HEARING ON HEALTH CARE PRICE TRANSPARENCY: A PATIENT'S RIGHT TO KNOW

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTEENTH CONGRESS

FIRST SESSION

MAY 16, 2023

Serial No. 116–FC11

Printed for the use of the Committee on the Ways and Means

U.S. GOVERNMENT PUBLISHING OFFICE
54–353 WASHINGTON : 2024

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PUBLIC SUBMISSIONS FOR THE RECORD

United States House Committee on
Ways & Means
CHAIRMAN JASON SMITH

FOR IMMEDIATE RELEASE
May 9, 2023
No. FC-11

CONTACT: 202-225-3625

Chairman Smith Announces Hearing on Health Care Price Transparency: A Patient's Right to Know

House Committee on Ways and Means Chairman Jason Smith (MO-08) announced today that the Committee will hold a hearing to examine how a lack of transparency in America's health care system increases costs and prevents patients from being effective health care shoppers. The hearing will take place on **Tuesday, May 16, 2023, at 10:00 A.M. in 1100 Longworth House Office Building.**

Members of the public may view the hearing via live webcast available at https://waysandmeans.house.gov. The webcast will not be available until the hearing starts.

In view of the limited time available to hear the witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record can do so here: WMSubmission@mail.house.gov.

Please ATTACH your submission as a Microsoft Word document in compliance with the formatting requirements listed below, **by the close of business on Tuesday, May 30, 2023**. For questions, or if you encounter technical problems, please call (202) 225-3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee.

The Committee will not alter the content of your submission but reserves the right to format it according to guidelines. Any submission provided to the Committee by a witness, any materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed but will be maintained in the Committee files for review and use by the Committee.

All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Please indicate the title of the hearing as the subject line in your submission. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.
All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

ACCOMMODATIONS:

The Committee seeks to make its facilities accessible to persons with disabilities. If you require accommodations, please call 202-225-3625 or request via email to WMSubmission@mail.house.gov in advance of the event (four business days' notice is requested). Questions regarding accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the Committee website at http://www.waysandmeans.house.gov/.

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HEALTH CARE PRICE TRANSPARENCY: A PATIENT'S RIGHT TO KNOW

TUESDAY, MAY 16, 2023

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The committee met, pursuant to call, at 10:03 a.m., in Room 1100 Longworth House Office Building, Hon. Jason T. Smith [chairman of the committee] presiding.

Chairman SMITH. The committee will come to order. Good morning.

Today, when a family faces a sudden illness, a chronic health issue, or a life-threatening accident, their first thought is fear for the health of their loved one. Their second is to worry about how they will afford it.

When concerned about their health, patients don't want to be contestants on a game show trying to guess which hospital door leads to the lowest prices, yet they frequently lack access to the price of a medical service before they receive it. Without greater price transparency, patients are in the passenger seat of their health care decisions. We want them to drive it.

More than two years ago, President Trump signed into law the No Surprises Act, which contained consumer protections against surprise billing. It created a historically significant transparency tool for patients and advance explanation of benefits, or AEOB, to explain the cost associated with care before it ever takes place. And yet, so far, the Administration has not implemented the AEOB program, keeping important information from patients and families. We remain hopeful that we can achieve our bipartisan goal of protecting patients.

Why did Congress and the Trump Administration prioritize this effort? Because price transparency works.

In the past 20 years the prices of medical services increased by 130 percent. Meanwhile, other shoppable commodities like TVs, for example, decreased by nearly 100 percent. Transparency and competition deliver better results. We have seen the price of shoppable health care services such as Lasik eye surgery decrease by 20 percent over the last 15 years, while innovation and quality have increased.

That is not a coincidence. Instead of keeping patients in the waiting room for real reform, we should pursue further price transparency tools to lower cost. According to one estimate, less than 25 percent of hospitals are fully compliant with President Trump's historic price transparency rules, and those are just the ones re-

viewed. To date, the Centers for Medicare and Medicaid Services has only fined four hospitals for non-compliance, four hospitals. There are 6,000 hospitals in the United States.

Do we really think that nearly every American hospital is in compliance? We don't know, because CMS doesn't make compliance reviews and enforcement actions public. We can get more information about a local restaurant from Yelp than you can get about your local hospital from CMS.

Cash-strapped patients in dire situations need to be able to easily compare prices and decide for themselves where to get care. And lawmakers and innovators alike need to be able to see these trends with real data that will enable us to see where further reforms are needed. Americans want to know, and they have the right to know what their health care will cost.

Price transparency has support from all over. Just a few weeks ago I met with rapper Fat Joe to hear how he and his community are advocating for this very effort.

Health care price transparency is crucial, but other reforms will also ensure patients can get better value for their dollars in health care. For example, tax advantaged health accounts such as health savings accounts allows patients to better save for medical expenses. When combined with the true up-front knowledge of prices, this can be powerful for families to plan and budget, yet certain patient populations, including working seniors on Medicare and service members and their families on Tricare are excluded from using HSAs. Outdated red tape prevents certain innovative health care delivery options for patients and employers using HSAs.

We should make these types of accounts easier to use, not harder. A health emergency should not become a financial catastrophe. I am looking forward to a bipartisan discussion on how to increase price transparency to strengthen our health care system and empower patients.

Chairman SMITH. I will now turn to the ranking member, Mr. Neal, for the purposes of his opening statement.

Mr. NEAL. Thank you, Mr. Chairman. I want to thank our witnesses for appearing here before the committee this morning.

Over a decade ago Democrats transformed American health care with the Affordable Care Act. More Americans have health care coverage than ever before; 135 million Americans with pre-existing conditions have protections; women are no longer charged more than men; and this committee's premium tax credits put an average of $2,400 a year back into family pockets.

Thanks to the investments and work of this committee, with Democrats in Congress and now with Joe Biden, the 2023 open enrollment season was the most successful in our history. Over 16 million people enrolled in coverage through the marketplace: absolutely life-changing, and the type of success we could only dream of when we made the ACA a pillar of our health care system.

Meanwhile, the other side continues to double down on challenging our accomplishments, proposing draconian cuts, stripping Americans of the coverage that they rely upon. Their latest attempt to take away Americans' health care would put 21 million Americans on Medicaid at risk of losing their coverage. A reminder: $0.56 on the Medicaid dollar goes to nursing home care.

It has been 12 years, and we still haven't seen a comprehensive health care plan from our colleagues on the other side, just repeat efforts to criticize what it was that we did. Republicans have never agreed on health care in all the years I have been on Congress. They have not provided an alternative, ever. So, while we can't speak to their goals or their plans, I think we can see through what they are attempting to do.

Today we are going to promote transparency along with health savings accounts, high deductible health care plans that promote consumer shopping as a way to lower health care costs. But pushing more burdens onto consumers and expecting them to navigate the red tape at a time of vulnerability only tilts the field against patients, and will result in even more medical debt, which I still believe is the largest cause of bankruptcy in America.

Patients already have skin in the game when they seek medical care. We want to improve their health. This approach exacerbates disparities and contributes to the unsustainable medical debt that has become too pervasive throughout our country. Relying on just transparency and shopping to solve our health care challenges is only part of the potential that we have to improve the system. We want what is best for our patients, and that means an accessible, affordable, and transparent health care system with robust protections for consumers.

Democrats on the committee have been approaching this transparency from every angle over several years. We have pushed for better data collection to make more informed policy decisions for our nation's seniors, and we have sought to better understand the impact of private equity on health care.

Back in 2021 we worked together to provide consumers with more transparency when we passed the "No Surprises Act". I am enormously and immensely proud of what Kevin Brady and I were able to do at that time, and it continues to stand up to challenges in courtrooms. And Kevin and I have indicated we still intend to be witnesses at the right moment in proceeding cases.

Since 2021 hospitals have been required to publicly post standard charges and negotiated rates for common health services and procedures. This committee has led the charge with bipartisan efforts on drug price transparency.

Another major push for transparency came out of the drug pricing provisions of the Inflation Reduction Act, where Democrats stood up to special interests and put an end to profits over people. Insulin is now capped at $35 a month for seniors, and soon Medicare will be able to negotiate on drug prices, giving our seniors the peace of mind knowing what they can expect when they visit the pharmacy.

We should not pretend, however, that transparency shopping alone is the magic of the marketplace. We are going to try to fundamentally address coverage gaps, medical debt, and cost burdens, and health inequities. Democrats will continue to support those provisions. We want to make sure that the improvements in transparency may help around the margins, but we know we likely will have to go much farther in making sure that consumers actually have access to affordable, dependable, and comprehensive coverage that won't leave them high and dry in a time of need.

So that is what this committee should be focused on, not on serving special interests and powerful industry players. We want to make sure that sicker, poorer, and more segmented America is returned to good health, and that is what I hope we will hear about this morning.

Mr. NEAL. With that, I yield back the balance of my time.

Chairman SMITH. Thank you, Mr. Neal. I will now introduce our witnesses.

I want to thank you all for taking time out of your busy schedules to be here. We are very grateful and appreciative.

Our first witness is Kendy Troiano. She is the human resources director for Clark Grave Vault Company.

Then we have Ron Piniecki is the co-founder and medical director of Wellbridge Surgical.

We have Christopher Whaley, who is a professor at RAND Pardee Graduate School.

We have Bill Kampine is the co-founder and chief innovation officer of Healthcare Blue Book.

We have William Short is the executive chairman of Ameriflex.

And Rick Gilfillan is former CMMI director and former CEO of Trinity Health.

Ms. Troiano, you are recognized.

STATEMENT OF KENDY TROIANO, HUMAN RESOURCES DIRECTOR, CLARK GRAVE VAULT COMPANY

Ms. TROIANO. Good morning. Thank you for inviting me to be here today. My name is Kendy Troiano, and I am the human resources director at Clark Grave Vault Company in Columbus, Ohio.

For 125 years Clark Grave Vault has manufactured steel, stainless steel, and copper burial vaults. Our company employs 114 people, most of whom are in Ohio, though we have companies' employees in 11 other states. Most of our employees are blue collar workers with a high school education or GED. Our company is made up of 98 percent men who range in age from 18 to 67.

I have worked at Clark for 26 years, and I am responsible for managing all human resources and employee benefits. But I am here today to talk about our health care insurance, and why we believe price transparency is so important.

During our annual renewal for health care, we were told our premiums were going to increase 35 percent because of one large claim and two claims that were between 20 and $30,000. A 35 percent increase was not feasible for us or the employees. The cost of raw goods has increased, and we cannot continue our current cost structure when costs continue to increase at such a high rate. We knew there had to be something available to allow our employees to shop for the cost of health care, just like they shop for a car, dishwasher, or other personal items.

We decided to switch from our traditional health plan to a new kind of health plan called Sidecar Health. We were seeking a long-term partner that could lower health care costs without jeopardizing quality or access to care. My employer values being able to offer generous benefits to our employees. And as a two-time cancer survivor, I need the security of knowing that I am covered and that I can afford my health care coverage.

Maintaining the coverage that is affordable to both the company and the employee is very important to our company. We chose Sidecar Health for our employees because their model is designed to give consumers control over cost and choice. Their plan allows us the freedom to choose any licensed provider who accepts cash or credit card because we are not constrained by networks, formularies, or prior authorizations. We are provided a budget or benefit amount for any medical need, and it allows us to choose a provider based on that budget. It is our choice to stay within the budget or pay out a little bit more sometimes, about the amount of a co-pay.

When we find care for less, we keep the savings through a credit. For the first time, we have the kind of price transparency needed to shop for care. With Sidecar Health, we can engage with our health care system the way we do everything else in our lives and pay for care at the time of service. Employees have a credit card tied to the Sidecar Health account to pay their expenses up front without tying up their cash.

In addition to the savings we see as a company, our employees also see savings at the provider's office and the pharmacy. For example, my husband's oncology visit last year was billed to my insurance company for $233. Through self-pay I paid $100 for the same visit. His lab work went from $80 per visit to $30 per visit for cash pay. Prescription coverage is costing me $44 every 3 months instead of $115. A procedure for one of our employees decreased from $4,500 to $2,000.

Our employees love the prescription drug coverage, and they can utilize mail order services or online coupons. Both generic and brand prescriptions are covered under Sidecar Health. By shopping through Sidecar's website, they know how much their costs are going to be before they go to the pharmacy, making them informed consumers.

