-of-pocket costs for chronic condition medications, that limit patient financial burden for medication management can improve health and reduce spending. These policies are particularly important for lower-income Americans and those with multiple chronic conditions. However, a key challenge with these programs that limit patient out-of-pocket burden is that they are borne by a patient s pharmacy benefit, while savings due to improved health accrue to a patient s medical insurer. Aligning incentives between prescription drug and medical insurance coverage could spur programs that reduce patient financial burden for chronic condition medications.

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U.S. SENATE SPECIAL COMMITTEE ON AGING

"HEALTH CARE TRANSPARENCY: LOWERING COST AND EMPOWERING PATIENTS"

JULY 11, 2024

QUESTIONS FOR THE RECORD

Cora Opsahl

Ranking Member Mike Braun

Question:

As detailed in the Wall Street Journal, the 32BJ Health Fund's decision to remove a large hospital system, New York-Presbyterian, from its network in 2022 and the subsequent payment demands made by New York-Presbyterian are emblematic of the outsized market influence of hospitals. As you state in your testimony, these contracting practices ultimately impact not just cost, but transparency and the member experience. Can you describe how the events reported by the Wall Street Journal influenced the health fund's ability to select a benefit administrator, and any other consequences that resulted?

Response:

New York-Presbyterian's demands as described in the Wall Street Journal article limited the 32BJ Health Fund's ability to select a third part administrator (TPA) vendor during a standard procurement process. This is the latest example of New York-Presbyterian's anti-competitive practices, which the 32BJ Health Fund has been challenging for years.

As our testimony references, in 2018, we sought to tier our network after our claims data showed certain hospitals, including New York-Presbyterian, charged significantly more for some services without relation to quality. The Health Fund's TPA at the time indicated their contract with New York-Presbyterian prohibited the tiered arrangement. After a public campaign, New YorkPresbyterian agreed to be placed in a non-preferred tier with a significant copay differential.

In 2021 New York-Presbyterian informed the 32BJ Health Fund's TPA that the TPA would have to reduce its non-preferred co-pay structure. Targeted programs accessible through hospitals selected on the basis of competitive bidding and superior quality performance, including our Maternity Program could not be continued in their current design. In 2022, the 32BJ Health Fund was able to remove New York-Presbyterian from its network after their refusal to negotiate directly with the Health Fund to provide participants with high-quality care at affordable prices and another public campaign.

In 2023, the 32BJ Health Fund embarked on a standard procurement process to select a TPA vendor that could administer the 32BJ Health Fund's hospital and medical benefits.

In April 2024, after months of deliberation, the 32BJ Health Fund Trustees terminated final contract negotiations with its newly selected TPA vendor after the vendor reported they could no longer maintain New York-Presbyterian as an out-of-network facility unless the 32BJ Health Fund complied with New YorkPresbyterian's demand for additional payments amounting to tens of millions of dollars that New York-Presbyterian claimed it was owed for out-of-network emergency services provided to 32BJ Health Fund participants in 2023. No documentation or list of claims was provided at that time with this demand, and the 32BJ Health Fund's review of its records determined that the payment demand was without merit, and no additional payment was made.

Instead of using the arbitration processes that the federal law provides through the No Surprises Act to resolve this type of payment disputes, New YorkPresbyterian attempted to make this additional payment part of the contract negotiations between the TPA vendor and the 32BJ Health Fund.

After this demand by New York-Presbyterian, the 32BJ Health Fund terminated its contract negotiations with that TPA vendor. This left the 32BJ Health Fund no choice other than selecting the only TPA vendor with an existing agreement with New York-Presbyterian to be out-of-network for the 32BJ Health Fund. The Health Fund has been told that New York-Presbyterian intends to remove this provision in the agreement when its contract with the newly selected TPA vendor is up for renewal in 2025.

Question:

You mention in your testimony that hospitals use their market power to make contract demands that impact the ultimate terms agreed upon between your third-party administrator of the medical and hospital benefits provided by your health fund. Based on the news reported by the Wall Street Journal, is this essentially what happened with New YorkPresbyterian? Can you share more about the impact of this on the Fund?

Response:

Yes, the demands made by New York-Presbyterian impacted the 32BJ Health Fund's ability to select a vendor during our 2023 medical and hospital benefit third party administrator (TPA) procurement. New York-Presbyterian demanded additional payments they claimed they were owed for out-of-network emergency services provided to 32BJ Health Fund participants in 2023 with no documentation or list of claims provided at that time. In April 2024, the 32BJ Health Fund's newly selected TPA vendor reported they could no longer maintain New York-Presbyterian as an out-of-network facility unless the 32BJ Health Fund complied with this additional payment demand by New York-Presbyterian. This left the 32BJ Health Fund no choice other than selecting the only TPA vendor with an existing agreement with New York-Presbyterian to be out-of-network for the 32BJ Health Fund.

Question:

What further policy recommendations do you have beyond transparency proposals?

Response:

Prohibiting anti-competitive contracting practices in hospital provider contracts is an important step to realign healthcare system incentives to enable employer-sponsored health plans like 32BJ Health Fund to better steward their resources for the benefit of plan participants.

The 32BJ Health Fund recommends Congress expand on recent legislation that bans certain anti-competitive contracting clauses in hospital provider contracts. In the Consolidated Appropriations Act (CAA) of 2021, Congress enacted a prohibition of gag-clauses that restrict certain information sharing with health plans and health insurance issuers.[1] While the CAA enactment of the gag-clause prohibition was a positive step forward, more action is needed to regulate other common anti-competitive contracting practices.

State legislatures have also made attempts to ban or regulate anti-competitive contracting practices but have encountered resistance from the hospital lobbies when proposals are filed. The Hospital Equity and Affordability Legislation (″HEAL″) Act, which passed in New York State in 2022, bans health plan and provider contract provisions that restrict the disclosure of provider claims cost, price, or quality information. However, other anti-competitive contracting practices -- ″all-or-nothing″ and ″anti-tiering″ clauses -- were removed from the final version of the HEAL Act following opposition by the Greater New York Hospital Association.

Congress should pursue enacting Federal regulations to prohibit ″most favored nation, ″anti-tiering/anti-steering,″ and ″all-or-nothing″ clauses in provider and insurer contracts. Given the opposition experienced in State legislatures, further action is needed by Congress to protect employers and self-funded plans from these anti-competitive contracting practices by providers and carriers that impact the ability to steward health plan resources effectively. We strongly encourage Congress to continue advancing proposals that ban anti-competitive contracting practices.

Question:

What actions can we take to decrease health costs?

Response:

There is no silver bullet for decreasing health care costs, but rather targeted policies that can help to lower healthcare costs. One policy in particular that would provide constructive relief for employer-sponsored health is enacting site neutral payment policies.

Under current Medicare fee schedules, reimbursement is typically higher for routine procedures provided at a hospital outpatient department versus a freestanding doctors' office. Site-neutral payment policies seek to eliminate downstream incentives for hospital acquisition and mergers by instituting price regulation on routine services that are safe to be delivered at a freestanding doctor's office.

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[1] Rochman, Harvey. (November 29, 2023). The Gag Clause Prohibition Compliance Deadline Is Approaching: What Plans and Issuers Need to Know. https://www.manatt.com/insights/newsletters/health-highlights/the-gag- clause-prohibition-compliancedeadline-is

There are multiple site-neutral proposals before Congress today. Introduced in the U.S. Senate in June 2023, the Site-based Invoicing and Transparency Enhancement Act (the SITE Act), proposes updating Medicare reimbursement at off-campus hospital outpatient departments to follow site-neutral requirements these facilities were previously exempted from in the 2015 Bipartisan Budget Act.[2] Also in the current session, in December 2023, the U.S. House of Representatives passed the Lower Costs, More Transparency Act, which would ensure Medicare pays the same prices for physician-administered drugs in different settings.[3] However, in March 2024, the bipartisan legislation stalled in Congress.[4]

There are potential savings across commercial payers if site-neutral payments were enacted beyond Medicare fee schedules. The Committee for a Responsible Federal Budget estimates commercial payors could save between $140 and $466 billion in the next 10 years if a site-neutral payment policy were implemented nationwide.[5]

We strongly encourage Congress to continue advancing proposals that enact siteneutral payment policies for Medicare and commercial insurers and self-funded plans.

Question:

What impacts have you experienced because of health care consolidation?

Response:

As the hospital markets where 32BJ Health Fund participants' care is provided are becoming increasingly consolidated, participants are experiencing shifts in where their routine care is provided.

