HEALTHCARE PRICE TRANSPARENCY: A Patient's Right to Know

House Ways and Means Committee

May 16, 2023

Written Testimony from Richard J. Gilfillan, MD

Chairman Smith, Ranking Member Neal and Members of the Committee, thank you for the opportunity to present testimony on this important topic of Healthcare Price Transparency: A Patient's Right to Know. I am Rick Gilfillan , MD a family physician by background and currently an independent consultant here in Washington DC. I do mostly volunteer work for non-profit organizations as well as health policy research and writing. Previously I was the CEO of Trinity Heath, a large national Catholic Healthcare System located in Michigan. Prior to that I was the Deputy Administrator at CMS and the Director of the Center for Medicare and Medicaid Innovation. Prior to that I was the CEO of Geisinger Health Plan. My comments today are based on the learnings and experience gained though my 30-year career that includes primary care practice and executive positions in health insurance organizations, health systems and government. They reflect my own views and not those of any organization.

I believe we should be as transparent as possible with patients, and with each other, about the quality and high cost of health care services. To evaluate solutions, we also need to be transparent about the root causes of these realities. I believe the underlying assumption for discussing transparency is that if we can just get market forces to work, healthcare will function better, costs will lower, outcomes will improve and America's families will not continue to suffer from the burden of medical debt and bankruptcies that have become too common. That is, if we give patients pricing information, they will respond as logical economic actors in the marketplace. I find it quite ironic that in a healthcare system where virtually every other actor is favored by non-market-based opportunities, we want patients and their families to shoulder the burden of decreasing healthcare costs by "shopping" or "having skin in the game" as some say. As my colleagues Don Berwick has often pointed out, patients quite literally have their own skin in the game every time they obtain care. That should be enough.

I will make five points:

1. Despite remarkable improvement in medical care, and the commitment of millions of healthcare professionals our current healthcare system, when compared to those of similar countries and what it could be, is relatively ineffective, inefficient and fraught with inequities .
2. Over the past 40 years we have built a vast financial and administrative superstructure that sits on top of the actual delivery of care, creating a system that seems more driven by the pursuit of wealth for institutions than health for communities.
3. The Employer based health insurance system results in high unit prices, high commercial costs, and the channeling of resources to rich communities, away from lower income communities, perpetuating an inequitable and segregated healthcare system.
4. The combination of Commercial Prices and systematic underinsuring of people covered under employer-based coverage has become a major driver of family medical debt and bankruptcy.

5. Asking America's families to address the shortcoming of our healthcare system by shopping for care when they are most vulnerable seems inappropriate, ineffective and to date has failed.

I will offer 7 principles for policy change to reestablish health as the primary outcome for healthcare delivery.

1. Ensure comprehensive health insurance coverage for everyone in America
2. Eliminate overpayments in government programs like Medicare Advantage
3. Create an all-payer payment system using administrative pricing to equalize payment for all populations and to simplify administration and financing of the system.
4. Create a public option available to all individuals and employers utilizing the all-payer payment mechanism and utilizing a network of accountable provider entities.
5. Maintain current levels of employer contribution to healthcare coverage via requirements for provision of coverage or a healthcare supplemental tax.
6. Use savings from these efforts to create social programs that address SDOH issues including housing and nutrition to improve overall life expectancy.
7. Continue transparency efforts to collect meaningful information on cost and outcomes of care utilizing tools like patient reported outcome measures (PROMs) and Registries etc.

1. Despite remarkable improvement in medical care, and the commitment of millions of healthcare professionals our current healthcare system, when compared to those of similar countries and what it could be, is relatively ineffective, inefficient and fraught with inequities.

Life United States life expectancy has been diverging from that of other OCD countries for almost 40 years. Prior to Covid, US Life Expectancy was a full 4 years less than the OCD Average[1] (US Life Expectancy has declined vs. OCED Countries). Post Covid we have seen an actual decrease in life expectancy of 3 years, from 79 to 76. Black life expectancy at 5- 6 years less represents one of the most striking of all heath inequities. As shown in Table 1, we are spending on average twice as much as other OECD countries for healthcare while getting these outcomes. [2]

The causes of these differences in life expectancy have been studied extensively. They are not due only to poor health care, access to health care, or insurance coverage. We know that the Social Determinants of Health, access to firearms, the opioid epidemic etc. are all part of the story. But there is evidence that some of this is results from lack of coverage and underperformance of our health system including perinatal care and the care of chronic disease.[3] Why are we paying twice as much and getting less from our health care system?