It is no secret employers pay the highest rates for health care in the U.S., but these investments often do not result in better benefits for employees. Not anymore. Sidecar Health does not compromise quality or access.

Health care providers have been programed that the only way to have health insurance is to negotiate with insurance companies for discounts, bill them, and wait for payment. Sidecar Health is changing that by paying the provider in advance using a cash discount. We believe very strongly that our employees are consumers of health care and need access to pricing information and data to make intelligent choices. No one should be denied access to knowing what services cost in our health care system.

For years we tried to find a company that would provide us care and feel we have finally found that partner.

People shop when they purchase furniture, cars, or services, yet they cannot price shop when they search for their health care needs. We feel it is vital that our employees know what their health care costs them and the company. By knowing the cost beforehand, they make the choice to remain within a budgeted amount or spend a little more. Knowing the cost in advance brings them power to choose how to spend their health care dollars.

Thank you again for the opportunity to testify today, and I look forward to your questions.

[The statement of Ms. Troiano follows:]

Testimony of Kendy Troiano
U.S. House of Representatives
Committee on Ways and Means
Full Committee Hearing
Health Care Price Transparency: A Patient's Right to Know
May 16, 2023

Good morning, thank you for inviting me to be here today.

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Thank you again for the opportunity to testify today, and I look forward to your questions.

Chairman SMITH. Thank you, Ms. Troiano. Now, Mr. Piniecki.

STATEMENT OF RON PINIECKI, CO-FOUNDER AND MEDICAL DIRECTOR, WELLBRIDGE SURGICAL

Dr. PINIECKI. Good morning. I would like to thank Chairman Smith and the committee members for the opportunity to speak here today. My name is Ron Piniecki. I am a clinical anesthesiologist in active clinical practice in Indianapolis, have been doing so for about 13 years now. And in the past, part of a private physician group environment prior to starting the business. And I am currently a co-founder in Wellbridge Surgical.

My motivation for being here today is based upon my frustrations and disappointments within the current health system. I am not alone in that view, although I guess I am the representative for that view here among physicians nationally.

Basically, that frustration kind of came to—came about with a series of questions that I got asked by patients. Not long into clinical practice, patients began asking simple questions in the pre-op consultation before surgery: "Are you in network with, you know, my network?" or, "Do you know what the cost is for the services that you are providing today?"

And I spent tens of thousands of hours learning how to provide clinical care, but I didn't spend a single minute in residency or medical school training learning how to answer that question. So, I felt it was somewhat, you know, my responsibility to be able to have a decent answer. And so that kind of started the journey to kind of figuring out, hey, how does this system work, where do the costs lie, and what are my actual charges to any individual patient?

So, six years ago I was introduced to the Free Market Medical Association. That association is a group of physicians and leaders in and around the country who are looking for transparent options and ways to promote transparency in health care, and they want to do it better, basically. For the first few years I spent time building on a pro forma learning about costs, meeting with surgeons, and figuring out, hey, can we actually offer bundled, transparent-price services to members of our community in and around Indianapolis?

And we thought maybe initially we would be able to save 10 or 15 percent over the, you know, current cost of care. But when we finished the analysis, we realized that actually we could save between 50 and 70 percent from the current negotiated payouts after negotiated discounts by the insurers. And so that really kind of opened up the door to providing care across multiple demographics and people groups. We started with four surgical specialties, and now we are up to 30 credentialed and privileged surgeons across 10 surgical specialties providing that clinical care today.

I brought with me today a document that I think kind of reflects the circumstances that we are in. This—I have kind of blocked out some things on here, but basically these are—this is actually a suit authorization form. I have been out of private practice with my previous group for about 2 years now, and there are probably about 15 names on here. Basically, a third and final request for suit authorization. Is a suit authorized? Circle yes or no.

I don't remember the clinical care for those individual patients, some of which were back in 2019, and they ranged from $19.54 to $375. Essentially, I am going to ruin a patient's credit score if I circle yes, and they probably won't have the option to buy a house or a car in the future over $19. And if I circle no, I don't get compensated for that clinical service at all. And so basically, I am kind of, you know, donating my time for those individual cases. So, I am stuck in a situation where I just don't circle yes or no, I don't submit the form back. So, we had to come up with a better way.

So, what we did is we actually bundled individual episodes of care together across outpatient surgeries, from general surgery to orthopedics to GYN to pediatrics, and actually quoted that price up front, put it on the website, and said, hey, the price is the same for everyone. It came out to be, in the case of, you know, ear tubes for your infant, between—it is about $2,380 at our facility. The local price amongst the other health systems, about $6,000.

On the other end of the spectrum, with the larger procedures, total joint replacement, it is $23,500 at our facility. We have had patients travel as far away as from Nebraska because they were quoted prices of $80,000. So, there is about a $50,000 savings with one surgery.

It has been very interesting because the speaker just before me mentioned their employees needing access to fundamentally transparent price and valuecentric care. That is most of the clients that we serve. We have actually contracts with small and medium-sized companies in and around the state that are looking for just that. And so, we actually provide the price up front, it includes the entire episode of care, meaning the facility fee, the professional fees for the surgeon and anesthesia, pre-op evaluation, and post-op follow-up.

So, what is interesting here, and I think maybe worthwhile discussing, or just at least getting the thought out there, is that when you look at the total cost of care, 90-plus percent of that cost is a facility fee cost. That goes to the health system, the actual building or the entity that is actually providing the care. Less than 10 percent of that goes to all physicians involved in the care. And so, I am not really here advocating for physician payment increases, but it gives you a little bit of contextual information to kind of see where most of the dollars are actually going.

So, I would just like to continue to work towards this front, and just kind of introduce these ideas and circumstances to the committee here. What has been interesting for me is that it has been pretty bipartisan.

[The statement of Dr. Piniecki follows:]

Ronald Piniecki, MD
Co-Founder / Medical Director
Wellbridge Surgical ASC

Testimony

I'd like to thank the US House of Representatives and the Committee on Ways and Means for allowing me the honor of speaking on behalf of Physicians and as an American interested in finding ways to improve and correct the cost and transparency crisis that we are currently facing within healthcare in this country.

To provide a bit of context, I am a board-certified practicing anesthesiologist in Indianapolis, IN. I personally have had the desire to practice medicine since childhood. I moved to Indiana in 2001 from Louisiana and completed my medical school and residency training within the IU health system and affiliated hospitals. I started clinical practice in 2010 well-prepared for providing clinical care for patients in my field and joined a private group practice. I became acutely aware that while my training had well-equipped me for the complexities of practicing medicine, it provided no preparation for the business of medicine. Training did not address patients' needs navigating the complex health system at large. Patients would routinely ask the morning of surgery, "Is your group in my network?" or "will my insurance pay the anesthesia fees for today's surgery?" I was not prepared with answers and did not know where to find them. I also realized if I did not understand the system as a physician, it was likely impossible for patients to navigate this issue. Furthermore, each patient was in a position of vulnerability and at the mercy of the health system for their immediate needs so had no leverage if the costs were beyond their means.

Because I felt complicit in this broken system, I began my personal journey to gain a better understanding of how the system works, what barriers were present and how could they be navigated to allow patients to have transparency, decision-making capability, and a level of autonomy and control over their health and in my case, their surgical needs. The end result of this was the creation of Wellbridge Surgical.

Fundamentally, the Wellbridge Surgical model of care delivery isn't novel or really that complex. Organizations such as the Free Market Medical Association and the Surgery Center of Oklahoma have been providing transparent-priced, value-based surgical care for years. The goal with Wellbridge, was to approach the delivery of care from the approach that has been utilized for decades across other fields and industries. First, determine the need: transparent priced surgical procedures that are all-inclusive with higher quality experience and outcomes and lower price. Second, provide that service to all patients without price discrimination based on the presence or absence of insurance or payment methods.

A common phrase that we throw around is that you would not purchase a car or home prior to knowing what it costs, and healthcare should be no different. In addition, using the car example, you also would expect a car to include all components needed to serve the purpose of a car, transportation. A car sold without wheels is useless and absurd and so is surgical care without to entire episode of care included in the services provided. So, that is what we did. We included surgeon pre-op consultation, facility fee, surgeon and anesthesia professional fees, and standard post-operative follow up in one up front price based on the procedure (CPT codes) provided.

The next step was to determine the ability to deliver. Starting with a basic proforma we determined what it would cost to build a state-of-the-facility, contract with the best surgeons locally across surgical specialties offered, and price the services provided factoring a small margin of profit. The initial

expectation was to save 10-20% over the current costs of care. After full analysis we determined we could actually provide surgical procedures at nearly 55% savings on average and approaching 70% savings on some of the more complex procedures performed. We started with 4 primary specialties and gradually built out the service lines and types of procedures performed once we had the surgeon commitments, necessary staff expertise, and processes and protocols to ensure safety from start to finish. Today, we currently have over 30 board certified surgical specialists operating representing more than 10 surgical groups.

This model of care delivery has solved multiple problems related to surgical care. The first is patient accessibility. Typically, specialist access is rationed and the ability to receive care is delayed due to out of pocket costs. With our approach, patients receive an assigned patient navigator and they are scheduled to be seen based on their surgical acuity with even routine consultations being seen within 2 weeks or less. In addition, because the average American has a significant out-of-pocket cost, patients often elect to defer surgical care until emergent. It is common for patients to have $6000, $8000, or more out of pocket deductibles in some cases. We perform surgical ear tube placement for $2380 compared to the local health systems cost exceeding $6000. On the far other extreme, a total joint replacement at our facility is $23,500 vs $80,000 or more locally.

The second problem solved is escalating costs passed on to employees and employers. In Indiana, approximately 70% of companies are self-insured and other states have similar numbers. In this scenario, the employee and employer are paying the claims. Ultimately this translates to year over year increased costs of doing business and increased premiums paid by employees. Because there are multiple health systems within our city and most others, it appears that there is competition, but because there is no transparency, the negotiated rates for any given procedure across the health systems are nearly the same. When savings of 50% or more are achieved, then out of pocket deductibles can often be waived and the employee and employer both save thousands for every episode of surgical care. This forces the hospitals to find ways be competitive and increase quality outcomes.

The third problem that is being solved is being an active consumer of your healthcare vs. a passive participant ushered through the system. If you can provide an alternative to the current elevated cost system, you are incentivizing individual Americans to be active decision-makers of their healthcare. The hospital referral call centers will always refer to their facility specialists to capture the very profitable surgery facility fees. Once patients have more choices and are educated that they have a choice, they begin to seek out high-quality, patient-focused centers of excellence with surgeons who have fantastic reviews and outcomes. Entities like Healthcare Bluebook focus on providing this information. Recent data provided by the RAND studies show where the highest cost centers are for routine outpatient procedures and recent data has not supported high cost with high quality.

The fourth problem that this model solves is the gross disparity across demographics regarding needed medical and surgical services. In this country, 2/3 of bankruptcies are due to medical bills. In many cases, the working-class American is functionally uninsured because their annual deductible far exceeds their emergency fund or cash on hand. Health sharing organizations like, CHM, Medishare, Samaritans, and Sedera need access to high quality services for their members and Wellbridge is contracted and actively caring for these patients. In the Midwest, the Amish and Hispanic communities often pay out of pocket for surgical services at rates higher than negotiated BUCAH payors and market competition and transparency has become critical. We have had the privilege to provide surgical services for Indiana municipalities and their employees, firefighters, teachers, maintenance workers as well as local unions. Those managing the healthcare of all these groups are working within annual budgets that require transparency and market competition.

Transparency means a lot of different things depending on the organization that you ask. For true transparency, we need the hospitals to take ownership of this problem by providing an actual, all-inclusive price for the service provided and make it easy to obtain. The intermediary entities like brokers and TPA's need to be transparent on their compensation model to weed out the bad actors like those with conflicts of interest being compensated based on a percentage of the claim. Finally, for physicians to understand their fee schedule and commit to cash pricing for services rendered when patients ask for one.

Prior to starting Wellbridge, I was a part of a 95 physician anesthesiology group. This group was contracted to provide all anesthesia services to a large local health system including 4 hospitals and many hospital-owned surgery centers in the city. When the hospital leadership learned of my plan to create a transparent-priced surgery center, the hospital president threatened the managing member of my group, demanding that I be fired. Because there were no clinical grounds for doing so, the hospital leadership threatened to terminate the contract for the entire group of physicians who provided all emergency operating room coverage, trauma surgery coverage, emergency obstetric coverage, as well as all nights and weekend anesthesia services. To wield patient lives callously over market needs and transparency demonstrates the importance of this topic and changes necessary to ensure American lives are not gambled with and Americans have the highest quality care as well as a choice.