New York State and City, where a majority of 32BJ Health Fund participants' healthcare is provided, has experienced hospital market consolidation. One 2018 study reviewing hospital consolidations in New York State found the 12 largest systems now control half of all the acute care hospitals in New York and 70 percent of the inpatient acute care beds.[6] New York hospitals continue to pursue consolidation. In February 2024, Northwell Health announced a proposal to acquire the Nuvance Health system, which operates seven hospitals in Connecticut and New York State. The proposed merger would expand the Northwell System to include 28 total hospitals valued at $20 billion.[7]

While large hospital systems are merging in New York, their net financial assets are also growing. From 2016-2022, collectively, six academic medical centers in the New York City region (New York-Presbyterian, Northwell Health, New York University Langone, Mount Sinai Hospital, Catholic Health Services of Long Island, and Montefiore Health System) increased its total net assets from $16 billion to $24 billion. New York-Presbyterian recorded the highest total net assets among these hospitals in 2022 at nearly $11 billion.[8]

At the same time net financial assets increased for large hospital systems in the New York City region, the site of care for some routine procedures also shifted for 32BJ Health Fund participants. The 32BJ Health Fund reviewed its claims to examine changes in billing from office settings to hospital outpatient departments. The analysis showed a shift over time in the site of care for many routine procedures like allergy shots, acupuncture, and glaucoma screenings from doctors' offices to hospital outpatient departments. In 2016, 29% of nonemergency CT scans for 32BJ Health Fund participants in New York were conducted in hospital outpatient departments, meaning 71% took place in doctors' offices. By 2022, the number of these CT scans conducted in hospital outpatient departments rose by 12 percentage points, and the number in doctors' offices decreased by the same amount.

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[2] Key Takeaways from the Site-based Invoicing and Transparency Enhancement (SITE) Act-2023-06-13 (crfb.org)

[3] Lower Costs, More Transparency Act (2023). House Committee on Energy and Commerce. https://energycommerce.house.gov/LCMT

[4] Sullivan, P. (March 5, 2024). Hospitals and PBMs seem to have dodged big federal reforms, for now. Axios Health. https://www.axios.com/2024/03/05/hospitals-pbms-dodge-reforms-congress

[5] Equalizing Medicare Payments Regardless of Site-of-Care (February 21, 2021). Committee for a Responsible Federal Budget. https://www.crfb.org/papers/equalizing-medicare-payments-regardless-site-care

[6] Uttley, L., Hyde, F., HasBrouck, P. and Chessen, E. (May 2018). Empowering New York Consumers in an Era of Hospital Consolidation

[7] Gagne, M. (March 4, 2024). Will patient care, costs in CT improve with Nuvance-Northwell merger? 'Cautiously optimistic.' Newstimes. https://www.newstimes.com/news/article/danbury-norwalk-hospital- nuvance-northwell-merger18695997.php.

[8] Audited Financial Statements for FY 2022, as posted on Electronic Municipal Market Access (https://emma.msrb.org/)

Without further regulatory action from Congress to reduce incentives for hospital consolidation, 32BJ Health Fund participants may continue to experience changes in their location for routine care and navigate concentrated hospital markets.

Senator Kirsten Gillibrand

Medicare for All Act

The current medical system is complicated and is not patient friendly. The Medicare for All Act would simplify this process and ensure every American has access to quality, affordable health care regardless of income.

Question:

Ms. Opsahl, would Medicare as a uniform health care insurance plan simplify the health care process for union members and their families?

Response:

The 32BJ Health Fund strives to simplify access to and maintain affordable healthcare for our plan participants. We also value efforts to do the same for all working Americans. Containing hospital prices is a critical prerequisite for success in any global healthcare delivery, access and cost reform effort. Policies to maintain affordable healthcare for both the payer or purchaser and the patient, like regulating inflated hospital prices, is a foundational step to achieving broader healthcare reform.

Capping Prescription Costs Act of 2024

The average drug price increase between January 2022 and 2023 was 15.2 percent. The Capping Prescription Costs Act of 2024 would cap individual cost-sharing for prescription drugs to help those with limited incomes and high costs.

Question:

Ms. Opsahl, how much of the overall Health Fund costs do prescriptions contribute to the 32BJ Health Fund?

Response:

In 2023, the 32BJ Health Fund spent $1.4B in total on medical and pharmacy benefits. Of the $1.4B the 32BJ Health Fund spent in 2023 on medical and pharmacy benefits, 18% ($262M) was spent on pharmacy benefit costs.

Question:

How would a cap on out-of-pocket costs affect the union members'and their family's health care costs?

Response:

Price caps, and other drug pricing mechanisms, are but one way for the 32BJ Health Fund to manage prescription costs. The 32BJ Health Fund is responsible for creating and implementing a cost-effective plan design that offers plan participants accessible and affordable prescription drug benefits. We contract with vendors, such as pharmacy benefit managers (PBMs) to provide benefits to plan participants. Maintaining affordable prescription drug benefits for our participants is a guiding principle in our vendor partnerships. In 2021, the 32BJ Health Fund transitioned our PBM vendor to OptumRx with the CoreTrust Group Purchasing Coalition. After the first year of this change, the 32BJ Health Fund saved 15% on prescription drug cost spend and 10% in the second year. The 32BJ Health Fund will continue to prioritize access and affordability in the prescription drug benefits provided to our participants.

U.S. SENATE SPECIAL COMMITTEE ON AGING

"HEALTH CARE TRANSPARENCY: LOWERING COST AND EMPOWERING PATIENTS"

JULY 11, 2024

QUESTIONS FOR THE RECORD

Sophia Tripoli

Senator Kirsten Gillibrand

Compliance

A recent report showed that less than 36 percent of hospitals were fully compliant with transparency requirements issued by the Centers for Medicare and Medicaid Services Hospital Price Transparency Rule.

Question:

Ms. Tripoli, how would patients benefit from hospitals posting price transparency data in a standardized format?

Response:

The United States is in the midst of a severe health care affordability and quality crisis, stemming from high, rising, and variable prices across a wide range of health care goods and services, particularly for hospital care.[1] Large health care corporations have destroyed competition in the health care sector, and hospitals are dramatically increasing their prices year after year without any oversight from policymakers.[2] This practice has become a central strategy in the business model of health care corporations: generate profit by buying up other hospitals and doctors' offices to become large corporate health care systems that can increase health care prices, and then block policymakers and the public from seeing those prices, while maximizing service volumes of the highest-priced services.[3] The ability of hospitals to increase prices year over year is the direct result of their ability to keep the underlying price of health care service hidden from public oversight and scrutiny.

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 are delivered. For the majority of Americans (66%) who receive health care through private insurance, health care prices are established in closed-door negotiations between large hospital corporations and health plans based on who has more market power.[4] These health care prices, often referred to as the negotiated rate, are buried in proprietary contracts without insight into or oversight over the price of health care services by the public and policymakers.[5]

It is critical that we achieve meaningful price transparency to infuse healthy competition back into the health care system and not allow large hospital corporations to secretly set their prices to price gouging levels at the expense of the health and

[1] Robert A. Berenson et al., Addressing Health Care Market Consolidation and High Prices, The Urban Institute https://www.urban.org/sites/default/files/publication/101508/addressing—health—care—market—consolidation—and—high—price s—1.pdf. See also, Naomi N. Levey, "100 Million People in America are Saddled with Health Care Debt," Kaiser Health News, June 16, 2022, Health https://khn.org/news/article/diagnosis-debt-investigation-100-million-americans-hidden-medical-debt/

[2] Health Care Cost Institute, 2020 Health Care Cost and Utilization Report, May 2022. https://healthcostinstitute.org/images//pdfs/HCCI—2020—Health—Care—Cost—and—Utilization—Report.pdf; The Impact of Hospital Consolidation on Medical Costs. NCCI Insights. 2018. https://www.ncci.com/Articles/Pages/II—Insights—QEB—Impact-of-Hospital-Consolidation-on-Medical-Costs.aspx

[3] Sophia Tripoli, Frederick Isasi, and Eliot Fishman, Bleeding Americans Dry: The Role of Big Hospital Corporations in Driving Our Nation's Health Care Affordability and Quality Crisis (Washington, DC: Families USA, September 2022), https://familiesusa.org/wp-content/uploads/2022/09/People-First-Care—Role-of-Hospitals.pdf.