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[1] Downloaded from Peterson Foundation Website – Health System Tracker – How does U.S. life expectancy compare to other countries? - Peterson-KFF Health System Tracker

[2] Ibid

[3] Avendano M, Kawachi I. Why do Americans have shorter life expectancy and worse health than people in other high-income countries. Annual Rev Public Health. 2014:35:307-325

Table 1 Country	Life Expectancy	Average Healthcare Cost/capita
United States	76.1	$12,318
Comparable Countries Average	82.4	$6,003
United Kingdom	80.8	$7,383
Germany	80.9	$7,385
Austria	81.3	$6,693
Netherlands	81.5	$6,190
Belgium	81.9	$5,274
France	82.5	$5,468
Sweden	83.2	$6,262
Australia	83.4	$5,627
Switzerland	84	$7,179
Japan	84.5	$4,666

2. **Over the past 40 years we have built a vast financial and administrative superstructure that sits on top of the actual delivery of care, creating a system that seems more driven by the pursuit of wealth for institutions than health for communities.**

Morphing from the original vision of HMO's as non-profit care providers, the introduction of for-profit managed care entities in the early 1980's started this process with the introduction of precertification, capitation, claims reviews, limited networks and assorted other business processes. Multiple cycles of innovation, legislation, regulation, deregulation and private sector investment, all pursued under the banner of decreasing costs and improving quality, fragmented the delivery, administration and financing of care. Consumer Directed Healthcare, one of these innovations, brought forth deductibles, HSA's, HRA's and now medical debit cards. It was based on the belief that because the marketplace was broken patients should shoulder the burden of making it work. Meanwhile, virtually all the major actors benefit from non-market-based features of the system.

In the commercial insurance sector, Health Plans act as an intermediary between the customer, patients, and the providers of the services. With 73% of Markets being highly concentrated [4]per federal guidelines, incumbents, often Blue Cross plans operating under an antitrust waiver, use a business model that simply takes a cut off the top, usually about 17% of the actual cost of healthcare services, to cover their administrative costs and profits. The Plans attempt to drive provider prices down. However, as described below, the reality is that they have been largely ineffective in limiting commercial prices for providers with significant market power. Because market share is always a primary goal, incumbents tend to meet their customers' demand for broad networks. The convenient reality that higher provider prices lead to higher premiums and Plan profits doesn't compel them to do otherwise. Incumbents don't need markedly lower rates, they just need to be sure they have the best rates.

[4] AMA Press Release. Sept. 21, 2021 accessed 5/14/23 at AMA publishes new study monitoring competition in U.S. health insurance markets | American Medical Association (ama-assn.org)

In the even more highly concentrated world of privatized Medicare, Medicare Advantage (MA) plans receive large subsidies that increase payments well above the costs in the FFS program. As we recently documented the entire cost of the improved MA benefits that drive MA growth results from subsidies, not better care. [5] These subsidies will reach almost $1 Trillion over the next 8 years. [6] Many of these are a result of risk code gaming where plans make their populations look sicker to increase their payments from CMS. [7] We used data provided by the largest MA Plan, United Healthcare, to show that such gaming allowed them to increase their payment up to 35%. [8] The pursuit of risk scores has come to permeate primary care practices. This is most evident in the creation of MA specific PCP companies like Oak Street Health and Agilon Health. The 5 Star Quality bonuses have similarly focused the attention of providers and plans on performing to the test. The goal is not achieving broad based clinical improvement, but rather managing to specific codes and services that drive more payment. Hence, the overwhelming presence of "quality and coding" gap closure efforts. All these activities are driven by the opportunity to create more revenue for the parent organization, not better care.