Chairman SMITH. Mr. Piniecki, we are 30 seconds over, and I want to make sure we get every witness the time available, but we will have questions.

Mr. NEAL. Mr. Chairman, he was just getting to the point of bipartisanship. I was——

[Laughter.]

Mr. NEAL. We might let him go.

Chairman SMITH. We will make sure we get in the questions.

Dr. PINIECKI. Thank you.

Chairman SMITH. We love bipartisanship.

Dr. PINIECKI. Thank you for the time.

Chairman SMITH. Thank you.

Dr. Whaley, you are recognized.

STATEMENT OF CHRISTOPHER M. WHALEY, PH.D. PROFESSOR, RAND PARDEE GRADUATE SCHOOL; HEALTH ECONOMIST AT THE RAND CORPORATION

Dr. WHALEY. Thank you. Chairman Smith, Ranking Member Neal, and members of the committee, thank you for the opportunity to testify today. My name is Christopher Whaley. I am a health care economist at the non-profit, non-partisan RAND Corporation, where I focus on price transparency and the evolving structure of health care markets. The information I am going to share today draws on a variety of studies that my colleagues and I have conducted over the last several years.

The United States leads the world in health care spending, largely due to high and variable prices. Rising spending strains government finances, as well as erodes worker wages and other benefits, particularly for lower-income Americans. Health care prices are opaque, fueling consolidation activity and leading to patient frustration with the current state of the U.S. health care system.

In response, policymakers have undertaken efforts to increase price transparency. However, many of these efforts are currently incomplete. Today I will discuss potential solutions to improve the use of price transparency data and to make this market more transparent.

First, it is really important to recognize that price transparency is not a cure-all but is critical to improve the efficiency and regulatory oversight of health care markets. While patients have an ethical reason to know about prices in advance, the reality is that many patients don't actually shop for care. However, my research has shown how entrepreneurs and innovators can use price transparency data to improve health insurance benefit design and create competition in health care markets.

In addition, price transparency is critical for employers to fulfill their fiduciary obligation to provide health insurance benefits to their workforce at fair and efficient prices.

An appropriate use of price transparency is not a magic wand for the health care system or as a way to burden patients with navigating the complexities of the U.S. health care system. But rather, as a hub that enables other benefit design innovations and policies that will reduce health care spending and improve health care quality.

As just one example, we have collected medical claims data from many employers in the State of Indiana, and reported to these employers what they are paying for hospital care in prices for hospital care. Indiana employers have used this type of price transparency data to both negotiate lower prices for health care, to direct patients to high-quality and lower-priced providers such as Wellbridge Surgical Center, and to also push for policies that improve competition in health care markets in the State of Indiana.

To allow for these types of initiatives to happen nationwide, recent Federal policies seek to increase access to price transparency data through two main requirements: first, there is a requirement that hospitals must post prices for roughly 300 shoppable services; and second, insurers are required to put prices for their negotiated rates.

Unfortunately, each policy has important implementation barriers that limit effectiveness. As mentioned by Chair Smith, on the hospital side roughly 75 percent of hospitals are actually non-compliant with policies to post prices, with many hospitals actually not posting any data at all or hospitals that do post posting incomplete or inaccurate data.

On the insurance side, insurer-posted transparency and coverage rates have largely not been used due to file size and complexity.

To improve data quality, important changes could be made. On the hospital side, penalties for not complying could actually be enforced. As mentioned earlier, a total of four penalties have actually been assessed, despite many hospitals not complying.

There are also important lessons from states. So, for example, the State of Colorado recently implemented a policy where hospitals that do not comply and do not post prices aren't allowed to go after patients for medical debt.

Finally, compliance with the requirements could be, like many other data reporting requirements, a condition for participating in Medicare.

On the insurer side, file sizes are needlessly large due to duplicate entries and posting of prices for providers who don't actually perform services. This means that much of the data is, unfortunately, not accurate. Requiring insurance to limit posted prices to providers who actually perform services or include the volume of services that providers bill could be one way to actually improve the use of this data and to improve data quality.

So just to wrap up, the large variation and opaque nature of prices in the U.S. health care system drives patient frustration with the current state of the health care system. Federal policies to improve price transparency, I think, are very important first steps. And just as we have seen in Indiana, I believe that building on these efforts will improve the efficiency of the U.S. health care system, reduce spending, and improve quality. Thank you.

[The statement of Dr. Whaley follows:]

Health Care Price Transparency

Opportunities to Improve Affordability and Data Effectiveness

Christopher M. Whaley

CT-A2767-1
Testimony presented before the U.S. House of Representatives Committee on Ways and Means on May 16, 2023

For more information on this publication, visit www.rand.org/t/CTA2767-1

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Published by the RAND Corporation, Santa Monica, Calif.

Health Care Price Transparency: Opportunities to Improve Affordability and Data Effectiveness

Testimony of Christopher M. Whaley[1]
The RAND Corporation[2]

Before the Committee on Ways and Means
United States House of Representatives

May 16, 2023

Chairman Smith, Ranking Member Neal, and members of the committee, thank you for the opportunity to testify today. My name is Christopher Whaley. I am a health economist at the nonprofit, nonpartisan RAND Corporation, where I focus on health care price transparency and the evolving structure of health care markets and the impacts of those changes on the quality of care and health care spending. The information I share today draws on a variety of studies conducted by my RAND colleagues and me over the past several years.

My remarks today focus on variation in prices paid for common health care services and health care price transparency. The United States leads the world in health care spending, in large part due to high and variable prices paid to providers.[3] Rising health care spending erodes worker wages and other benefits, particularly for lower-income Americans, and strains government finances.[4]

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[1] The opinions and conclusions expressed in this testimony are the author's alone and should not be interpreted as representing those of the RAND Corporation or any of the sponsors of its research.

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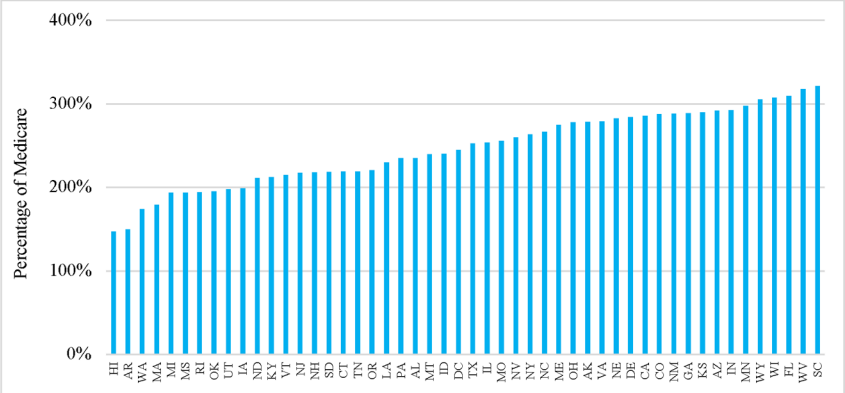
[3] Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan, "It's the Prices, Stupid: Why the United States Is So Different from Other Countries," *Health Affairs*, Vol. 22, No. 3, 2003; GF Anderson, P Hussey, and V. Petrosyan. "It's Still The Prices, Stupid: Why the US Spends So Much on Health Care, and a Tribute to Uwe Reinhardt," *Health Affairs*, Vol. 38, No. 1, 2019.

[4] Daniel Arnold and Christopher M. Whaley, "Who Pays for Health Care Costs?: The Effects of Health Care Prices on Wages," RAND Corporation, WR-A621-2, 2020, https://www.rand.org/pubs/working_papers/WRA621-2.html.

Health care price variation occurs in both commercial insurance and in Medicare. RAND research highlights that hospital prices paid by commercial insurers vary significantly, ranging from 1.5 times the prices paid by Medicare in Hawaii to 3.2 times the prices paid by Medicare in South Carolina (Figure 1).[5] In the Medicare program, while Traditional Medicare sets prices administratively, prices vary based on the site of care in which care is delivered for the same type of service. For example, Medicare pays $1,059 for a colonoscopy performed in a hospital outpatient department, compared with $591 for the same service delivered in an ambulatory surgical center.[6]

Figure 1. Inpatient and Outpatient Hospital Prices Paid by Private Insurers Relative to Medicare Rates, by State



SOURCE: Whaley et al., 2022.

With both Medicare and commercial payers, price variation and site-of-care payment differentials create an "arbitrage opportunity" that drives provider consolidation. My research shows that, once previously independent physicians consolidate into hospitals or health systems, physicians refer patients to higher-priced sites of care, substantially increasing revenues to the provider organization and increasing health care spending.[7] Despite the increase in revenues to

[5] Christopher M. Whaley, Brian Briscombe, Rose Kerber, Brenna O'Neill, and Aaron Kofner, *Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative*, RAND Corporation, RR-A1144-1, 2022, https://www.rand.org/pubs/research_reports/RRA1144-1.html.

[6] Christopher M. Whaley, Xiaoxi Zhao, Michael Richards, and Cheryl L. Damberg, "Higher Medicare Spending on Imaging and Lab Services After Primary Care Physician Group Vertical Integration," *Health Affairs*, Vol. 40, No. 5, 2021.

[7] Whaley et al., 2021; Michael R. Richards, Jonathan A. Seward, and Christopher M. Whaley, "Treatment Consolidation After Vertical Integration: Evidence from Outpatient Procedure Markets," *Journal of Health Economics*, Vol. 81, 2022; David M. Cutler, Leemore Dafny, David C. Grabowski, Steven Lee, and Christopher

hospitals and health systems, research that I've conducted finds that physicians themselves do not appear to benefit financially from consolidation.[8] Importantly, studies have found that higher private insurance prices are not driven by underpayments from public payers or uninsured patients (e.g., "cost-shifting") or differences in provider quality and that consolidation does not improve provider quality.[9]

Policymakers have undertaken efforts to increase price transparency as one means to address these underlying drivers of increased health care spending. In this testimony, I will first share how price transparency has helped address price variation and health care spending; second, describe recent actions taken to make prices more transparent; and, third, identify potential solutions to improve the use of price transparency data, and in particular, recent Transparency in Coverage data from insurers.

How Price Transparency Can Help Health Care Innovation

Developing policies to address the wide variation in prices requires information on provider prices. Historically, health care prices have been notoriously opaque to those that pay the bills—employers, consumers, and both state and federal governments. Many commercial payers consider price information to be a trade secret, and gag clauses commonly prohibit disclosure of the prices paid to providers. Although it is ethical to provide patients with price information, research shows that consumers do not often effectively use price transparency to shop for care,[10] the lack of transparent, usable price information hinders the ability of researchers to understand

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Ody, "Vertical Integration of Healthcare Providers Increases Self-Referrals and Can Reduce Downstream Competition: The Case of Hospital-Owned Skilled Nursing Facilities," National Bureau of Economic Research, Working Paper 28305, 2020.

[8] Christopher M. Whaley, Daniel R. Arnold, Nate Gross, and Anupam B. Jena, "Physician Compensation in Physician-Owned and Hospital-Owned Practices," *Health Affairs*, Vol. 40, No. 12, 2021.

[9] Austin B. Frakt, "How Much Do Hospitals Cost Shift? A Review of the Evidence," *Milbank Quarterly*, Vol. 89, No. 1, 2011; Austin B. Frakt, "The End of Hospital Cost Shifting and the Quest for Hospital Productivity," *Health Services Research*, Vol. 49, No. 1, 2014; Chapin White, "Contrary to Cost-Shift Theory, Lower Medicare Hospital Payment Rates for Inpatient Care Lead to Lower Private Payment Rates," *Health Affairs*, Vol. 32, No. 5, 2013; Peter S. Hussey, Samuel Wertheimer, and Ateev Mehrotra, "The Association Between Health Care Quality and Cost: A Systematic Review," *Annals of Internal Medicine*, Vol. 158, No. 1, 2013; Zack Cooper, Joseph J. Doyle, Jr., John A. Graves, and Jonathan Gruber, "Do Higher-Priced Hospitals Deliver Higher-Quality Care?" National Bureau of Economic Research, Working Paper 29809, February 2022, revised January 2023; Daniel J. Crespin and Christopher Whaley, "The Effect of Hospital Discharge Price Increases on Publicly Reported Measures of Quality," *Health Services Research*, Vol. 58, No. 1, 2023; Nancy D. Beaulieu, Leemore S. Dafny, Bruce E. Landon, Jesse B. Dalton, Ifedayo Kuye, and J. Michael McWilliams, "Changes in Quality of Care After Hospital Mergers and Acquisitions," *New England Journal of Medicine*, Vol. 382, No.1, 2020.