[4] Katherine Keisler-Starkey and Lisa N. Bunch. "Health Insurance Coverage in the United States: 2020." United States Census Bureau. September 2021. https://www.census.gov/library/publications/2021/demo/p60-274.html. See also, Sarah Kliff and Josh Katz. "Hospitals and Insurers Didn't Want You to See These Prices. Here's Why." The Upshot: The New York Times. August 21, 2021. https://www.nytimes.com/interactive/2021/08/22/upshot/hospital-prices.html

[5] Jaime S. King. "Examining State Efforts to Improve Transparency in Healthcare Costs for Consumers: Testimony before the House Committee on Energy and Commerce and Subcommittee on Oversight and Investigations." U.S. House of Representatives. July 17, 2018. https://docs.house.gov/meetings/IF/IF02/20180717/108550/HHRG-115-IF02-Wstate-KingJ-20180717.pdf

financial security of our nation's families. 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.[6] Further, unveiling prices can inform where the highest and most irrational prices are occurring in the health care system, so policymakers can implement targeted policy solutions to bring down the cost of health care.[7] All Americans, and particularly older Americans who heavily rely on the health care system, should be able to easily access the price of health care services at a hospital or health care facility before they receive care.

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 the 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.[8] But many large hospital corporations have bucked the federal requirements and are actively working to keep their prices hidden.[9] The Lower Costs, More Transparency Act and the Health Care PRICE Transparency Act 2.0 make clear, without any exception, that all hospitals and insurers are required to post the underlying price of health care services, in a standardized machine readable and consumer-friendly format.

The American public is in broad agreement about the need for action on price transparency, with polling showing that a large majority (95%) of the public say it is important for Congress to pass a law to make health care costs more transparent to patients, including 60% who call this a top priority.[10]

Medicare for All Act

The current medical system is complicated and is not patient friendly. The Medicare for All Act would simplify this process and ensure every American has access to quality, affordable health care regardless of income.

Question:

Ms. Tripoli, how would a system with one insurance plan improve the issues that health care consumers currently face?

Response:

Every individual and family throughout the nation should have access to the best health and health care, regardless of who they are, where they are from, or how much money they make. This includes putting in place a sustainable, competitive, and affordable system of health care and coverage for all. There are a number of pathways to achieve universal health coverage. In all of them, it is critical to address the underlying drivers of our nation's health care affordability and quality crisis, including reining in the impact of unchecked health care industry consolidation on health care prices. Policymakers should enact a range of bipartisan, commonsense policy solutions to address high and rising health care prices including

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[6] Robert A. Berenson, Jaime S. King, and Katherine L. Gudiksen, et al., ″Addressing Health Care Market Consolidation and High Prices,″ The Urban Institute, January 2020, https://www.urban.org/sites/default/files/publication/101508/addressing—health—care—market—consolidation—and—h igh—prices—1.pdf.; See also, Jaime S. King, ″Examining State Efforts to Improve Transparency in Healthcare Costs for Consumers: Testimony before the House Committee on Energy and Commerce and Subcommittee on Oversight and Investigations,″ U.S. House of Representatives, July 17, 2018, https://docs.house.gov/meetings/IF/IF02/20180717/108550/HHRG-115-IF02-Wstate-KingJ-20180717.pdf

[7] Phillip Longman and Harris Meyer, ″Why Hospitals Keep Their Prices Secret,″ Washington Monthly, July 6, 2020, https://washingtonmonthly.com/2020/07/06/why-hospitals-keep-their-prices-secret/

[8] ″Transparency in Coverage Final Rule Fact Sheet (CMS-9915-F),″ Centers for Medicare & Medicaid Services, October 29, 2020, https://www.cms.gov/newsroom/fact-sheets/transparency-coverage-final-rule-fact-sheet-cms-9915-f.

[9] PatientsRightsAdvocate.org, ″The Fifth Semi-Annual Hospital Price Transparency Compliance Report,″ PatientsRightsAdvocate.org, July 2023, https://www.patientrightsadvocate.org/july-semi-annual-compliance-report-2023; See also, PatientsRightsAdvocate.org, ″The Fourth Semi-Annual Hospital Price Transparency Compliance Report,″ PatientsRightsAdvocate.org, February 2023, https://www.patientrightsadvocate.org/february-semi-annualcompliance-report-2023; See also, Justin Lo, Gary Claxton, Emma Wagner, et al., ″Ongoing Challenges With Hospital Price Transparency,″ Peterson-KFF Health System Tracker, February 10, 2023, https://www.healthsystemtracker.org/brief/ongoing-challenges-with-hospital-price-transparency/.

[10] Shannon Schumacher, Kunna Lopes, and Grace Sparks, et al., ″KFF Health Tracking Poll December 2022: The Public's Health Care Priorities For The New Congress,″ KFF, December 20, 2022, https://www.kff.org/mental-health/poll-finding/kff-health-tracking-poll-december-2022/

strengthening and codifying hospital price transparency rules,[11] so that hospitals provide real prices (in dollars and cents) to consumers in advance of delivering care; enacting comprehensive site neutral payments as recommended by MedPAC that ensures consumers pay the same price for the same service regardless of where that care is delivered,[12] as well as billing transparency reforms that ensure large hospital systems do not overcharge for the care they deliver in outpatient settings; banning anti-competitive contracting terms in health care provider and insurer contracts - such as ″all-or-nothing,″ ″anti-steering,″ and ″anti-tiering″ clauses - and in clinician and health care worker employment arrangements - such as ″non-compete″ clauses; and requiring meaningful ownership transparency and strengthening FTC authority to effectively oversee health care markets.

[11] Gallup, Record High in U.S. Put Off Medical Care Due to Cost in 2022, January 2023. https://news.gallup.com/poll/468053/record-high-put-off-medical-care-due-cost-2022.aspx. See also, NORC at the University of Chicago and West Health, Americans' Views on Healthcare Costs, Coverage and Policy, March 2018 https://www.norc.org/NewsEventsPublications/PressReleases/Pages/survey-finds-large-number-of-people-skipping-necessarymedical-care-because-cost.aspx; Naomi N. Levey, 100 Million People in America are Saddled with Health Care Debt, Kaiser Health News, June 16, 2022, https://khn.org/news/article/diagnosis-debt-investigation-100-million-americans-hidden-medical-debt/; Robert A. Berenson et al., Addressing Health Care Market Consolidation and High Prices, The Urban Institute https://www.urban.org/sites/default/files/publication/101508/addressing—health—care—market—consolidation—and—high—prices—1.pdf

[12] Medicare Payment Advisory Commission, ″Medicare and the Health Care Delivery System, Report to the Congress,″ MedPAC, June 2023, https://www.medpac.gov/wpcontent/uploads/2023/06/Jun23—MedPAC—Report—To—Congress—SEC.pdf; H

Statement for the Record

U.S. SENATE SPECIAL COMMITTEE ON AGING

"HEALTH CARE TRANSPARENCY: LOWERING COST AND EMPOWERING PATIENTS"

JULY 11, 2024

STATEMENT FOR THE RECORD

Statement of 75 Alliances, Unions, and Employers

We write asking you to support the bipartisan Senate Bill 3548, The Health Care PRICE Transparency Act 2.0, introduced by Senate Health Education Labor and Pensions (HELP) Committee Chairman Bernie Sanders and Committee member Senator Mike Braun. The transparency provisions in this bill will empower employers and unions like ours, which provide coverage to nearly 160 million Americans, to greatly reduce our health plan costs, improve our business competitiveness, and share savings with employees through higher wages and lower premiums.

Currently, employers and unions nationwide are blocked from accessing, auditing or leveraging their own health claims data. The situation is so dire that many have had to sue their own insurers and third-party administrators (TPAs) to gain access to their own data and fulfill their fiduciary duty.

The Health Care PRICE Transparency Act will, among other priorities, empower us as employers to access our claims data through a daily data transaction set. This data feed acts as a daily receipt for our plan payments to providers, allowing us to confirm that the claim amounts match both the payments by the TPA and the negotiated prices. It will enable the identification and remedy of overcharges and erroneous billing, allowing us to perform the fundamental oversight of our health plan spending. The bill also removes anti-audit and similar obstacles currently rampant in health plan administrator contracts, making it easier for employers to audit and oversee our plan spend effectively.

By building on the existing Transparency in Coverage (TiC) regulation, this bill strengthens consumer access to health plan pricing data with all billing and coding elements, helping us protect our employees from overcharges and assess the value and performance of our plan. Seeing systemwide prices across all plans will empower us to negotiate higher quality, lower cost care, as we do for every other aspect of our supply chains.