Health Plans like United Health Care/Optum, Humana, Aetna and Cigna take this one step further. By owning primary care practices they can increase payment from CMS, collect the insurance profits and the extra payments to PCPs.[9] As a result, they avoid the 85% MLR requirement, spending only spend about 70% of the dollars for healthcare services and put the rest of their overpayments into profits. When CMS proposed to change this system to decrease the Plan subsidies, the industry pushed back hard saying the only option they would have in response would be to decrease benefits for their most vulnerable populations. There were no cries of "let the marketplace rule", it was simply maintain the subsidies. Fortunately, CMS maintained their position and as a result took important steps to decrease these overpayments this year. However there remain significant opportunities for overpayment.

MA Plans are further favored by not having to obtain their own provider contracted rates because their entire payment systems are since they have access to Medicare's contracts with providers. The reality is that both the Medicare and Medicaid privatized markets operate under administrative pricing established by the Federal and State governments. Furthermore, we exclude MA Plans from requirements we have for commercial plans. MA Plans are not required to report either their broker fees or any provider prices they negotiate that are different from MA prices. Clearly they are not playing by ordinary market- based rules.

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[5] Gilfillan R, Berwick D. Health Affairs Forefront March 27,2023; Born On Third Base: Medicare Advantage Thrives On Subsidies, Not Better Care | Health Affairs

[6] Kronick R, Berwick D, Gilfillan R, Gordon J, 03/23/24 Letter to Senator Warren; warren letter rgrk 032423 clean final.pdf (senate.gov)Senator Warren Letter

[7] Gilfillan R, Berwick D Health Affairs Forefront 9/21/21; Medicare Advantage, Direct Contracting, And The Medicare 'Money Machine,' Part 1: The Risk-Score Game | Health Affairs

[8]Gilfillan R, et al Comment Letter to CMS;03/06/23; MA-Advance-Notice-gp19-Comment-final-9-030923.pdf (thecapitolforum.com)

[9]Gilfillan R, Berwick D Health Affairs Forefront 9/21/21; Medicare Advantage, Direct Contracting, And The Medicare 'Money Machine,' Part 1: The Risk-Score Game | Health Affairs

Pharmaceutical companies have a classic non-market like advantage – a 17-year patent life on new drugs. Not satisfied with that, they routinely use a variety of schemes to try to extend their patent protection further. But that isn't enough. They also generated a law that banned the government from negotiating prices on drugs. Fortunately, Congress recently enacted legislation that begins to reverse this prohibition, allowing negotiation around 10 drugs to start. This should be the start of a more market-based approach that could significantly alter the cost trajectory of new drugs.

Private physician practices are typically for-profit partnerships or corporations. Over the past 30 years physicians, primarily specialists, have become more entrepreneurial. With the advent of managed care and more aggressive negotiation of professional fees, physicians sought additional revenue sources. The result was a proliferation of physician owned hospitals, ambulatory surgical centers, imaging centers, infusion centers all of which typically produce much more revenue than the professional fees. The secret sauce for these ancillary services is that despite efforts to control self-referrals, physicians benefit enormously simply by using their owned centers to provide highly profitable services that they order themselves.

Other ancillary services like radiology, Ambulatory Surgical Centers, Hospices and Skilled Nursing Facilities have attracted investors. More recently private equity has moved into healthcare, with a focus on hospital-based services provided by ER physicians, Anesthesiologists and radiologists. They sought easy arbitrage-based profits by refusing to negotiate contracts with payers, and then billing patients directly for services that occurred while the patient was in the hospital. That scheme was countered by Congress through the No Surprise Act. But PE backed physician practice firms are still at it, attempting now to force hospitals to pay them more under threat of becoming non-par with payers and billing members directly. These efforts are all an attempt to operate in places where normal marketplace rules are not functional. PE firms are also pursuing their usual business model[10] of buying providers using debt financed by the business, charging high management fees and then flipping the heavily indebted entity to the next buyer.