[10] Christopher Whaley, Jennifer Schneider Chafen, Sophie Pinkard, Gabriella Kellerman, Dena Bravata, Robert Kocher, and Neeraj Sood, "Association Between Availability of Health Service Prices and Payments for These Services," *JAMA*, Vol. 312, No. 16, 2014; Sunita Desai, Laura A. Hatfield, Andrew L. Hicks, Michael E. Chernew, and Ateev Mehrotra, "Association Between Availability of a Price Transparency Tool and Outpatient Spending," *JAMA*, Vol. 315, No. 17, 2016; Sunita Desai, Laura A. Hatfield, Andrew L. Hicks, Anna D. Sinaiko, Michael E. Chernew, David Cowling, Santosh Gautam, Sze-jung Wu, and Ateev Mehrotra, "Offering a Price Transparency Tool Did Not Reduce Overall Spending Among California Public Employees and Retirees," *Health Affairs*, Vol. 36, No. 8, 2017; Christopher Whaley and Austin Frakt, "If Patients Don't Use Available Health Service Pricing Information, Is Transparency Still Important?" *AMA Journal of Ethics*, Vol. 24, No. 11, 2022.

competition dynamics and the impacts on cost and quality, of entrepreneurs from developing new benefit design innovations to help control spending, and of policymakers from overseeing market conduct and competition. The lack of transparent pricing also creates barriers to understanding the drivers of health care solutions and designing solutions. Rather than placing the responsibility of putting downward pressure on health care spending by trying to navigate the complex payment system,[11] price transparency can be an effective tool to enable policymakers to design impactful programs and policies.

I will illustrate how this can be done. Following the Great Recession in 2009, the California Public Employees' Retirement System (CalPERS), which is the second largest public purchaser of private health insurance in the country, faced budgetary consequences caused by rising health care costs. CalPERS recognized the same variation in provider prices, driven in part by site-of-care price differentials. In collaboration with its workforce, CalPERS used price transparency data to design and implement a reference-based pricing model in which patients are given financial incentives to receive care from lower-priced and high-quality providers, including non-hospital facilities, such as ambulatory surgery centers. For common outpatient services, CalPERS patients who receive care from an ambulatory surgical center are exempt from additional cost sharing. Patients who receive care from a higher-priced hospital are financially responsible for the difference in provider prices.

Across several procedures, using price transparency data to create patient financial incentives to receive care from lower-priced providers led to sizable financial savings for CalPERS and its employees. As shown in Figure 2, by the second year of the program, 90 percent of eligible CalPERS patients received care from lower-priced providers.[12] While not a direct price transparency program, this benefit design innovation would not have been possible without CalPERS' access to transparent information on provider prices. Other employers and innovators have used price transparency information to implement similar benefit design innovations, create bundled pricing payment programs, and audit the prices negotiated on their behalf.[13] The state of

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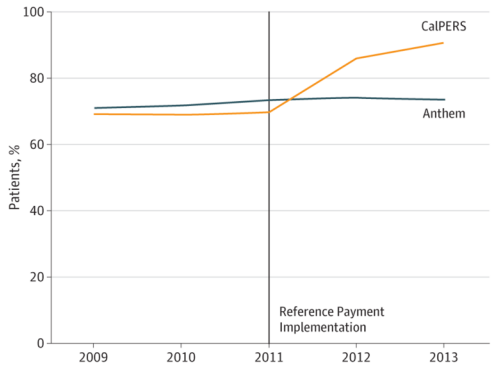
[11] Michael Chernew, Zack Cooper, Eugene Larsen Hallock, and Fiona Scott Morton, "Physician Agency, Consumerism, and the Consumption of Lower-Limb MRI Scans," *Journal of Health Economics*, Vol. 76, 2021.

[12] James C. Robinson, Timothy T. Brown, Christopher Whaley, and Emily Finlayson, "Association of Reference Payment for Colonoscopy with Consumer Choices, Insurer Spending, and Procedural Complications," *JAMA Internal Medicine*, Vol. 175, No. 11, 2015.

[13] Christopher Whaley, Timothy Brown, and James Robinson, "Consumer Responses to Price Transparency Alone Versus Price Transparency Combined with Reference Pricing," *American Journal of Health Economics*, Vol. 5, No. 2, 2019; Jonathan Gruber and Robin McKnight, "Controlling Health Care Costs Through Limited Network Insurance Plans: Evidence from Massachusetts State Employees," *American Economic Journal: Economic Policy*, Vol. 8, No. 2, 2016; Anna D. Sinaiko and Meredith B. Rosenthal, "The Impact of Tiered Physician Networks on Patient Choices," *Health Services Research*, Vol. 49, No. 4, 2014; Christopher M. Whaley, Christoph Dankert, Michael Richards, and Dena Bravata, "An Employer-Provider Direct Payment Program Is Associated with Lower Episode Costs," *Health Affairs*, Vol. 40, No. 3, 2021; Lisa Esquivel Long, "Anthem-Parkview Reach Agreement," *Fort Wayne Business Weekly*, July 30, 2020.

Indiana has used price transparency data to limit hospital facility fees and implement hospital price benchmarks.[14]

Figure 2. Percentage of Patients Choosing Ambulatory Surgery Centers Over Hospital Outpatient Departments Before and After Implementation of Reference-Based Benefits



SOURCE: Robinson et al., 2015.

As recently highlighted by the Congressional Budget Office,[15] price transparency information enables innovators and entrepreneurs to develop programs such as reference pricing that improve care efficiency. Gaining access to price data is challenging, which limits the ability to understand market dynamics and develop tools that direct patients toward lower-priced providers, stifling competition and innovation of new insurance products and payment models. Obtaining health care price data, whether for designing insurance benefit design innovations, regulating markets, or conducting research, has traditionally required obtaining medical claims data from national health insurers. These data can be expensive and often come with limitations—such as restrictions on identifying prices for specific providers. In RAND's price transparency work, to disclose provider-specific prices, we have obtained medical claims data from self-funded employers across the country and 11 state all-payer claims data.[16] While important for informing policy, this process is not replicable for other important uses of health care price transparency data.

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[14] Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare and Medicaid Services, Department of Health and Human Services, "Transparency in Coverage," *Federal Register*, Vol. 85, November 12, 2020.

[15] Michael Cohen, Daria Pelech, and Karen Stockley, *Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services*, Congressional Budget Office, September 2022.

[16] Whaley et al., 2022.

Recent Initiatives to Increase Price Transparency

I will now speak to recent federal policies that have expanded the scope of available price information, with two requirements—hospital-posted rates for common services in machine readable files and insurer-posted rates for all services through Transparency in Coverage (TiC) requirements.[17] As of February 2023, only one-quarter of hospitals are estimated to be fully compliant with the requirements, including posting prices for 300 services.[18] The *Wall Street Journal* found hospitals purposefully hiding price information from online search queries.[19] The Centers for Medicare & Medicaid Services (CMS) has been reluctant to penalize non-compliant hospitals and has only issued four fines for non-compliance since the rule took effect on January 1, 2021. CMS has recently announced efforts to increase enforcement and fines of hospitals that are noncompliant with the price transparency rules.[20] Stronger penalties and enhanced federal enforcement are likely to improve the usability of these data. As with other mandatory data reporting, such as Hospital Cost Reports, compliance with price transparency requirements could be a requirement for Medicare participation. At the state level, Colorado recently passed legislation that prohibits hospitals that do not post price transparency information from sending medical debt to collections.[21] These actions are likely to increase compliance and could serve as a national model for ensuring compliance with federal regulations.

Potential Policy Options to Improve Transparency in Coverage Data

While the hospital-posted data currently have limitations in availability and standardization that limit use, the more recent insurer-posted TiC data, which became public starting July 2022, offer more promise to drive entrepreneurial, policy, and research activity around understanding health care prices and developing policies to restrain spending growth. Insurers have largely complied with the TiC requirements, and the data are widely available. Because all in-network prices are posted, rather than the selected services in the hospital requirement, these data are comprehensive. They are also updated on a regular basis, allowing for monitoring of price changes over time and in response to market activity.

However, the TiC data have suffered from the opposite problem of too much data, which makes the data unusable. Although promising, these data have not been widely used due to

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[17] Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare and Medicaid Services, Department of Health and Human Services, 2020.

[18] Cynthia A. Fisher, Ilaria Santangelo, Marie B. LaRobardier, Olivia Dann, and Linda Bent, *Fourth Semi-Annual Hospital Price Transparency Report*, PatientRightsAdvocate.org, February 2023.

[19] Tom McGinty, Anna Wilde Mathews, and Melanie Evans, "Hospitals Hide Pricing Data from Search Results," *Wall Street Journal*, March 22, 2021.

[20] Centers for Medicare and Medicaid Services, "CMS OPPS/ASC Final Rule Increases Price Transparency, Patient Safety and Access to Quality Care," press release, November 2, 2021.

[21] Meg Wingerter, "Hospitals Can't Send Patients' Medical Debt to Collections or Sue Them Unless They Have Prices Posted Under New Law," *Denver Post*, June 20, 2022.

challenges with how the data are constructed and reported by insurers.[22] Many TiC data files are terabytes in size, rendering them difficult to open without advanced computational resources.

One problem with using the existing TiC data is that insurers frequently report prices for every possible combination of procedure and provider. For example, prices for cardiology services will be listed for dermatologists, who rarely provide such services. This construction creates two main problems. First, it greatly expands the size and scope of the data. The inflation of file size due to overpopulation of data fields is a large reason why the data are currently inaccessible. Second, it can create misleading findings from the data. If dermatologists are not providing cardiology services (but are included in the data), then using TiC data to measure prices for cardiac care will create misleading interpretations of prices.

I will conclude my remarks today with a couple of recommendations for how to improve the submission of data that will facilitate broad use of these data as a tool in improving health care affordability.

First, it is critical that TiC data only include prices for providers and facilities that actually perform those procedures. CMS could require insurers to post prices only for providers who have submitted bills for a given procedure within the past year. An alternative would be to require hospitals to include the number of billed services within a given reporting period, allowing users to measure provider volume. This restriction would make the TiC data informative and more usable to employers, regulators, and researchers.

Secondly, CMS could implement other possible changes to collect price information and make those data transparent for use in policymaking. For example, rather than insurers individually reporting prices, the Department of Health and Human Services could require insurers to report data to CMS or another third party, which could audit data submissions and make data available in a user-friendly format. Rather than large insurer-hosted JavaScript Object Notation (JSON) files, modern relational database technologies enable users to query this central data source and create accessible data extracts, similar to other data hosted by CMS.

Conclusion

Significant progress has been made to increase the transparency of health care prices at the federal and state levels, but much more needs to be done to leverage these data as a powerful tool in controlling growth in health care spending. Largely due to data collection and reporting limitations, data use is minimal nearly one year after the data started being reported. Actions are required to improve the data reporting and useability to empower policymakers, employers, and consumers to make informed purchasing decisions. Enabling broader use of these data can help address the large variation in health care prices and improve health care affordability.

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[22] Yang Wang, Jianhui (Frank) Xu, Mark Meiselbach, Yuchen Wang, Gerard F. Anderson, and Ge Bai, "Insurer Price Transparency Rule: What Has Been Disclosed?" *Health Affairs Forefront*, February 2, 2023.

Chairman SMITH. Thank you, Dr. Whaley.
Mr. Kampine, you are recognized.

STATEMENT OF BILL KAMPINE, CO-FOUNDER AND CHIEF INNOVATION OFFICER, HEALTHCARE BLUEBOOK

Mr. KAMPINE. Chairman Smith, Ranking Member Neal, members of the committee, thank you for this opportunity to share my perspective on how transparency lowers health care costs for employers and consumers, and promotes a more competitive health care system.