This bill also requires disclosure of all hospital pricing data including all negotiated rates and discounted cash prices not estimates, averages, or percentages. This price disclosure will enable us to identify wide price variation, steer employees to lower priced facilities, and compare our plans negotiated prices with others.

Finally, the bill expands price disclosure requirements to laboratories, imaging centers, and ambulatory surgical centers, informing consumers of alternatives to high-priced hospital systems.

On behalf of the over 21 million employees we collectively represent, we ask you to please support the Braun-Sanders Health Care PRICE Transparency Act 2.0 in the reconciliation process. By bringing systemwide transparency and accountability to healthcare, this bill provides employers and unions with the necessary tools to lower our healthcare costs, with no added cost to the government. The significant savings can then be used to increase earnings and wages, ultimately improving competitiveness and stimulating the American economy.

Sincerely,

75 Alliances, Unions and Employers Nationwide

CC: United States Senate

Alliances

Alabama Employer Health Consortium
Dallas-Fort Worth Business Group on Health
Employers' Advanced Cooperative on Healthcare
Employers' Forum of Indiana
Florida Alliance for Healthcare Value
Greater Philadelphia Business Coalition on Health
HealthCareTN
Houston Business Coalition on Health
Independent Colleges and Universities Benefits Association (ICUBA)
Kansas Business Group on Health
Lehigh Valley Business Coalition on Health
MidAtlantic Business Group on Health

Midwest Business Group on Health
Nevada Business Group on Health
Oklahoma Business Collective on Health
Rhode Island Business Group on Health
Texas Business Group on Health
Texas Employers for Affordable Healthcare
The Alliance - Midwest
Washington Health Alliance

Unions

32BJ SEIU
International Union of Bricklayers and Allied Craftworkers Local 1 CT
National Association of Police Organizations
New Jersey State Policemen s Benevolent Association
Teachers Health Trust

Employers

Agra Industries, Wisconsin
American Licorice, Indiana
Applied Laser Technologies, Wisconsin
Broadway Metal Works, Virginia
Conner Insurance, Indiana
Consolidated Scrap Resources, Inc., Pennsylvania
Curran Group, Illinois
Dick Myers, Inc., Virginia
Diversified Industrial Service Company, Texas
Dupre Logistics, Louisiana
Dynamic Aviation Inc., Virginia
Enerquip, Wisconsin
Faulks Bros Construction, Wisconsin
Frank Blum Construction, North Carolina
Glass and Metals Inc., Virginia
Harman Construction, Inc., Virginia
Health Rosetta, Washington
Hospice of Wichita Falls, Texas
Hyster-Yale, Ohio
InterChange Group; Inc., Virginia
Lantz Construction Company, Virginia
LD&B Insurance & Financial Services, Virginia
Lincoln National Bank, Kentucky
Lynch Companies, Wisconsin
Mayville Engineering Company, Inc., Wisconsin
Menasha Joint School District, Wisconsin
Meshoppen Stone, Pennsylvania
Midwest Carriers, Wisconsin
Mitchell Metal Products, Wisconsin
Moose Pharmacy, North Carolina
Myers Ford Co., Inc., Virginia
Nolato Contour, Wisconsin
Nordic Group of Companies, Wisconsin
Pacific Steel & Recycling, Montana
Partners Excavating Company, Virginia
Ponsse North America, Wisconsin
Railside Enterprises, Inc., Virginia
Rockingham Cooperative, Virginia
Rosen Hotels & Resorts, Florida
SavATree, New York
Second Harvest Food Bank of Central Florida, Florida
SFS Tools & Safety, LLC, Virginia
Shickel Corporation, Virginia
Synthomer, Ohio
Team Schierl Companies, Wisconsin
The Frazier Quarry, Inc., Virginia
The Weber Group, Wisconsin
Valley Engineering, PLC, Virginia
Vero Orthopaedics, Florida
Walker Forge, Inc., Wisconsin

U.S. SENATE SPECIAL COMMITTEE ON AGING

"HEALTH CARE TRANSPARENCY: LOWERING COST AND EMPOWERING PATIENTS"

JULY 11, 2024

STATEMENT FOR THE RECORD

Statement of Patient Rights Advocate.Org Letter

Thank you for holding a hearing on health care price transparency, lowering costs, and empowering patients. As a nonprofit advocating for systemwide price transparency in healthcare, we believe that empowering consumers and employers with actual, upfront prices will create a functional, competitive market, protect patients from overcharges, and greatly reduce healthcare costs.

We strongly endorse the bipartisan Senate Bill 3548, The Health Care PRICE Transparency Act 2.0, introduced by Senate Health Education Labor and Pensions (HELP) Committee member Senator Mike Braun and Committee Chairman Bernie Sanders. Earlier this year, 75 alliances, unions and employers from across the country, representing more than 21 million employees, also endorsed this bill in the attached letter sent to bipartisan Senate leadership.

The price transparency provisions in this bill will empower employers and unions like them to greatly reduce their health plan costs, improve their business competitiveness, and share savings with employees through higher wages and lower premiums. Currently, employers and unions nationwide are blocked from accessing and analyzing their own health claims data to identify overcharges and savings opportunities. Many have had to sue their own insurers and third-party administrators (TPAs) to gain access to their own data and fulfill their fiduciary duty.

The Health Care PRICE Transparency Act 2.0 will, among other priorities, empower self-insured employers and union health plans to access their claims data through access to a daily transaction data set. This data feed will act as a daily receipt of plan payments to providers, allowing employers to confirm that the claim amounts match both the payments by the TPA and the negotiated prices. It will enable employers and union health plans to identify and remedy overcharges and erroneous billing, allowing them to perform the critical oversight of their health plan spending. The bill also removes anti-audit and similar obstacles rampant in health plan administrator contracts, making it easier for employers to audit and oversee their plan receipts for payment.

This bill also requires transparency of all hospital pricing data including all negotiated rates and discounted cash prices not estimates, averages, or percentages. This price disclosure will enable consumers to identify wide price variation, find lower priced care, and compare their plan s negotiated prices to those of other plans. The bill requires increased enforcement for noncompliant hospitals, at a time when only 34.5% of hospitals reviewed are fully compliant and the Centers for Medicare and Medicaid Services (CMS) has only penalized fifteen hospitals for noncompliance.

By building on the existing Transparency in Coverage (TiC) regulation, this bill strengthens consumer access to health plan pricing data with all billing and coding elements, helping employers protect their employees from overcharges and assess the value and performance of their health plan. Seeing systemwide prices across all plans will empower employers to negotiate higher quality, lower cost care, as is the case for every other aspect of supply chains.

Finally, the bill expands price disclosure requirements to laboratories, imaging centers, and ambulatory surgical centers, informing consumers of alternatives to high-priced hospital systems.

By bringing systemwide transparency and accountability to healthcare, this bill provides employers and unions with the necessary tools to lower our healthcare costs, with no added cost to the government. The significant savings can then be used to increase earnings and wages, ultimately improving competitiveness and stimulating the American economy.

Sincerely,

Cynthia Fisher
Founder & Chairman PatientRightsAdvocate.org

CC: United States Senate

U.S. SENATE SPECIAL COMMITTEE ON AGING

"HEALTH CARE TRANSPARENCY: LOWERING COST AND EMPOWERING PATIENTS"

JULY 11, 2024

STATEMENT FOR THE RECORD

Statement of Leukemia and Lymphoma Society

On behalf of the more than 1.5 million Americans living with a blood cancer diagnosis, The Leukemia & Lymphoma Society (LLS) appreciates the opportunity to provide recommendations to address the nation's rising healthcare costs and improve transparency in our healthcare system. As an organization that has invested in the fight to cure cancer, LLS knows that the cost of care associated with a blood cancer diagnosis is too high and continues to rise. We receive over 20,000 calls to our Information Resource Center (IRC) annually, the vast majority of which pertain to the cost burden of cancer.

In response to cost growth in recent years, payers and policymakers have often passed the burden to patients in the form of increased cost-sharing and changes that erode the quality of care accessible to cancer patients. In 2019, the national patient economic burden associated with cancer care was over $21 billion, including direct patient out-of-pocket costs of more than $16 billion.[1]

LLS launched our Cost of Cancer Care initiative in 2017 to address this growing issue, and we continue to advocate for aggressive but feasible cost-cutting policy solutions that would not sacrifice quality of care.[2] We offer the following policy recommendations for the Committee to consider to help lower healthcare costs, incentivize high-quality care, and increase healthcare transparency.