For profit hospital firms now make up about 24% of hospitals. The wide differences in pricing for commercial vs. government insured patients provides an opportunity for them to cherry pick profitable segments. They execute this strategy by market selection, selection of affiliated physicians or their mix of services offered. They also focus on building local market share to get higher commercial rates. As a result, Medicare and Medicaid patient revenue is about 40% of total revenue at HCA, while it is 66% at non-profits like Trinity Health. In a broken marketplace where the customer has no good way to evaluate the quality of services they receive and has been typically isolated from the costs of services, operating margins have been above 10% for the past 6 years. [11] Stock prices have followed with the largest firms seeing stock prices increase more than 1,000 percent since the ACA in 2010.

Virtually all these activities introduce a for profit mentality into healthcare that contributes to the "financialization of healthcare." And all of them also drain resources from the non-profit hospital sector which had been the dominant institution in the healthcare landscape prior to the managed care

[10] Rafiei, Y The New Yorker August 25,2022; When Private Equity Takes Over a Nursing Home | The New Yorker

[11] MedPAC Report to Congress 2023

revolution. They often operated in a less financially acute way with much more focus on hospital operations and managing the physician and nursing staff. Under traditional indemnity insurance, payments were higher, competition was limited and the finances relatively straightforward. Over the past 40 years, that has changed dramatically.

As MedPAC has pointed out, margins in the non-profit hospital sector are highly variable.[12] The differences result from two primary issues: payor mix, and the level of commercial reimbursement. Pure safety net institutions rely primarily on Medicaid and Medicare reimbursement. They have limited leverage with payers and lower commercial rates. Margins are slim to negative, despite the addition of Disproportionate Share Payments. At the other extreme, "must have" hospitals typically have great leverage with payers, much higher commercial rates and a larger proportion of commercial business. As a result, Commercial hospital prices can vary up to 300%[13] across different providers in the same market. Average operating margins for non-profit hospitals can be misleading because the results for individual hospitals vary from slightly negative to above 10%.

Non-profit integrated hospital health systems have grown significantly because of the difficulty of operating standalone hospitals in this challenging environment. They have also acquired more physician practices to maintain a population of patients, develop more integrated, coordinated care systems, maintain access to services in their communities and activity in their hospitals. Margins for these systems tend to be lower than hospital margins because most owned physician practices have a negative margin. The distribution of profit margins for these systems is quite broad. Well situated local and regional systems have frequently established "must have status" that facilitates high commercial rates and market share. Pre-Covid many had high single digit operating margins. More national systems like those in Catholic Healthcare have had a greater presence in lower income communities consistent with the mission of their founding congregations. They have less leverage, lower commercial rates and market share. Pre-Covid most had low single digit operating margins. Post-Covid many are operating with negative margins. The combination of higher costs for supplies, contract nursing costs, limited staff, fixed commercial reimbursement and continually decreased inpatient volume has created major financial challenges. Even more than before, these systems will of necessity be focused on the key financial levers in their control.

There do remain significant differences between for profit and non-profit hospitals and health systems. As Glenn Steele, MD the former CEO at Geisinger often pointed out, the biggest difference was that we were operating in rural North Central Pennsylvania, not the Sunbelt. We were there because that was our community to serve. There is also a real difference in the sensibility of the two types of firms. As one of my colleagues at Coventry Health often said, we were not in the healthcare business, we were in the quarterly earnings business. The mission of delivering healthcare to those who need it most was clearly central in most non-profit health systems. At Geisinger it originated with Abigail Geisinger, and at Trinity Health it had been systematically passed on from various founding congregations of sisters. In both places it was deeply felt and attracted a staff with whom those values resonated. It also acts as a

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[12] MedPAC Report to Congress 2023

[13] White, Chapin and Christopher M. Whaley, Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely: Findings from an Employer-Led Transparency Initiative. Santa Monica, CA: RAND Corporation, 2019. https://www.rand.org/pubs/research_reports/RR3033.html.

major touchstone for executive and board decision making. For profits pay dividends to stockholders and buy back stock to boost executive pay and shareholder value. Their mission is to extract resources from communities and redirect it to shareholders. Non-profits reinvest in their community. Most significantly, non-profit health systems are found everywhere across America, available 24/7 to all. For profits operated where and however they can make profits.