Since our founding in 2007, Healthcare Bluebook has become one of the largest providers of cost and quality transparency solutions to self-insured employers, large state and municipal plans, and trusts. We are a large aggregator of commercial claims, as well as the carrier of machine-readable files, and we are a leading provider of transparency-compliant solutions to third-party administrators.

Through our Quantros quality analytic brand, we produce patient-specific outcomes on a national basis, as well as provide quality measurement solutions that are used by hospitals and other provider systems.

Our job at Bluebook is to make it really easy and intuitive for members to compare providers on cost and quality. So, for example, a patient can look up a joint replacement and immediately compare local in-network providers on both cost and quality. All this information is color coded, so green is high performing, red is low performing. Importantly, we rank first by quality and second by cost, where quality is measured, in this instance, by patient-specific outcomes for the roughly 3,200 hospitals that do joint replacements in the United States, as measured by complications, mortality, and readmissions.

Lastly, the majority of our employers reinforce good consumer behavior through either shared savings incentives or lower out-of-pocket costs.

In our experience, transparency works. We know that patients that shop for care are three times more likely to choose high-value care. And we also know that patients want this information. Over 15 years we have seen a dramatic rise in utilization. Initial monthly utilization was in the single digits. By 2018 we were double digits. Today it is not uncommon to see 25 to 35 percent or more.

That is a direct result of increased patient awareness, more relevant data, and so medical, pharmacy, and quality all on one platform, sophisticated analytics that enable us to better engage patients, and most importantly, alignment of benefit design and incentives with the desired outcome, which is use of high-value care.

We have also observed steadily increasing patient utilization of these high-value providers that directly puts money back into the patient's pocket through lower deductibles or lower coinsurance, or also through incentives.

Similarly, over a multi-year period our employer plan sponsors have seen their annual savings grow by 200 to 300 percent.

Recent Federal transparency initiatives have been helpful in these efforts. The hospital transparency requirements, the transparency and coverage rules, and the No Surprises Act provide a wealth of data for organizations like Bluebook. As an example, the

anti-gag provisions of the No Surprises Act ensure that our employer clients have access to their own claims data. It is table stakes in terms of being able to actually understand the problem before you can do something about it.

The hospital files—well, I would say imperfect, as we talked about—are still a good source of rate information and, importantly, the cash prices. And importantly, the network MRFs are a comprehensive source of rate and provider information, and we utilize that information to make available more services and more providers and more geographies in order to help patients shop.

Collectively, I think great progress, but there are still some gaps and maybe some areas that we can improve. So, I would start with pharmacy medications are the fastest-growing cost for employers and consumers. Pricing is opaque. The pharmacy MRF requirement was removed from the transparency and coverage final set of rules, and so I would encourage legislators to consider revisiting that data requirement.

The second is support for quality measurement initiatives and data. So, the consumer tools really focus on price and out-of-pocket cost. I think we have established that quality is critical in order to determine value. So, support for initiatives like all payer claims databases that make more data available to third parties to do quality measurement would be helpful.

I also think that there are probably some things that we can do to improve the quality of the MRF data files, both the hospital files and the carrier files. The carrier files, we are still in early days working with these files. I think with more experience we will get a little bit more efficient there. However, the files are large, and the data values and formats lack consistency, so I encourage steps to improve standardization, uniformity, and accuracy.

I am always concerned about anti-steering and anti-tiering provisions in provider contracts. It is incredibly important for employers to be able to steer members to high-value care and to discourage use of low-value care. I think those clauses work against the interests of employers, and I think we want to preserve that ability for employers.

Lastly, I think the literature is clear here, but provider consolidation results in higher prices. We certainly see this in the data. I know the committee has a hearing on this actually tomorrow, but I encourage legislators to pursue policies that foster competition in the provider market.

And with that I will conclude my remarks, but I look forward to questions.

[The statement of Mr. Kampine follows:]

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Testimony of

Bill Kampine
Co-founder and Chief Innovation Officer
Healthcare Bluebook

Before the

United States House of Representatives
Committee on Ways and Means

Hearing on Health Care Price Transparency:
A Patient's Right to Know

May 16, 2023
Washington, D.C.

Chairman Smith, Ranking Member Neal, and Members of the Committee,
thank you for this invitation to speak with you today to share my perspective and experience on how improved price and quality transparency reduces cost for employers and consumers, improves health outcomes for patients and promotes a more efficient, competitive healthcare delivery system.

My testimony is drawn from my experience as Co-Founder and Chief Innovation Officer at Healthcare Bluebook. We established Healthcare Bluebook in 2007 with a simple purpose: to protect patients by exposing the truth about price and quality differences and empowering consumers to make better healthcare choices.

Bluebook is now one of the largest independent providers of medical and pharmacy transparency solutions serving large, self-insured employers, state and municipal employee plans and employee benefit trusts. Bluebook is also one of the largest aggregators of commercial claims data and carrier Machine Readable Files (MRFs), and we are a leading provider of federal transparency compliance solutions to independent Third-Party Administrators (TPAs). Through our Quantros Quality Analytics brand we are also one of the largest providers of empiric, risk adjusted patient outcomes and quality measurement solutions to hospitals, integrated delivery systems and other provider organizations.

We serve over 7,000 employer clients encompassing millions of members who access Bluebook transparency tools in all 50 states and every US metropolitan area.

The Impact of Hidden Costs

Hidden price and quality variability have a significant impact on both patient outcomes and affordability. When patients don't understand what care should cost or lack the ability to compare providers, they frequently overpay for common healthcare services by as much as 1000%. When patients don't have access to outcomes-based quality information, they choose poor performing doctors or facilities, increasing their risk of complications, readmission and death.

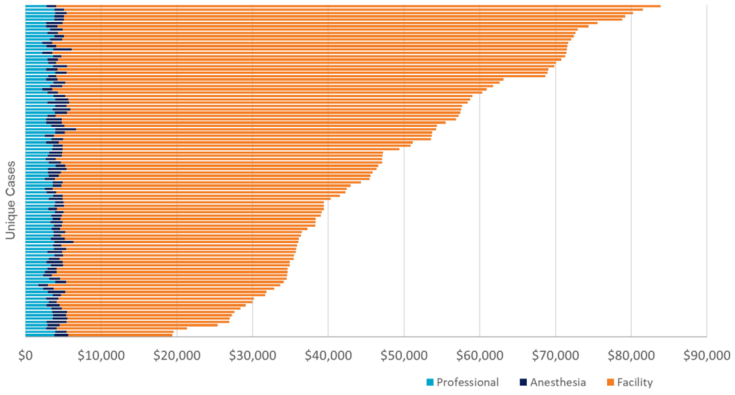
Lack of transparency also has a significant cost for employers and our broader economy. Roughly $2 trillion of our annual US healthcare expenditure is paid through private insurance or directly through consumer out-of-pocket costs (NHE 2021).

Conservatively, shoppable non-acute healthcare services account for 40%, or $800 billion. Based on historical analysis of commercial medical claims data, if consumers were to select better value in-network providers, both consumers and employer plan sponsors can save 50% of the costs on these shoppable services. In the commercial insurance market, alone, this would save employers and consumers $400 billion.

The Price and Quality Problem

In-network prices for the identical service, in the same community, can vary by 2-10x without an accompanying difference in quality or outcome for the patient. Moreover, high price variability is extremely consistent. We observe this level of variability in every US metropolitan area and across carrier networks.

Figure 1: Price Variation: Knee Replacement | Charlotte, NC

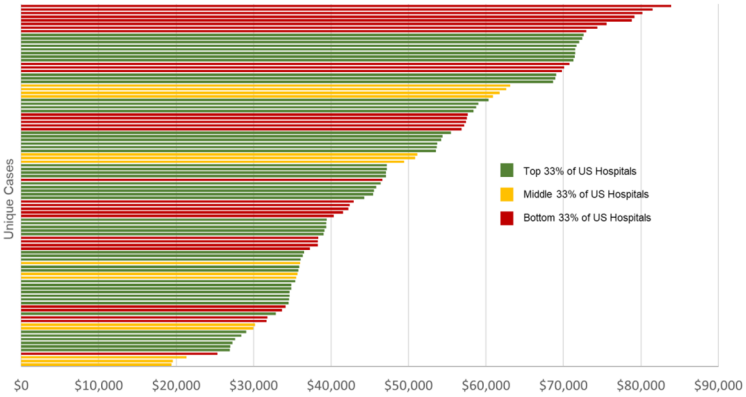


Sample of 100 total knee replacement surgeries. The price is the commercial allowed amount, or the amount paid after insurance discount is applied.

Quality exhibits similar variability. We use CMS data to evaluate risk-adjusted patient-specific outcomes for a wide range of clinical categories.[1] The metrics allow for direct comparison of individual hospitals or physicians benchmarked against their peers. Our analysis indicates several important consumer implications:

- Outcomes for different clinical departments *within the same hospital* exhibit significant variation. *Without data, patients cannot rely on hospital brand or reputation to make global quality determinations.*
- Selecting a high-quality hospital does not guarantee a high-quality physician. *Patients must be able to independently evaluate both facility and physician quality.*
- When combining clinical quality and price data, we do not observe any correlation between cost and quality. *Patients cannot rely on price as a proxy for quality.*

Figure 2: Facility Quality Variation: Knee Replacement | Charlotte, NC



Sample of 100 total knee replacement surgeries. The price is the commercial allowed amount, or the amount paid after insurance discount is applied. The color coding is the Bluebook national quality outcome percentile for joint replacement at the hospital where the case was performed.

[1] Bluebook composite quality ratings include individually scored dimensions for mortality, complications and unanticipated readmissions. All metrics are risk and volume adjusted using peer reviewed, published methodologies.

The ability to identify high-quality and cost-effective providers is the definition of value, and effective transparency solutions enable consumers to directly compare providers on both dimensions, and financially reward high value choices.

Data Shows Increasing Utilization and Measurable Cost Reduction

Nearly 20 years ago independent third-party transparency providers and their self-insured employer partners started the transparency movement out of the need to understand the cost of in-network price and quality variability and then put into place the tools to enable their members to directly compare providers and ultimately obtain better value from their healthcare benefit. Today's state of the art price transparency and navigation solutions offered by companies like Healthcare Bluebook provide capabilities and features that go beyond the cost-focused federal transparency requirements to include:

- Ability to search for providers, services, codes, facilities and conditions
- Intuitive direct provider comparisons on price and out of pocket obligation
- Facility and physician quality comparison using empiric, risk adjusted patient outcomes
- Single-platform shopping for pharmacy, medical and specialty medications
- Alignment of the benefit design and financial incentives to reward use of high value care
- Member concierge support and price and quality API integration into all patient facing services (wellness, on-site clinics, telehealth, etc.)
- Sophisticated digital engagement
- Data exploration tools and measurement to quantify waste, utilization and savings capture

As transparency tools and capabilities have evolved, so has the ability to predictably drive member engagement and grow measurable savings, making price and quality transparency solutions an indispensable tool for employers trying to manage the high growth in medical and pharmacy cost.

Over the past 5 years, monthly member utilization rates have grown from roughly 10% to 25% or higher. The jump is directly related to increased consumer understanding of the need to shop for care, advances in member engagement techniques, accurate actionable price and quality data and increased use of shared savings incentives that reward members for selecting high-value care.

Financial and quality outcomes have also steadily improved. For example, a large public employer client realized $9.5M in annual savings reflecting an increase of 260% over a 3-year period from inception, with member engagement growing by more than 250%. The transparency program was recognized with a national award for innovation in financial management. Another large public employer utilizing both transparency and benefit design levers increased savings from 1% of total medical expense to over 5%.

Adding quality data and aligning incentives also drives utilization of high-quality providers. A large client rewarding members for utilizing cost-effective providers for total joint replacements experienced a 6% annual increase in use of high-quality providers. The following year the client added quality data and tied the incentive to use of the transparency solution and selection of a provider that is both cost-effective and high quality. The result was a 58% increase in use of high-quality hospitals for joint replacement.

Recent Transparency Policy Initiatives and Future Considerations

It is important to recognize the contribution that recent federal regulatory and legislative transparency initiatives have made in terms of raising awareness and providing access to critical data for employers and third-party solution providers. The Hospital Transparency Reporting requirements, the Transparency in Coverage (TiC) rules and the No Surprises Act (NSA) ensure that employers have access to their own data in order to understand the financial impact of unwarranted price variability (as per the NSA anti-gag clause provisions), and service providers (TPAs) or third party solutions like Bluebook have dramatically increased access to provider rates (via MRF data) to expand the scope of searchable providers and services, and ensure that employers are compliant with the requirements.