Expand Site-Neutral Payments

LLS encourages Congress to pursue expanding site-neutral payments in Medicare. Expanding site-neutral payment-the practice of paying equally for services whether they are associated with a physician practice or an outpatient hospital setting-has the potential to lower patient out-of-pocket costs, reduce unnecessary Medicare spending, and reduce incentives for hospitals to participate in anticompetitive practices (such as buying up physician practices).

Vertical consolidation between hospital and physician office settings continues to rise, driven in part by the ability of hospital entities to receive higher hospital outpatient reimbursements for services performed at the facility that had previously been considered a physician office. According to the Government Accountability Office (GAO), between 2007 and 2013, the number of vertically consolidated physicians nearly doubled from 96,000 to 182,000.[3] Further, a 2016 study found that the proportion of chemotherapy infusions delivered in a hospital increased from 15.8 percent in 2004 to 45.9 percent in 2014 in the Medicare population.[4]

We urge the Committee to consider implementing site-neutral payment policies as outlined in H.R. 5378, the Lower Costs, More Transparency Act, which passed the House of Representatives on an overwhelmingly bipartisan basis last year. The site-neutral policies included in this bill take steps to adjust incentives by expanding existing site-neutral payments for drug administration services. LLS strongly supports advancing this policy and looks forward to working with Congress to advance and expand site-neutral payments or other payment changes intended to address the ways in which consolidation negatively impacts patients.

Experts have repeatedly identified site-neutral payments as an opportunity to save money for Medicare. The Congressional Budget Office (CBO) estimated that the site-neutral policies in the Lower Costs, More Transparency Act would result

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[1] K. Robin-Yabroff, PhD, Angela Mariotto, PhD, et al., Annual Report to the Nation on the Status of Cancer, Part 2: Patient Economic Burden Associated With Cancer Care, JNCI: Journal of the National Cancer Institute, Volume 113, Issue 12, December 2021, Pages 1670-1682, https://doi.org/10.1093/jnci/djab192

[2] The Leukemia & Lymphoma Society. Cost of Cancer Care Initiative. Accessed at www.lls.org/CancerCost

[3] GAO (2015) Increasing Hospital-Physician Consolidation highlights Need for Payment Reform. Accessed at https://www.gao.gov/assets/680/674347.pdf

[4] Milliman (2016) Cost Drivers of Cancer Care: A Retrospective Analysis of Medicare and Commercially Insured Population Claim Data 2004-2014. Accessed at https://www.communityoncology.org/wpcontent/uploads/sites/20/2018/07/Trends-in-Cancer-Costs-White-Paper-FINAL-20160403.pdf

in over $3.7 billion in Medicare savings.[5] More importantly, these policies also reduce cost-sharing for beneficiaries and limit non-clinical incentives to provide services in more expensive settings - without compromising beneficiary access to care or health outcomes. Research commissioned by LLS has demonstrated that requiring site-neutral payment for drug administration services can result in significant out-of-pocket savings for patients. A patient with multiple myeloma, for example, could save $1,200/year under this policy.[6] In addition to saving taxpayer dollars and reducing patient out-of-pocket costs, equalizing payments between these sites of service would weaken the incentive for provider consolidation, which would also produce long-term cost savings and provide patients with additional options for their care.

Unique Identifiers

Medicare payments to providers currently include limited information about where the service is provided. For example, codes do not distinguish if services are delivered on a hospital campus or at an affiliated provider, such as a primary care doctor or infusion center that may be geographically separate from the primary hospital's physical campus. Because Medicare payments for hospital outpatient departments (HOPDs) are reimbursed at a higher rate than physician's offices, hospitals are incentivized to purchase smaller providers and reclassify them as HOPDs.

In addition to site-neutral reforms, several proposals under consideration in Congress would, if passed, require hospitals and providers to report more granular data regarding where services are being provided-at a hospital's primary facility or at a provider beyond the boundaries of the hospital's physical campus. These simple transparency requirements would provide data that would help policymakers and researchers better understand hospital revenue cycles and consolidation trends, as well as their implications on patients and national budget outlays. LLS strongly supports legislation that would improve site-of-service transparency to better understand if healthcare systems are using consolidation and other anti-competitive behaviors to game federal payments.

Enforce Provider Price Transparency Rules

One crucial way this Congress can address provider consolidation and encourage competition in the healthcare system is through price transparency. While multiple federal rules are in effect requiring disclosure of negotiated prices between health plans, physicians, and hospitals, compliance is lacking. Price transparency is a means to an end, and stakeholders must be able to access and analyze data to identify cost drivers and make informed healthcare policy decisions. Congress should direct the Centers for Medicare and Medicaid Services (CMS) to provide hospitals and health plans with better datareporting standards and usability guidelines to ensure that transparency leads to the goal of a more cost-efficient healthcare system.

Bring Transparency to Pharmacy Benefit Managers (PBMs)

Given the nature of blood cancers, many patients rely on prescription drugs as their primary therapy. As a result, blood cancer patients often access their cancer therapy via their insurance plan's pharmacy benefit-typically managed by their plan's contracted pharmacy benefit manager (PBM). LLS believes that the healthcare system needs greater transparency, oversight, and guardrails in order to ensure that PBM financial incentives are aligned with the goals of both plans and patients.

Congress should require that PBMs provide comprehensive quarterly reporting to plan sponsors, including details about the list and net prices for drugs accessed through the pharmacy benefit as well as comprehensive rebate information for each drug. Additionally, PBMs should be required to provide important information related to the inflated out-of-pocket costs paid by plan enrollees utilizing a drug whose enrollee cost-sharing is based on its list price rather than net price. Plan sponsors should be aware of the impact on enrollees of choosing to base cost-sharing on an inflated list price, which dramatically increases the cost burden for patients who rely on drugs with high list prices in order to provide a small amount of savings either to plan cost or enrollee premiums. This trade-off has significant consequences

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[5] Congressional Budget Office. (2023) ″Estimated Direct Spending and Revenue Effects of H.R. 5378, the Lower Costs, More Transparency Act.″ Accessed at: hr5378-DS-and-Revs—12-2023.pdf (cbo.gov)

[6] Stewart, R. (2023) ″Site Neutral Payment Reform Has the Potential to Significantly Reduce Out-Of-Pocket Patient Spend″ Wakely. Accessed at: Site Neutral Payment Reform has the Potential to Significantly Reduce Out-of-Pocket Patient Spend (lls.org)

for plan enrollees with blood cancer and other chronic and/or life-threatening conditions, and plan sponsors should be aware of the impact on these enrollees.

Congress should also prohibit spread pricing-a practice that positions a PBM's financial incentives in opposition to the incentives of the plan sponsor for whom they are managing the prescription benefit. Spread pricing describes the practice of PBMs administering a plan's drug benefits charging a plan sponsor far more for a drug than the drug's pharmacy acquisition cost, with the potentially vast difference between the two costs going to the PBM's bottom line. This practice prevents plan sponsors, enrollees, and patients filling their prescriptions from experiencing the financial benefits of generic competition, and it serves no purpose other than to reward PBMs for behavior contrary to the interests of the entities on whose behalf they are contracted to work.

Facilitate Competition through Consumer-Friendly Plan Transparency

When shopping for coverage during enrollment periods, consumers do not have access to clear and transparent information about the amount they would be required to pay as their share of the cost of a medication. This is due largely to the prevalence of coinsurance, a cost-sharing technique that requires consumers to pay a percentage of a drug's total cost. Plan formularies typically represent coinsurance as a percentage only - e.g. ″30%″ or ″45%″ - with no accompanying information that consumers can use to translate that percentage to an actual dollar amount. Thus consumers must select and enroll in a plan without a full understanding of the affordability of one plan's drug benefit versus another.

This lack of transparency poses a real threat to patient well-being: patients are more likely to abandon treatment when the cost of their care is high, a dynamic that is exacerbated when patients are unable to anticipate and plan for the precise out-of-pocket cost of their care. This lack of transparency is harmful to the marketplace as well, as it diminishes competition among plans.

In order to facilitate greater transparency regarding cost-sharing for medications:

-Congress should require CMS to improve Medicare Plan Finder to convey important information on out-of-pocket drug costs so that consumers can judge their health care options based on complete information about the impact of their decision on their financial and physical health, and

-Congress should require qualified health plans (QHPs) to provide transparency regarding the plan's prescription drug formulary, including meaningful cost-sharing information, to consumers during the open enrollment process. At a minimum, QHPs should be required to include for every covered drug a range of out-of-pocket spending for the prescription (e.g. $-$$$$ OR $010, $11-25.$500+, etc.)