The same is true in insurers. I worked for Independence Blue Cross, a non-profit insurer in Philadelphia. They were an important anchor institution for the revitalization of center-city Philadelphia. The CEO made a conscious decision to stay there and help rebuild the city's business community. United Healthcare is anchored in Minnesota, with no such commitment across the many communities it extracts resources from.

Despite these very real differences, the management challenges and business practices in non-profit health systems today create one more piece of the "financialization" of health care superstructure.

Across all the segments of healthcare delivery every day dedicated highly capable staff provide excellent care to the patients before them. But most understand and feel the reality that the intrusion of the administrative and financial structures and processes create a healthcare system that feels more focused on optimizing financial results for institutions than on optimizing health for their communities.

3. **The Employer based health insurance system results in high unit prices, high commercial costs, and the channeling of resources to rich communities, away from lower income communities, perpetuating an inequitable and segregated healthcare system.**

Employer-based health insurance is a major driver of the broken commercial health insurance market. Simply put, over my 35 years in the industry, no other dictum is more impactful and unchanging than "*Human Resource (HR) departments that select Health Plans demand broad networks."* It has always been true, and seemingly always on the verge of changing. But it does not. HR has no interest in creating limited networks that will force employees to change their physicians. Most significantly they require prospective plans to include the hospitals and providers favored by their executives and their families. These people typically live in higher income communities and want to use their local, highly respected and presumably high-quality hospital and physicians. The resulting "must have providers" have immense market power allowing them to almost dictate rates to payers. Those without this status are left to negotiate as best they can to get adequate rates. Studies have shown that the rate differences between must have providers and non-must have providers are not small but can vary up to 300%.[14]

One seldom noted effect of this reality is that it directs healthcare spending into well to do communities, and away from lower income communities. The resulting unequal spending contributes to healthcare inequities reflecting yet another legacy impact from the racial redlining history of America's real estate industry. Many of the dollars used to pay high hospital rates to these "must have" hospitals come from the wages of employed individuals in lower income communities. Smaller dollars flow to institutions in

[14] Ibid

the lower income communities, who are frequently served by safety net providers. The result is a de facto segregated health system funded in part by transferring dollars from the poor to the rich.

As demonstrated by the sale of individual products on ACA Exchanges, limited network models can sell if they cost less. Plans on the Exchanges have done this typically by excluding high cost must have providers from their networks. However, there is no evidence that such networks deliver the same care or outcomes as broader networks.

4. The combination of Commercial Prices and systematic underinsuring of people covered through employer-based coverage has become a major driver of family medical debt and bankruptcy.

When employers decided they could not afford escalating commercial insurance costs, and insurers demonstrated their inability to bring costs down, a Harvard professor came up with the striking idea of Consumer Directed Health Care[15] - that is let's make the patient an effective bargaining agent. The idea combined catastrophic coverage, a large deductible with a medical spending account, soon to become an HSA, with the assumption that we would provide good information to facilitate meaningful choices by patients. Unfortunately, the assumption on adequate information was wrong, and over time employers tended to like the lower cost from the deductible more than the added cost of the HSA. Today the average American family with employer insurance faces an average $1,900 individual deductible, an Out of Pocket max of $6,000 in addition to paying premium of $2,000 for individual and $7,000 for family coverage. Only 18% have an HSA. Over the ensuring 15 years we have systematically underinsured people with employer-based health insurance. According to a recent Kaiser Family Foundation report, 1/2 of households could not afford their employer deductible and two thirds could not cover a high deductible. Given the level of hospital prices the average insured family is just one mild accident or illness away from incurring significant medical debt. Medical bankruptcy still occurs and is the driver of 4% of all under age 65 bankruptcies. Furthermore, over half of the KFF survey respondents (51%) on an employer plan reported that someone in their household skipped or postponed care or filling a prescription in the past year because of the expense. Finally as reported by KFF and others patients are not very discriminating in deciding what services to forego in the face of cost-sharing. They avoid necessary and unnecessary services potentially resulting in serious harm.

5. Asking America's families to address the shortcoming of our healthcare system by shopping for care when they are most vulnerable seems inappropriate, ineffective and has failed to date.