Collectively, the level of effort and engagement by payors, employers, TPAs and third-party vendors to deliver files and implement the first phase of consumer transparency tools under the TiC requirements with the required 500 services has been tremendous. While we are still in the early stages of implementation, there are some learnings that are instructive as we contemplate policy that furthers the overall objectives of transparency or as we consider incremental improvement to requirements in place.

As legislators turn their attention to policy and initiatives that can further price and quality transparency, I offer the following thoughts and observations for the committee's consideration:

- **Pharmacy Prescription Data:** Drug costs, including retail and specialty in both the PBM and Medical benefit are the fastest growing cost for employers and consumers. Net prices, or the amount the employer pays after rebate for any particular drug are virtually unknown making it extremely difficult to assess which formulary medications are most cost effective. The pharmacy MRF requirement was removed from the final TiC rules, but I would encourage legislators to consider revisiting this data requirement.

- **Support for Quality Measurement Initiatives and Data:** The TiC and NSA consumer shopping tool provisions focus exclusively on price and out of pocket cost. Both price and quality information are necessary for consumers to determine value. Third party quality measurement solutions like Bluebook's Quantros Quality Analytics utilize vast data sets to calculate quality. I encourage legislators to support initiatives, like the all-payor claims database, that make large commercial and Medicare databases available to innovators for calculating comprehensive quality metrics.

- **MRF Data Consistency:** While an important source of pricing information, the network MRF files are extremely large and complex. Many are bloated by the presence of codes associated with providers who do not perform the listed service. Moreover, there are non-standard fields and differences in formatting across file originators. I encourage legislators to consider steps to improve standardization of information and format, reducing file size and enhancing uniformity and accuracy.

- **Provider Consolidation:** When hospitals acquire other hospitals or outpatient facilities, local prices increase. When hospitals acquire physician practices, referral patterns reflect a shift to facilities or locations that have higher reimbursement rates due to unnecessary site of care payment differentials. I encourage legislators to be vigilant of the impact that consolidation has on healthcare prices and encourage policies that foster competition.

- **Anti-steering and Anti-tiering Provisions:** The most powerful cost control tool employers have at their disposal is benefit design. We have seen examples of uncorrelated cost and quality, and providers that clearly offer superior value. Transparency is a blunt instrument without the ability to align benefits to reward use of those high-value providers. Anti-steering, anti-tiering and favorite nations pricing

clauses in provider network contracts work contrary to the interests of employers and consumers. I encourage legislators to ensure that employers have the ability to use transparency in concert with benefit design and are not impeded from using price and quality information to encourage the use of high value care.

- **Re-affirm Employer Access to their Claims Data:** The anti-gag clause provisions of the NSA ensure that employers have the right to access their historical claims data. I encourage administrators to reaffirm that carriers and TPAs are obligated to make unredacted claims data available to employers.

Summary

For nearly two decades price and quality transparency solutions have evolved to continually increase both member engagement and capture of total savings for both the member and employer plan sponsor. As a result, price and quality transparency solutions are an essential part of most self-insured employers' cost management toolkit.

Recent transparency initiatives like the TiC rules and NSA have had a meaningful impact in terms of advancing transparency and improving access to data for third-party innovators. I believe continued thoughtful policy promoting price and quality transparency can help employer plan sponsors and their members lower health care cost while promoting a more competitive delivery system.

I thank the committee for the opportunity to testify and look forward to answering your questions.

Chairman SMITH. Thank you, sir.
Mr. Short, you are recognized.

STATEMENT OF WILLIAM SHORT, EXECUTIVE CHAIRMAN, AMERIFLEX

Mr. SHORT. Chairman Smith, Ranking Member Neal, members of the committee and staff, I extend my sincere gratitude for inviting me to testify today on the crucial topics of transparency, health savings accounts, and direct primary care as a means to make health care more affordable for the working class. It is an absolute honor to be here with you today.

Inefficient payment processing is the silent killer in American health care. The U.S. health care system faces a significant challenge that is often overlooked: the impact of inefficient payment processing. This acts as a silent killer affecting the overall cost, quality, and accessibility of care. It is imperative that measures be taken to address these inefficiencies.

We can address this problem through improved price transparency, modernizing health savings accounts, and facilitating direct primary care through direct payments can effectively tackle this challenge. By doing so, we can lower costs, enhance patient engagement, alleviate physician burnout, and attract more qualified individuals into the medical profession. Encouraging broader participation in direct payment markets ultimately leads to a more efficient and effective health care system in the United States.

I am William Short, executive chairman of Ameriflex, a prominent administrator of tax advantaged health care accounts headquartered in Texas. Ameriflex works in partnership with Main Street businesses across the country, empowering employees to become smarter consumers of their health care.

In addition, I proudly serve as a board member of the American Bankers Association of Health Savings Account Council. Today I come before the committee to serve as a resource and an ally as you explore and implement critical changes to our U.S. health care system to better ensure affordability, accessibility, and quality health care for all Americans.

To begin, increased transparency in health care pricing, coupled with modernized health tax accounts, empower patients to make informed decisions and wisely allocate their resources. Ameriflex plays an important role in this process. We collaborate with businesses, including those that serve the working-class, blue-collar sectors, rural communities, as well as public sectors across the nation. Through these partnerships we enable employees to take full advantage of tax advantaged health care accounts, granting them greater control over their health care expenditures.

According to the Devenir Research 2020 survey, a significant majority of households, over 78 percent, who have HSAs as part of their health care coverage make less than $100,000 per year.

Allow me to take a moment to share a story about how direct payments can work in an employee benefit plan. One of our partner businesses, A1 Locksmith based in Dallas, Texas, had an employee who was able to take advantage of the direct primary care arrangement, and through a wellness visit that had allowed for him, with his primary care physician, to uncover that he was a

type 2 diabetic. Through this arrangement, they were—developed a treatment plan that allowed for him to hopefully avoid serious medical conditions that could have resulted from the untreated diabetes.

In addition to our firsthand experience with employees, the Society of Actuaries commissioned Milliman, which found in a May 2020 report entitled "Direct Primary Care Evaluating a New Model of Health Care Delivery and Financing" that savings of 20 percent could be achieved by employers who had decided to install a direct primary care arrangement in their health plan.

In addition, our customers highly value HSAs as they provide individuals with the tax advantaged means to save for medical expenses, and encourage individuals to become proactive health care consumers, all translated into active participation and improved individual health outcomes.

However, the effectiveness of HSAs can be hindered by an opaque health care system. Without transparency and priority, pricing, quality patients face significant challenges in making informed decisions. It is imperative that we collectively address this issue to unlock the full potential of HSAs and empower patients to become wise health consumers.

While HSAs have demonstrated numerous benefits, there are still barriers to overcome. Currently working Medicare, TRICARE, Indian Health Services, and Medicaid beneficiaries are excluded from utilizing HSAs, limiting their ability to save for future health medical expenses. This discrepancy must be rectified, ensuring that all individuals, regardless of their health care coverage, can pay for their out-of-pocket costs with tax advantaged health care accounts.

In addition, special consideration should be given to low-income Americans. By spending HSA accounts—HSA accounts and Medicaid could greatly assist the working class in covering their out-of-pocket expenses.

Furthermore, out-of-date regulations obstruct the adoption of innovative health care delivery options for patients and employers, as current HDHP compliance barriers limit the integration of DPC arrangements with HSAs. Addressing these compliance challenges would enable more individuals to benefit from the advantage of DPC, while utilizing HSAs effectively.

In conclusion, transparency, health savings accounts, and direct primary care hold tremendous potential to make health care more affordable for the working class. By increasing price transparency and modernizing regulations governing HSAs, as well as overcoming compliance challenges related to DPC, direct primary care, we will create a more effective, inclusive, and affordable health care system.

Thank you once again for the opportunity to share these views with the committee.

[The statement of Mr. Short follows:]

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How the Interaction of Transparency, Health Savings Accounts and Direct Primary Care Can Make Health Care More Affordable for the Working Class

Testimony by William C. Short,

Executive Chairman, Ameriflex

10:00 AM Tuesday, May 16, 2023

Before the United States House of Representatives

Committee on Ways and Means in the main Hearing Room,

1100 Longworth House Office Building,

Washington, D.C. 20015

Chairman Smith, Ranking Member Neal, Members of the Committee and staff, I extend my sincere gratitude for inviting me to testify today on the crucial topic of transparency, Health Savings Accounts (HSAs), and Direct Primary Care (DPC) as a means to make healthcare more affordable for the working class. It is an absolute honor to be here with you today.

I am William C. Short, Executive Chairman of Ameriflex, a prominent administrator of tax-advantaged healthcare accounts, headquartered in Texas. Ameriflex works in partnership with main street businesses across the country, empowering employees to become smarter consumers of their healthcare. Today, I will explain the benefits of tax-advantaged health care accounts for all Americans, but especially for the working class; and describe how Direct Primary Care arrangements can effectively lower healthcare costs. Additionally, I will address the current barriers faced by small businesses and employees when attempting to leverage their tax-advantaged health care accounts.

In addition, I proudly serve as a Board Member of the American Bankers Association's Health Savings Account Council.

I. Importance of Price Transparency in Healthcare

A. Introduction

The famous saying, "No one cares about their health until they don't have it," encapsulates the universal truth that health is often taken for granted until we face a health crisis. It is crucial to empower individuals to be proactive in managing their health, and price transparency plays a fundamental role in achieving this goal. If individuals do not have the incentive to ask the question about the cost of their healthcare, they won't. Price transparency helps bridge this gap by enabling patients to make informed decisions about their care.

B. Addressing Key Issues in the US Healthcare System

The US healthcare system faces numerous challenges, but one critical issue that requires immediate attention is the payment inefficiency problem. The stakeholders involved in healthcare, including patients, providers, insurers, and pharmaceutical companies, are not always aligned in their objectives. This misalignment leads to a lack of coordination, unnecessary costs, and a suboptimal allocation of resources. Addressing payment inefficiency is essential for achieving a more sustainable and effective healthcare system.

II. The Payment Inefficiency Problem

A. Identification of the Payment Inefficiency Problem

Without a doubt, the payment inefficiency problem stands out as the number one issue in the US healthcare system. Our nation's healthcare system is unmatched in the history of humanity, and its capabilities are evident worldwide. In other countries, one routinely sees advertisements for healthcare centered around "American Trained Physicians." However, the crisis we now face in our healthcare system is primarily due to the inefficiency in how healthcare is paid for in the United States.

B. Consequences of Payment Inefficiency on Healthcare Costs and Quality

The consequences of payment inefficiency reverberate through the entire healthcare ecosystem. Escalating costs burden patients and families, strain government-funded programs, and hinder investment in innovative treatments and technologies. By addressing payment inefficiency, we can reduce costs and enhance the quality of care.

III. Need for More Primary Care Providers

A. Recognizing the Shortage of Primary Care Providers

Data clearly indicates a significant shortage of primary care physicians in various regions of the country. This shortage limits patients' access to timely and appropriate care, leading to delayed diagnoses, increased healthcare costs, and diminished health outcomes. Addressing this shortage is critical for building a strong foundation for our healthcare system.

B. Importance of Primary Care in Promoting Preventive Healthcare and Reducing Overall Costs

Primary care plays a vital role in promoting preventive healthcare and reducing overall costs. Studies consistently show that increased access to primary care leads to better health outcomes, reduced hospitalizations, and lower healthcare costs. By focusing on bolstering primary care services, we can improve population health and achieve long-term cost savings.

IV. Empowering Individual Patients

A. Empowering Patients to Take an Active Interest in Their Healthcare

Recent studies have consistently shown that engaged and informed patients have better health outcomes. When patients actively participate in decisions about their care, they become partners in their own health journey. By promoting patient education, shared decision-making, and access to health information, we can empower individuals to make informed choices, leading to improved health outcomes and patient satisfaction.

B. Benefits of informed decision-making and increased patient engagement

Research has unequivocally demonstrated that engaged patients are more likely to adhere to treatment plans and experience better health outcomes. When patients are actively involved in their care, they have a deeper understanding of their conditions, treatment options, and self-management strategies. This knowledge empowers them to make decisions aligned with their values and goals, resulting in more effective and personalized care.