Conclusion

LLS stands ready to work with you and your colleagues in Congress to advance the solutions we have outlined above and other proposals that would achieve savings without sacrificing patient access to appropriate cancer care. We share your belief that we are at a crucial juncture in our healthcare system, and we urge you and your colleagues to capitalize on this real opportunity to make the reforms necessary to promote patient access to appropriate care while eliminating incentives that drive unnecessary spending. We are grateful for your leadership.

Sincerely,

Brian Connell
Executive Director of Federal Affairs

U.S. SENATE SPECIAL COMMITTEE ON AGING

"HEALTH CARE TRANSPARENCY: LOWERING COST AND EMPOWERING PATIENTS"

JULY 11, 2024

STATEMENT FOR THE RECORD

Statement of American Hospital Association

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners - including more than 270,000 affiliated physicians, two million nurses and other caregivers - and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) writes to share the hospital field's comments on health care costs and transparency.

OVERVIEW OF NATIONAL HEALTH SPENDING

America's hospitals and health systems - physicians, nurses and other caregivers - understand and share concerns regarding the high cost of health care and are working hard to make care more affordable by transforming the way health care is delivered in our communities. Real change will require an effort by everyone involved, including providers, the government, employers and individuals, device makers, drug manufacturers, insurers and other stakeholders.

The AHA's most recent "Cost of Caring" report provides greater details on the challenges hospitals face with respect to treating patients with higher acuities while dealing with financial instability. The issues include workforce shortages and increasing supply chain costs, coupled with inadequate reimbursement from government payers and increased administrative burden related to commercial insurance efforts to reduce compensation. Taken together, these factors create an environment of financial uncertainty in which many hospitals and health systems are operating with little to no margin.

For this statement, we highlight two of the cost drivers incurred by hospitals and health systems: commercial insurer operating methods and prescription drug costs.

Commercial Insurer Practices

To truly reduce health care costs, we urge Congress to address practices by certain commercial health insurers. For example, additional oversight is needed to ensure that Medicare Advantage (MA) plans can no longer engage in tactics that restrict and delay access to care while adding burden and cost to the health care system.

While MA plans were designed to help increase efficiency in the Medicare program, data from the Medicare Payment Advisory Commission (MedPAC) found that MA plans will be responsible for $88 billion in excess federal spending this year, due in part to inappropriate upcoding practices, whereby plans report enrollees as having more health conditions and being sicker than they are to receive higher reimbursements. At the same time, health insurance premiums continue to grow - in fact, annual insurance premiums increased nearly twice as much as hospital prices over a 10-year period.[1]

Additionally, inappropriate denials for prior authorization and coverage of medically necessary services remain a pervasive problem among certain MA plans. A 2022 report from the Department of Health and Human Services (HHS) Office of Inspector General found that MA plans are denying at a high rate medically necessary care that met Medicare criteria.[2] The report highlights that 13% of prior authorization denials and 18% of payment denials met Medicare coverage rules and therefore should have been approved. In a program this size - covering more than half of all Medicare beneficiaries - improper denials at this rate are unacceptable. However, because the government pays MA plans a risk-adjusted per-beneficiary capitation rate, there is a perverse incentive to deny services to patients or payments to providers to boost profits.

These practices delay access to care for seniors and add financial burden and strain on the health care system through inappropriate payment denials and increased staffing and technology costs to comply with plan requirements. They also are a major burden to the health care workforce and contribute to provider burnout. To address these issues, the AHA supports regulatory and legislative solutions that streamline and improve prior authorization processes, including the Improving Sen-

[1] https://www.medpac.gov/wp-content/uploads/2023/10/MedPAC-MA-status-report-Jan-2024.pdf
[2] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

iors' Timely Access to Care Act (S. 4532), which would codify many of the reforms in the Interoperability and Prior Authorization Final Rule.

Though issues with denials are often felt most acutely with MA and Medicaid managed care plans, these practices also are followed by other commercial payers, where claims denials increased by 20.2% in 2023. Moreover, the time taken by commercial payers to process and pay hospital claims from the date of submission increased by 19.7% in 2023, according to data from the Vitality Index. For hospitals and health systems, these practices, which require hospitals to divert dollars away from patient care to instead focus on seeking payment from commercial insurers, result in billions of dollars in lost revenue each year.[3] Without further intervention, these trends are expected to continue and worsen. National expenditures on the administrative costs of private health insurance spending alone are projected to account for 7% of total health care spending between 2022 and 2031 and are projected to grow faster than expenditures for hospital care.[4]

Prescription Drug Prices

Congress also should address the high costs of prescription medications, given the regular increases in costs, as this impacts expenses for all providers, including hospitals. For instance, a report from earlier this year noted pharmaceutical companies raised list prices on 775 brand name drugs during the first half of January 2024, with a median increase of 4.5%, though the prices of some drugs rose by 10% or higher.[5] These increases were higher than the rate of inflation, which was 3.4% in December. A report by the HHS Assistant Secretary for Planning & Evaluation (ASPE) found that between 2022 and 2023 drug companies increased drug prices for nearly 2,000 drugs faster than the rate of general inflation, with an average price hike of 15.2%.[6]

Moreover, recent drug shortages also have fueled further expense growth. An ASPE report found up to a 16.6% increase in the prices of drugs in shortage; in many cases, the increase in the price of substitute drugs were at least three times higher than the price increase of the drug in shortage.[7] The costs incurred as a result of drug shortages are compounded by staff overtime needed to find, procure and administer alternative drugs, to manage the added challenges of multiple medication dispensing automation systems and changing electronic health records and to undergo training to ensure medication safety using alternative therapies.[8]

MEDICAL DEBT

Hospitals and health systems are very concerned about patients' medical debt, which is a consequence of patients not paying some or all their health care bills. While health insurance is intended to be the primary mechanism to protect patients from unexpected and unaffordable health care costs, for too many that coverage is either unavailable or falling short.

Trends in health insurance coverage that are driving an increase in medical debt include inadequate enrollment in comprehensive health care coverage, growth in highdeductible and skinny health plans that intentionally push more costs onto patients and misleading health plan practices that confuse patients' understanding of their coverage. These gaps in coverage leave individuals financially vulnerable when seeking medical care. The primary causes of medical debt are:

–There are still too many uninsured Americans. Affordable, comprehensive health care coverage is the most important protection against medical debt. While the U.S. health care system has achieved higher rates of coverage over the past decade, gaps remain.

–High-deductibles subject many Americans to cost-sharing they cannot afford. High-deductible plans are designed to increase patients' financial exposure through high cost-sharing in exchange for lower monthly premiums. Yet many individuals enrolled in high-deductible plans find they cannot manage their portion of health plan expenses. A Federal Reserve report found that 37% of adults would not be able

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[3] https://www.ama-assn.org/practice-management/prior-authorization/health-systems-played-payer-takeback-schemes

[4] AHA analysis of NHE projections of 2022-2031 expenditures.

[5] https://www.wsj.com/health/pharma/drugmakers-raise-prices-of-ozempic-mounjaro-and-hundreds-ofother-drugs-bdac7051

[6] https://aspe.hhs.gov/reports/changes-list-prices-prescription-drugs

[7] https://aspe.hhs.gov/reports/drug-shortages-impacts-consumer-costs

[8] https://link.springer.com/article/10.1007/s13181-023-00950-6:text=shortages%20compromise%20or%20delay%20medical,morbidity%20%5B1%2C%202%5D.

to afford a $400 emergency,[9] an amount $1,000 less than the average general annual deductible for single, employer-sponsored coverage.