Insurance companies, private equity firms, hospitals, entrepreneurial physicians, and big pharma all benefit from America's broken healthcare marketplace. Now because employers have decided they don't want to pay more, we have asked patients and their families to step in and play by marketplace rules by "Acting like you have skin in the game. Pay attention, read your benefits and shop for care." Have any of us done that?

Who is it we are expecting to shop for care, and when? The highest prices are in well to do communities. People there can afford to pay high prices. They want to see the local providers they believe are high quality. Many even bought the low premium, high deductible plan because they knew

[15] Herzlinger R. Let's Put Consumers in Charge of Health Care (hbr.org) , Harvard Business Review, July 2002

they could afford to pay for any care they needed. These are not the people likely to be affected by a high deductible. Rather it is lower income workers, many of whom live in lower income communities often times with safety net providers. There local providers are likely to be lower cost.

And when do we expect them to shop for care? It may work when a physician tells you it would be helpful to have an MRI of your knee. You can find a low-cost provider easily enough. But once you see the orthopedist there may be more questions like: " Why did you go there? The MRI was not powerful enough, I will need one done in our office where we have a more powerful machine." Or put yourself in the position of a woman who has just found a breast mass. Her PCP suggests she have additional studies. Does she shop online looking for the best price for a breast ultrasound, an office visit to the oncologist, a breast MRI, breast biopsy, or does she just decide to go to the local Oncology specialty hospital that has such a fabulous reputation but higher prices. Do people facing such a serious issue actually get comfortable choosing the least expensive provider in the absence of hard knowledge that the care they get will be as good as the expensive provider?

Has shopping worked to date? Today 18% of people have an HSA. According to a KFF survey[16],

> ". . . 17% of all employer covered individuals reported shopping behavior . . . the lowest rate of reporting these behaviors occurs among those in plans with no deductible, with a few exceptions, those in high deductible plans are not significantly more likely than those in lower deductible plans to report engaging in price-based shopping."

[17]Glied et all's review of HDHP's and HSA's found that :

> "Empirical evidence supports the view that higher deductibles and cost sharing reduce expenditures. Although descriptive evidence suggests that consumers with HDHPs are more cost-conscious, causal evidence based on unavoidable plan changes suggests that HDHP-related expenditure reductions are driven entirely by reductions in care, not by price shopping . . . In sum, promised gains in efficiency from HSAs have not borne out, so it is difficult to justify maintaining this regressive tax break."

HSA's have become one more tool that accentuates income and health inequities. Higher income people choose them to shelter tax exempt dollars. Lower income people, many without disposable income, bear the brunt of the high deductible and coinsurance, hoping that they won't need healthcare, and frequently avoiding it when they do.

America's declining life expectancy has many causes but central to it are an inadequate healthcare system and an inadequate social support system. To address these challenges we should consider policy changes based on the following principles:

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[16]Artiga S, Ubri P, Zur J. June 1, 2017; The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings | KFF

[17] Glied S, Remier D, Springsteen M. Health Affairs, Vol.41, No.6, June 2022; Health Savings Accounts No Longer Promote Consumer Cost-Consciousness | Health Affairs

1. Ensure comprehensive health insurance coverage for everyone in America
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5. Maintain current levels of employer contribution to healthcare coverage via requirements for provision of coverage or a healthcare supplemental tax.
6. Use savings from these efforts to create social programs that address SDOH issues including housing and nutrition to improve overall life expectancy.
7. Continue transparency efforts to collect meaningful information on cost and outcomes of care utilizing tools like patient reported outcome measures (PROMs) and Registries etc.

I believe the millions of women and men in healthcare, nurses, physicians, hospital and practice-based employees are dedicated to caring for all of us at our most vulnerable moments. Over the past three years they have repeatedly risen to meet extraordinary demands. Unfortunately, I believe over the past 40 years we have constructed a healthcare system that, despite the efforts of those deeply committed individuals, seems more driven to deliver wealth for institutions than health for communities. America's families and these dedicated healthcare professionals deserve a better system that matches their values and professional commitment.