V. Stakeholder Alignment for Proactive Patient Care

A. Importance of aligning healthcare providers and patients

Coordinated and collaborative care between healthcare providers and patients has consistently shown improved outcomes and reduced costs. When providers and patients align their goals, share information, and work together to develop personalized care plans, the results are remarkable. Patients receive better coordinated, proactive care that addresses their specific needs, leading to improved health outcomes, reduced hospitalizations, and cost savings.

B. Promoting proactive and preventive care measures

Research suggests that preventive care interventions significantly reduce the need for costly treatments and hospitalizations. By prioritizing proactive and preventive measures, such as regular screenings, vaccinations, and lifestyle interventions, we can catch health issues early, prevent the progression of diseases, and avoid unnecessary healthcare expenditures. Investing in prevention not only saves lives but also reduces the burden on the healthcare system and improves population health.

VI. Leveraging Direct Primary Care and Subscription Models

A. Utilizing Direct Primary Care and subscription-based models

Data consistently supports the effectiveness of Direct Primary Care (DPC) in improving patient access, reducing costs, and enhancing patient satisfaction. DPC models operate on a direct relationship between patients and their primary care providers, often facilitated through a fixed monthly fee. This approach allows for more personalized and comprehensive care, including extended office visits, preventive services, and enhanced care coordination.

Studies have shown that DPC results in improved health outcomes, reduced hospitalizations, and lower healthcare costs. By eliminating the fee-for-service model and its associated administrative complexities, DPC empowers providers to focus on patient care rather than billing and paperwork. This patient-centered model encourages better communication, greater provider availability, and improved patient engagement, leading to higher levels of patient satisfaction and overall wellness.

Furthermore, subscription-based models, similar to DPC, have demonstrated promising results in other areas of healthcare. These models often provide comprehensive care bundled into a single subscription, which can include primary care, specialist visits, and preventive services. By offering a fixed price for a range of services, patients have greater transparency in healthcare costs and can access necessary care without financial surprises.

B. Shifting payment and healthcare risk management to optimal stakeholders

To achieve the best outcomes, it is essential to align payment incentives with providers and patients. Studies consistently show that when payment models are designed to prioritize quality, care coordination, and patient outcomes, the healthcare system becomes more efficient and cost-effective. By shifting away from traditional fee-for-service reimbursement and embracing alternative

payment models that incentivize value-based care, we can foster better care coordination and promote optimal patient outcomes.

Aligning payment incentives with providers and patients also encourages more effective risk management. Providers who bear more significant responsibility for managing patient health outcomes are more likely to prioritize preventive care, chronic disease management, and patient education. Patients, in turn, become active participants in their healthcare, making informed decisions and adhering to treatment plans, which can result in better health outcomes and reduced healthcare costs.

VII. Strengthening the Private Sector Healthcare Benefits Industry

A. Importance of the private sector healthcare benefits industry

The private sector plays a vital role in the provision of healthcare benefits, covering approximately 180 million Americans. Strengthening the private sector healthcare benefits industry holds significant potential for optimizing healthcare delivery and resource allocation. By leveraging the expertise, innovation, and efficiency of private insurers, we can achieve better outcomes, cost savings, and improved access to care for individuals across the nation.

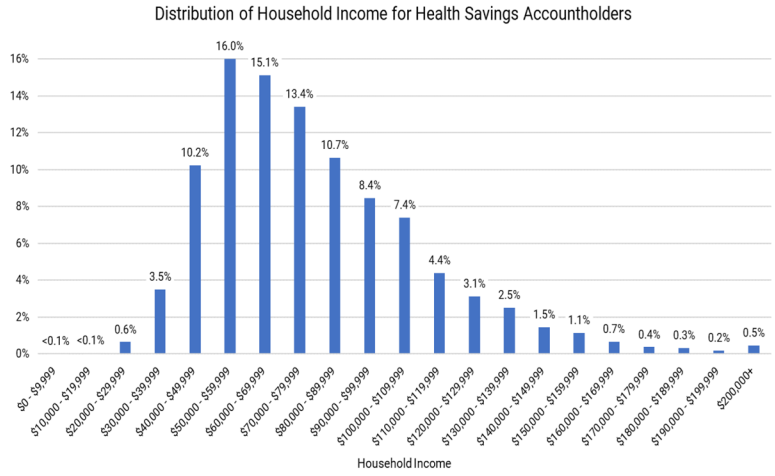
Moreover, by enhancing the private sector's capacity to provide healthcare benefits, we can alleviate the strain on government-funded programs such as TRICARE, Medicare, and Medicaid. This collaborative approach ensures a balanced distribution of resources, maximizes the effectiveness of both public and private sectors, and supports the overall sustainability of our healthcare system.

VIII. Enhancing Pretax Resources for Patient Care

A. Removing barriers to Health Savings Accounts (HSAs), Flexible Spending Accounts (FSAs), and Health Reimbursement Arrangements (HRAs)

To empower individuals and families in planning and paying for their healthcare needs, it is imperative to remove barriers to pretax resources, such as HSAs, FSAs, and HRAs. These financial tools provide flexibility, promote savings, and offer tax advantages, empowering patients to take control of their healthcare expenditures.

HSAs have emerged as the favored healthcare payment option among the middle class, as revealed by the joint research conducted by Devenir Research and the American Bankers Association's Health Savings Account Council. Their findings for 2021 indicate that an overwhelming majority of Americans covered by HSAs, approximately 78%, belong to households earning less than $100,000 annually.



By eliminating unnecessary restrictions and expanding the scope of these resources, we can provide patients, families, employers, and government entities with increased financial options. This will enable them to plan for healthcare expenses more effectively, access necessary treatments, and mitigate the financial burden associated with healthcare costs. Furthermore, it encourages individuals to be more proactive in managing their health, resulting in better health outcomes and reduced healthcare spending in the long run.

In conclusion, Chairman Smith, Ranking Member Neal and other members of the committee, strengthening the private sector healthcare benefits industry and enhancing pretax resources for patient care are crucial steps towards building a more efficient, patient-centric healthcare system. By leveraging the expertise and capabilities of the private sector, we can optimize healthcare delivery, improve access to care, and generate cost savings. Additionally, expanding the availability and accessibility of pretax resources will empower individuals and families to take control of their healthcare expenses, leading to better health outcomes and financial security. I urge this committee to consider these recommendations as we work together to transform and improve our nation's healthcare system.

Thank you for your attention, and I welcome any questions or further discussion on these important matters.

Chairman SMITH. Thank you, sir.
Mr.—Dr. Gilfillan.

STATEMENT OF RICK GILFILLAN, MD, FORMER CMMI DIRECTOR AND FORMER CEO OF TRINITY HEALTH

Dr. GILFILLAN. My name is Rick Gilfillan. I am a family physician and currently an independent consultant doing mostly volunteer work. In addition to practicing medicine, my prior positions include CEO of Trinity Health, a large national non-profit health system; the deputy administrator and director of CMMI at CMS; CEO of Geisinger Health System; Senior Vice President for Contracting at Coventry Health; and chief medical officer of Independence Blue Cross. My comments today are strictly my own.

I believe we should be as transparent as possible about the quality and cost of health care, but I don't believe today's operative assumption that if we give patients pricing information they will respond as logical economic actors in a well-functioning marketplace, thereby lowering costs and improving outcomes. It seems quite ironic and inappropriate to me that, given America's broken health care marketplace, where most businesses operate outside of usual marketplace constraints, we want patients to provide market discipline by shopping.

Meanwhile, insurers with near monopolies take 17 percent of the cost of care for operations and profits. Medicare Advantage Plans with near monopolies take 17—I am sorry—receive subsidies at $1 trillion over the next 8 years. For-profit hospitals and surgical centers cherry pick profitable communities and patients and services, leaving lower-income communities to non-profits. Drug companies with 17-year monopolies keep the price of insulin so high that patients ration it for themselves.

And by the way, congratulations on passing the No Surprise Act and the Inflation Reduction Act to allow negotiation of drug prices.

But there remain powerful drivers of cost in the system. And against all that we ask mostly lower-income patients, when they are sick and vulnerable, to find the best price for services they desperately need. Have any of us actually done that? I haven't.

In my written testimony, I provided five conclusions.

One, despite the dedication and skill of our health care workforce, our system, compared to similar countries, is less effective, less efficient, and fraught with inequities. We spend twice as much, $6,000 per person versus 12,000. In 2019 our life expectancy was three to five—three to four years less than these other countries. Post-COVID, our life expectancy actually decreased three years. And for Black Americans, life expectancy is five years less than for White Americans.

Over the past 40 years we have built a financial and administrative structure on top of the actual delivery of health care. This financialization has created a complex health care system that seems more driven by the pursuit of wealth for institutions than health for populations.

Employer-based insurance results in high service prices and commercial costs, and shifts resources from low-income to high-income communities, perpetuating inequitable and segregated health care.

Despite the ACA's great improvement in coverage, increased cost sharing, and high deductibles, exposed families to higher prices, causing care avoidance, family medical debt, and bankruptcies. And studies show that high deductibles decreased cost marginally, but due to patients avoiding care, not due to shopping.

HSAs have been shown to not encourage shopping, but to serve more as planning tools for taxes for high-income individuals and families.

I offer the following principles for your consideration. One, ensure comprehensive health insurance to cover everyone in America; two, eliminate overpayments in government programs like Medicare Advantage; three, create an all-payer system with standard pricing for all populations; four, create a public option built on a network of strengthened primary care and accountable providers; five, maintain current levels of employee contributions; six, use savings resulting—and redistribute other spending to address the social determinants of health; and seven, continue publicizing cost and quality data.

Across America in each of your districts, some for over 150 years, non-profit health providers have been a lifeline. Their dedicated staff are available 24/7 to anyone who needs them, unlike for-profit institutions who limit their care to high-paying individuals with the wealth or commercial insurance to afford it. Non-profits remain committed to their founders' values and missions to serve. Yet non-profit health care is often portrayed as the problem here in Washington. We should address the concerns that you all raise about that. But as we work to improve health care, I believe we should support these organizations so that they can continue to be that vital lifeline in your communities.

Thank you very much. I look forward to answering any questions.

[The statement of Dr. Gilfillan follows:]

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

[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
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 like ACOs.
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.

Chairman SMITH. I want to thank you all for your testimony. We will now proceed to the question-and-answer session, and I will first begin.

Dr. Whaley, in my opening statement I referenced analysis citing less than 25 percent of hospitals are currently complying with the price transparency rules. And you noted that, as well, in your testimony. In your research, what response have you seen from hospitals complying or, more likely, not complying with the price transparency rules and regulations we already have in place?

Dr. WHALEY. Thank you, Chairman Smith. As I noted in my opening testimony, there have been audits of price transparency postings that have noted that roughly 25 percent of hospitals are actually compliant, meaning that 75-ish percent of hospitals are actually not complying with these requirements.

As I also noted in my opening testimony, I think there are important Federal actions that could be done to improve compliance.

Chairman SMITH. Mr. Short, we have armed Americans with patient first health accounts such as HSAs, and then told them to go out into a world where they struggle to find out what their care will actually cost. That is a little like giving a gift card to someone and sending them to a store with no price tags on the clothing.

Given your work on HSAs in particular, how will more price transparency enhance the benefits of such health savings accounts?

Mr. SHORT. And speaking for over the million American families that Ameriflex has helped, you know, efficiently spend their health care dollars to get the care that they need, the 30 million HSA accounts that are currently in market and the additional 35 million tax advantaged accounts, FSAs and HRAs, by opening up more price transparency options we can make them more powerful consumers in terms of looking for care and being able to get the care that they need at an efficient price below the deductibles, beyond items that wouldn't be covered by catastrophic insurance.

Chairman SMITH. Ms. Troiano, price transparency is critical not just because patients have a right to know, but also because it disrupts the regular payment and insurance models, encouraging competition and therefore lowering cost. How have you seen price transparency lower cost for your small business and its employees?

Ms. TROIANO. It has lowered our—first of all, let me make it clear that our premiums did not lower this year. Our premiums were—originally came back at 35 percent. With Sidecar it—they were 10 percent higher. So, our premiums did not lower. Ten percent was the palatable amount that we could take in, thirty-five percent was not. And there were several companies that refused to even bid on our business because we are small, and we had big claims.