–Certain health plans provide inadequate benefits and frequently lead to surprise gaps in coverage. Short-term, limited-duration health plans and health sharing ministries cover fewer benefits and include few to no consumer protections, such as required coverage of pre-existing conditions and limits on out-of-pocket costs. Patients with these types of plans often find themselves responsible for their entire medical bill without any help from their health plan, including for critical services such as emergency medical and oncology care. These denials can lead to an accumulation of significant medical debt.[10]

–Complex health plan benefit design and misleading marketing can expose patients to unexpected costs. Many health plans have complex benefit designs that are not transparent to patients, such as what is covered predeductible, the interaction between point-of-service copays, coinsurance and deductibles and poor communication and education about what the plan covers. For example, a recent National Association of Insurance Commissioners report found significant gaps and inconsistencies with the way that insurers share information about pre-deductible, no cost-sharing preventive services with their members, resulting in a ″meaningful barrier to effective understanding and use of preventive service benefits.″[11]

Hospitals are the only part of the health care sector that provide services to patients regardless of their ability to pay. They underscore that commitment by offering financial and other assistance, including helping patients qualify for federal and state health care programs, such as Medicaid. In doing so, patients can receive regular preventive care, not just episodic care for serious injuries or illness. In addition, hospitals absorb billions of dollars of losses for patients who are unable to pay their bills, mainly due to inadequate commercial insurance coverage; in 2020, the latest figure available, hospitals provided more than $42 billion in uncompensated care.[12]

This is why hospitals are staunch supporters of ensuring everyone is enrolled in some form of comprehensive coverage. However, we appreciate that closing the remaining coverage gaps may be a longer-term solution and that more immediate steps can be taken. To that end, the AHA has routinely developed patient billing guidelines to help prevent patients from incurring medical debt. The AHA's Board of Trustees adopted the most recent set of guidelines in 2020, which reaffirm the hospital field's commitment to:

-Treating all people equitably, with dignity, respect and compassion.

-Serving the emergency health care needs of all, regardless of a patient's ability to pay.

-Assisting patients who cannot pay for part or all the care they receive.

Notably, several of the guidelines directly address medical debt, including encouraging hospitals to forego adverse credit reporting of medical debt, so far, nearly 2,800 hospitals and health systems have affirmed their commitment to the guidelines, and the AHA revisits them regularly for updating.

PRICE TRANSPARENCY REQUIREMENTS

We appreciate Congress' ongoing interest in hospital price transparency to provide consumers with the price information they need specific to their course of treatment.

Hospitals and health systems have invested considerable time and resources to comply with the Hospital Price Transparency Rule, which requires online access to both a machine-readable file and a list of shoppable services. Recent data from Turquoise Health shows that 93.4% of hospitals have met the requirement to post a machinereadable file.

We are concerned, however, with recent legislative efforts to no longer recognize price estimator tools as a method to meet the shoppable services requirement. This change would both reduce access to a consumer-friendly research tool and unfairly penalize hospitals that have spent significant capital to comply with the regulation. These facilities would instead need to develop and maintain a shoppable services spreadsheet, which may be difficult for consumers to navigate and will not reflect the different policies that their insurer may apply to determine the final price for

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[9] https://www.federalreserve.gov/publications/2023-economic-well-being-of-us-households-in-2022expenses.htm

[10] https://kffhealthnews.org/news/sham-sharing-ministries-test-faith-of-patients-and-insurance-regulators/

[11] https://healthyfuturega.org/ghf—resource/preventive-services-coverage-and-cost-sharing-protectionsare-inconsistently-and-inequitably-implemented/

[12] https://www.aha.org/system/files/media/file/2020/01/2020-Uncompensated-Care-Fact-Sheet.pdf

a service. Price estimator tools offer consumers an estimate of their out-of-pocket costs based on their insurance benefit design, such as cost-sharing requirements and prior utilization, as well as the patient's annual deductible. This is an important feature of these tools that is not available from a shoppable services spreadsheet. Eliminating the use of price estimator tools as a method to meet the shoppable services requirement of the Hospital Price Transparency Rule would therefore reduce price transparency for patients. We urge Congress to reject this potential change.

As Congress seeks to make statutory changes to price transparency standards, it is important for legislators to take into consideration the adjustments to the Hospital Price Transparency Rule made by the Centers for Medicare & Medicaid (CMS) on a regular basis. These include changes related to standardization, new data elements, file accessibility, an accuracy and completeness affirmation, as well as changes to CMS' monitoring and enforcement processes. Most notably, CMS now requires hospitals to use a standard format to comply with the machine-readable file requirement, which includes new data elements such as negotiated rate contracting type or methodology, an accuracy and completeness affirmation and (as of January 1, 2025) an ″estimated allowed amount.″ CMS also now requires that hospitals' price transparency information be more easily found on their websites.

Regarding compliance and enforcement, hospitals may be required to have an authorized hospital official certify the accuracy and completeness of the hospital's machine-readable file during the monitoring and enforcement process. CMS also can require hospitals to provide additional documentation at the agency's request, including contracting documentation needed to validate the hospital's negotiated rates and verification of the hospital's licensing status.

In addition, CMS increased its efforts to publicize hospital-specific information on all compliance assessment and enforcement activity, which it now updates regularly on a public website. This includes details related to CMS' assessment of hospital compliance, any compliance actions taken against a specific hospital, the status of the compliance action(s) and the outcome of the action(s). A list of the civil monetary compliance notices and fines issued to date is available on the CMS website. The fines vary in scope, from $55,000 to nearly $1 million, for those hospitals that have been deemed out of compliance with the Hospital Price Transparency Rule. CMS clearly has the authority and willingness to enforce compliance with the rule and assess significant fines, regardless of statutory activity.

CONCLUSION

Thank you for your consideration of the AHA's comments on issues related to health care expenditures. We look forward to continuing to work with you to address these important topics on behalf of our patients and communities.

U.S. SENATE SPECIAL COMMITTEE ON AGING

"HEALTH CARE TRANSPARENCY: LOWERING COST AND EMPOWERING PATIENTS"

JULY 11, 2024

STATEMENT FOR THE RECORD

Statement of AHIP

AHIP is the national association that represents health insurance plans that provide coverage, services, and solutions for over 205 million Americans through public programs such as Medicare and Medicaid, employer-sponsored insurance, and the individual insurance market.

We appreciate the Committee's attention to the issue of health care transparency and encourage efforts to increase transparency and accessibility of health care for older Americans. We share the Committee's goal of achieving better health outcomes and more affordable health care, and increased price transparency is a step in the right direction.

Our statement for the Committee's July 11 hearing outlines several policy considerations and highlights the ways health insurance plans are implementing innovative solutions to increase access and transparency for older Americans, such as providing clear information on coverage options, strengthening Medicare, and addressing the cost of high-priced prescription drugs.

Commitment to Price Transparency

AHIP and our member health insurance plans fully support the goals of providing actionable information about the cost and quality of health care services to enable older Americans to make better-informed decisions.

Health insurance plans are often the best resource for providing consumers with personalized and accurate cost information, offering tools that enable consumers to obtain specific data about their coverage while protecting the privacy and security of their personal health information. For example, consumers use these tools to understand their benefits and provider networks, and cost sharing.

Health insurance plans continue to work to increase consumer awareness and use of these tools through, among other methods, member portal messages, outreach efforts, and text messaging campaigns. Older Americans deserve to know how much their care and prescriptions will cost before they receive them, as well as how to access the highest value services. Health insurance plans are committed to empowering seniors with the information they need, when they need it, so they can make health care decisions that are right for them.

Medicare Advantage Provides Choice, Value and Transparency for Older Americans

More than 33 million seniors and people with disabilities actively choose Medicare Advantage (MA) for their Medicare coverage. MA offers high-quality care and support, financial protections, and affordable coverage options so enrollees can pay less and receive better care.

MA Empowers Choice

MA offers a market-based framework that encourages competition and provides seniors and people with disabilities with options for finding a package of benefits that best meets their needs. An average Medicare beneficiary in 2024 has access to 43 MA plans, with specialized plans also available to certain populations such as retirees or individuals who also have Medicaid coverage.[1]

These different options provide enrollees with the same basic covered benefits available in feefor-service (FFS) Medicare. However, unlike FFS, all MA plans are required to limit annual outof-pocket spending, with most offering a wide range of extra benefits, called supplemental benefits. These benefits can include reduced cost sharing for basic Medicare benefits and offer important benefits unavailable in FFS such as dental, vision, and hearing services; innovative telehealth options; wellness programs; and nutrition, transportation, and in-home caregiver services. The Medicare Payment Advisory Commission (MedPAC) reports that in 2024, MA enrollees on average have access to more than $2,100 in added benefits.[2] In addition, most MA enrollees can obtain Part D drug coverage through an MA plan for no additional premium.

To obtain similar financial protection or supplemental benefits, individuals in FFS Medicare must purchase coverage at an additional monthly premium. One analysis found that "MA enrollees spent, on average, $2,541 less on healthcare costs (spend-

ing on premiums and out-ofpocket expenses) than FFS Medicare enrollees in 2021.″[3] Another analysis found that a 65-yearold retiree who chooses to enroll in MA needs more than 40% less in savings to cover health care costs over their remaining lifetime as a person who chooses FFS Medicare.[4]

Transparency Aids Consumer Decision-Making and Program Analysis

Medicare beneficiaries have access to information about the plans available to them through a variety of sources, including the Medicare program's Medicare Plan Finder. This tool provides data to beneficiaries, researchers, and others so they can understand Medicare coverage options and benefits available under each available plan in a particular service area.

In addition, significant data on MA supplemental benefits is currently available and additional data will soon be available. The Centers for Medicare & Medicaid Services (CMS) requires supplemental benefits data reporting through plan Medical Loss Ratio (MLR) reporting. Effective for plan year 2024, CMS is collecting additional data through annual reporting requirements and ″encounter data″, including use and cost data. CMS typically posts public use files of plan-reported data, which can be used by researchers and other data analysts.[5] Beginning in 2026, MA plans will be required to send mid-year notices to enrollees regarding unused supplemental benefits.

MA plans also submit details to CMS on every claim they receive from providers, including demographic information, diagnoses, and descriptions of services provided. This ″encounter data″ is made publicly available for analysis by researchers and analysts, and detailed ″landscape″ files are released in advance of the annual Medicare open enrollment period to allow analysts to identify key trends in the program.

In summary, whether it's more choices for the health plan that fits a person's needs, more widespread availability of high-quality, integrated health coverage, and greater access to health plans with $0 premium and drug coverage, MA is helping drive immense value for the millions of older Americans the program serves.

-Recommendation: AHIP urges lawmakers and regulators to invest resources to make further improvements to the comparison functionality on certain benefits (including supplemental benefits) and to make other changes based on public input. Q05

The Importance of Transparency in Reducing Drug Prices

Rising drug prices impose a heavy burden on all Americans, especially older adults living on fixed incomes. This situation is a direct result of high list prices determined solely by drug companies. Due to the high prices manufacturers set in the U.S., twenty-two cents of every health care dollar go toward prescription drugs - with drugs contributing more to health care costs and growing at a rate faster than any other type of health care service.[6]

AHIP looks forward to working with the Committee to advance market-based solutions that hold drug makers accountable for setting high list prices and provide relief to American families.

Manufacturers Set High Drug Prices

Any assessment of prescription drug affordability must start with the root causes of high drug prices: drug manufacturers often hold monopoly power over medicines and continue to prevent and undermine competition to keep drug prices as high as possible in the U.S. This anticompetitive dynamic has a profound impact on older Americans. For instance, over the 2009-2018 period, the average price of a brand-name drug prescription more than doubled in the Medicare Part D program and increased by 50% in Medicaid.[7]

To make prescription drugs available and affordable for patients, health insurance plans and their pharmacy benefit manager (PBM) partners negotiate with drugmakers. These savings are passed along to patients and consumers through lower premiums and out-of-pocket costs. However, the lack of transparency on how drugmakers' set prices or why they routinely increase prices on Americans multiple times a year creates a barrier to developing new solutions to lower drug prices.

Solutions to Enhance Drug Pricing Transparency and Reporting

Consumers and taxpayers should have access to information on manufacturing and research and development costs, net profits, and marketing and advertising costs for expensive medications and manufactures should publicly justify price increases.

-Recommendation: AHIP urges Congress to consider policies that would require drugmakers to publicly justify high prices and report pricing information. Congress should advance S.1218, the Fair Accountability and Innovative Research

(FAIR) Drug Pricing Act, to apply basic transparency to drug pricing and require drug manufacturers to justify price increases.

Disclosure of Drug Prices in Direct-to-Consumer (DTC) Advertising

Greater transparency is a crucial component of the broad-based strategy by lawmakers that is needed to provide consumers with relief from prescription drug prices.

-*Recommendation:* Congress should pass S. 1250, the Drug-Price Transparency for Consumers Act, which would require drugmakers to disclose list prices in DTC advertisements and provide disincentives for them to continue price gouging patients.

Accessing Affordable Alternatives

Older Americans should be able to get the medications they need at costs they can afford, including more affordable generics and biosimilars. However, drug companies are regularly abusing the patent system to keep lower-cost generic drugs from reaching the market. AHIP supports supports a number of bipartisan Senate legislative proposals to promote more competition and reduce drug costs, including:

-S.79, the Interagency Patent Coordination and Improvement Act, which would establish an inter-agency cooperative task force to spur more collaboration in patent-related functions.

-S.142, the Preserve Access to Affordable Generics and Biosimilars Act, which would prevent anticompetitive ″pay-for-delay″ deals that delay and prevent the introduction of more affordable alternatives.

-S.148, the Stop STALLING Act, which would authorize the Federal Trade Commission (FTC) to take action against drug companies when they game the patent system by filing frivolous petitions with the Food and Drug Administration (FDA).

-S.150, the Affordable Prescriptions for Patients Act, which would begin to limit drug manufacturers' anti-competitive tactics such as product hopping and manipulating the patent litigation process.

-*Recommendation:* AHIP recommends the Committee work with the House of Representatives to advance these pieces of legislation expeditiously and create a more competitive drug market and lower costs for older Americans and all consumers.

Our members are fully committed to advancing solutions that provide relief to the American people from out-of-control prescription drug prices. Common-sense steps are needed to ensure that people have access to affordable medications. With solutions that deliver real competition, create more consumer choice, and reduce drug prices, we can deliver more savings.

Additional Considerations

Impact of Concentrated Health Systems and Private Equity

A growing body of research consistently finds that the consolidation of health care providers into health systems with market power is a primary driver of the high costs of health care in the United States.[8] Concentrated health systems often stifle competition and limit the ability for health insurance plans to negotiate lower prices for patients.

Private equity's growing influence over portions of the provider market - from nursing homes to ambulance providers to important specialties - has also resulted in higher costs for the same, or worse, care resulting in higher out-of-pocket costs and higher premiums.[9] Additional growth of private equity ownership focused on extracting short-term profits, could further inflate health care costs.

-*Recommendation:* AHIP urges the Committee to prioritize policies that remove the incentives and opportunities for private equity firms focused on extracting short term patients to exploit patients by acquiring specialty practices, ambulance providers, and other portions of the system vulnerable to such abuses.

Improving Hospital Transparency by Advancing Site-Neutral Payments

Advancing site-neutral payments is a competition-enhancing approach that would improve affordability and access for older patients and all Americans. Medicare's outdated payment structure has created an incentive for hospitals to acquire physician practices and superficially convert them to off-campus, provider-based hospital outpatient departments. This loophole allows providers to charge patients substantially more for the same services and outcomes.

Expanding site-neutral payment reforms would require transparency of these locations and improve payment accuracy in the Medicare program. Solutions that permit comparable payment for comparable services would protect consumers from hidden fees and encourage a more efficient and competitive market. An industry analysis found that if enacted site-neutral payments would save patients and taxpayers close to $500 billion over ten years.[10]

-*Recommendation:* We urge the Senate to advance the bipartisan S. 1869, SITE Act, which would reduce costs for consumers and the system by expanding site-neutral payments and billing transparency.

Conclusion

Consumers need access to reliable estimates and explanations of their health care costs. Health insurance plans will continue to help older Americans can get the information they need to make important decisions about their coverage and care. Through meaningful collaboration with the Committee, we believe we can achieve such a framework and help older Americans make wellinformed health care decisions aided by transparent information.

Footnote References

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U.S. SENATE SPECIAL COMMITTEE ON AGING

"HEALTH CARE TRANSPARENCY: LOWERING COST AND EMPOWERING PATIENTS"

JULY 11, 2024

STATEMENT FOR THE RECORD

Statement of Healthsystem Association of Pennsylvania

We are concerned that individual examples cited do not provide full information and do not accurately reflect hospital pricing. The Committee should undertake a holistic discussion about health care costs for patients, providers, and others in the health care system. A recent report from the Pennsylvania Health Care Cost Containment Council (PHC4) found that more than half of Pennsylvania general acute care hospitals are operating in the red. As you continue to evaluate opportunities for health care reform, HAP strongly encourages you to address the underlying challenges facing hospitals in Pennsylvania and across the nation, including inadequate reimbursement for the cost of care, outdated regulations that drive administrative burden and cost, and continuum-wide workforce shortages. HAP and Pennsylvania's hospital community are committed to working with you to address these core challenges.

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