So, the savings that we are seeing is for our employees, which was more important to us than making sure that our savings were there. And what we are seeing is a person whose spouse had back fusion surgery that would have been $160,000 and ended up being about $80,000. We see our employees are able to go to any pharmacy so they can use Mark Cuban's Cost Plus pharmacy. They are saving a lot of money through that. SingleCare, which is an app; GoodRx, which is an app. And they do not have that money. They

are not out putting money up front. Sidecar puts the money out up front, and all the prescriptions are paid for.

Chairman SMITH. Dr. Piniecki, you run an outpatient surgery center that has employed transparent, up-front pricing for patients. How have your patients reacted to confidently knowing the price they will pay for their procedure?

Dr. PINIECKI. It has been super encouraging for me. One of the reasons why I did it, and probably what fuels me moving forward, you know, we understood—I understood that employers were actively pursuing value, quality, and price—defining value as quality and price—in their care for their employees. So, I knew that that was going to be a likely participant for our business.

But what has been really interesting is there has been folks that have actually been shopping for care, so they have actually been online. We actually receive a fair number of patients. I mentioned the patient from Nebraska. We have had a patient travel from the upper Peninsula of Michigan for a colonoscopy. That is a relatively low-priced procedure compared to a, you know, joint replacement, or some of these larger surgeries we do.

And so, the feedback that I get from them has been super encouraging. They said, "Hey, I have looked around, I have called around the hospital. It was this price. We called the neighboring city; the hospital is that price. We are willing to travel 10 hours to come here to receive a bundled price that we knew was—exactly what the cost was going to be." There is no balance billing or a la carte billing outside of that. So, it has been super encouraging.

Chairman SMITH. Mr. Kampine, as we look at the price transparency rules for hospitals and health insurers, we need to ensure that the public data is actually usable for patients. Given your experience running Healthcare Bluebook, what are the current rules limitations, and how can we enhance the usability of pricing information for the individual patient?

Mr. KAMPINE. Sure. I will start on the hospital side first.

First of all, we need compliance, right? Second is the files. When you have seen one, you have seen one. So, we need some standardization in terms of the values that are in those files.

On the hospital side, it is 300 services. You know, reasonable coverage, only 70 of which, if I am remembering correctly, are standardized and required. And you are looking, in most instances, at the facility piece of the charge, right? So, we don't know what the anesthesia is necessarily, or the doctor, if the doctor is not affiliated with the hospital.

So, it is really helpful, right, when we think about consumers and how we present prices. It is in the context of an encounter. Everything you need to know about the cost of that service for the day that you go in. This is what is so great about the surgery center and the bundled pricing; you know, these things.

Secondly, so much care—care is moving into the outpatient environment. Generally speaking, right, the hospital outpatient department is the most costly alternative in terms of site of care for something like an ACL repair. So today you only look and can compare, let's say, for example, across the lowest cost among the most expensive provider type. So, you really need to have all of that information.

What do the independent ASEs charge? What is their price? What is the total price with everything combined? How do you compare that with the hospital? So, I think those are some of the ways that one can improve that data and make it more usable. Of course, that is our job, right, at Bluebook, is to do things like that. But those are some of the gaps.

We are a little bit earlier, right, on these carrier files. As Chris had alluded, these are enormous files. We will get better at it. We like these problems, but we already know that the data—the file formats, again, when you have seen one, you have seen one. So, it takes a ton of time to load them, clean them. There are what we generally refer to as zombie codes in this, where every provider is given a price, despite the fact that those providers may not actually perform that service. That is not helpful to anybody.

And importantly, there needs to be some sort of check. We sit in sort of a unique position, in that we are a large aggregator of claims data. Adjudicated medical claims data think of as an itemized receipt. You know what was actually paid, according to that contract on those services, and you can compare it to what is being reported in the rate files.

The rate files are just the contract files. Remember, rates have to be run through an adjudication system before you know what the receipt looks like.

Again, early stages there, but I think we will probably get better and better at aligning those two.

Chairman SMITH. Thank you. I now recognize the ranking member, Mr. Neal, for any questions.

Mr. NEAL. Thank you, Mr. Chairman. I want to thank our witnesses again, and to remind all that Democrats have pushed for health care improvements from the bottom up, focusing on those who need the greatest supports, working to fill the coverage gap, making marketplace coverage more affordable, and lowering drug costs.

We want the other side to help in these achievements, and to continue to look at consumer-focused gains that Democrats have achieved, and their health platform appears to be all the time on the other side for the healthy and, often times, for the wealthy. Consumer shopping and tax cuts for the well-off through health savings accounts alone won't do it.

Dr. Gilfillan, we have heard from a number of our colleagues that price transparency and consumer shopping is the cure-all for the nation's health care challenges. This approach is unlikely to yield large price reductions for consumers and seems to have a significant downside for those very consumers, forcing them to shoulder more responsibility as they shop for better health care services. Aren't these proposals more of the same, leaving consumers unprotected, sticking them with high bills, and then, of course, more tax cuts for the well-off through HSAs?

Dr. Gilfillan, one of my concerns with that notion has been that HSAs are going to revolutionize health care when most consumers don't have enough money in their bank accounts to contribute to one. And the average value of the HSAs really doesn't pay for all that much. We know that unpaid medical bills are one of the larg-

est sources of consumer debt. Doesn't this approach just risk shop—shifting more costs onto consumers?

Dr. Gilfillan, from your perspective, having worked with providers and insurers, it is important that we hear your contribution this morning.

I want to acknowledge something, as well, in the Trinity health care system. They have been a long-time friend and champion of the Sisters of Providence. Long before the law required that people be cared for at the entrance of a doctor or a hospital, the Sisters of Providence knew that mission statement. They were running health care systems. They were running school systems across America, and our lives are much improved because of what they did. They, as you know, administer Mercy Health Care System, which is part of the Trinity Health Care family, and they have always played a critical role in making sure that the poor were treated, and that disadvantaged patients would not be those who were left only to profitable institutions for the decision as to whether or not they would get health care.

So, I ask you, as you have done in your testimony, to discuss some of the proposals that we are hearing today that might well exacerbate inequities that are already present in our health care system. I think that many of these proposals could worsen the delivery of health care, tilting again in favor of those who are indeed healthy and wealthy. So let me give you some time to talk about those issues.

Dr. GILFILLAN. Thank you, Ranking Member Neal, and I share your admiration for the Sisters of Providence and the many congregations that formed health care systems in needy communities across America and other voluntary organizations who have done that and have been the backbone of the health care system in America.

And I note one of the major aspects of the financialization of health care in America has been the fragmenting of care, the cherry-picking of care, the creating organizations, services, both financial and delivery, intended to profit from taking those segments where there is the most money, the most opportunity to make more money, and then taking that, taking those profits, and paying them out as dividends to shareholders or stock repurchases to increase executive compensation, taking money out of the health care system, while non-profits continually reinvest in health care.

So, I think that is central, and I think the specific stories we hear frequently are actually telling anecdotal stories about small instances of shopping behavior. Large-based studies have shown HSAs do not increase shopping activity. Large studies have shown that deducts deductibles, cost sharing led to people avoiding both needed care and perhaps unnecessary care, both. That is where cost savings come from.

Once again, we are trying to solve the problems of a commercialized, financialized health care system on the backs of people who can least afford it.

Mr. NEAL. Thank you, and I want to wish a special shout-out today to Sister Mary Caritas, who, at 100 years old, is still helping to run Mercy Health Care System, and also former president of the Sisters of Providence. Thank you.

Dr. GILFILLAN. Indeed, and a noting of her remarkable constituency, but also the great health care that actually has gotten so much better in America over these past 40 years. We just need to create a health care financing administrative system that allows our great professionals to be their very best.

Mr. NEAL. Thank you.

Thank you, Mr. Chairman.

Chairman SMITH. Thank you, Mr. Neal. Mr. Buchanan is recognized.

Mr. BUCHANAN. Thank you, Mr. Chairman, and I want to thank all of our witnesses.

The reality is this year health care will be about $4.3 trillion. When you look down the road, Medicare is going broke in a matter of three or four or five, six years. So, what we have got is not working. As somebody that has been in business 30 years before I got here, we paid for all our employees the first 20 years, no deductibles, nothing. What has happened in the last 10 years has gone—the train has gone off the track.

I mean, there is a very high percentage that is getting pushed now, not just to higher premiums to the company, but to the employees. So, I am talking about start-up companies, small businesses, medium-sized businesses. It is a big number, and a lot of them can't even afford the insurance. But I can tell you, in the real world the companies used to pay it all, but now maybe they are paying 7 or 800, and the family of 4 is paying another 6, $700 out of pocket. And these are a lot of blue-collar workers. So that is the reality. That is where we are at.

So, the idea to think that we could just keep doing the same is insane. We need to find a way. This is one way, is transparency and competition. It works everywhere else. It needs to work here. It needs to be somewhat applicable, because a lot of these companies are paying 20 percent average a year for the last 5 to 10 years, and that is the reality in Florida.

Ms. Troiano, what are you—just out of curiosity, in terms of your employees, what percentage do you pay? What gets passed to them, or do you pay at all?

Ms. TROIANO. We do pay. The company pays the majority. We pay about 86 percent of the premium, and the rest of it—that is on average. We keep our single coverage at $153 for our employees to make it affordable for——

Mr. BUCHANAN. What about a family, if they have got a family of four?

Ms. TROIANO. Family coverage has gone from a—prior to 2012 it was 30—it was $50 a month. It is $450 a month, a——

Mr. BUCHANAN. So, what is——

Ms. TROIANO [continuing]. Family.

Mr. BUCHANAN. What does the employee pay?

Ms. TROIANO. The employee pays 450.

Mr. BUCHANAN. Okay, so that is my point.

Ms. TROIANO. Yes.

Mr. BUCHANAN. That is something that doesn't get talked about. But they shouldn't be paying anything or, ideally—or a minimal amount. And $450 a month when you are living paycheck

to paycheck, that is the harsh reality. And you have got 100 employees. It is not like you have got 10.

Ms. TROIANO. Correct.

Mr. BUCHANAN. So—and by the way, you got a tough job as HR. It is not the easiest job.

Mr. Piniecki, I want—talk a little bit more about—you mentioned about the percentage was 35 percent or—what was the percentage you were talking about, what you are seeing? A 70 percent reduction or increase or something. You threw a big number out there. I am very excited about better understanding what you are doing, and how you are doing it, because I think some level of competition is—does make a difference in transparency.

I know personally people that shop, take their time, buy a house, buy a car, all the things we are talking about, they are going to get much more of a better deal, ideally, not—this doesn't work for everybody, but it will work for a lot of folks. Without competition, you—it is a monopoly. So, let's call it what it is.

So, what is your thoughts on what you are seeing for small and medium businesses? What is the reality that you are finding?

How much are the employees paying? How much are the employers paying? And what is that increase over the last 5 or 10 years?

Dr. PINIECKI. Yes, that is—everything I have heard so far from the last couple testimonies is spot on. And what you mentioned is also correct.

In the State of Indiana, once you reach about 100 employees, it becomes cost advantageous to be self-funded, self-insured. So then individual companies, you know, greater than about 100 employees, are paying the cost of those claims. And so, it is not just, you know, a small percentage of businesses. In Indiana it is about 70 percent of those businesses are basically footing the bill, in addition to the premiums that are being paid——

Mr. BUCHANAN. So——

Dr. PINIECKI [continuing]. By the employees.

Mr. BUCHANAN. So, what is the employees paying? Because that is—to me, there is 100 million employees out there that are having to chip in a lot more than they ever imagined before. And that is why they are living paycheck to paycheck.

Dr. PINIECKI. What I have seen is at least 25 percent, with the employers being roughly 75 percent. But in certain circumstances, it is even more than that.

Mr. BUCHANAN. And then what are you just seeing in terms of reduction with what you are doing? Take a minute to talk a little bit more about competition and transparency, the difference it is making in premiums.

Dr. PINIECKI. When we were building the prices for the delivery of care based upon the CPT codes—like if you need your gallbladder taken out, there is a CPT code associated with that—we knew what Medicare was paying for that, and we had some commercial insurance data. And so, the question was could we actually save significant amounts?

You know, and honestly, I thought maybe we could find 10, 15 percent savings. That number that I mentioned earlier, that 50 percent savings, the payout from a commercial insurer for, you know, a lap coli, which is a gallbladder removal, in our state is

somewhere around $20,000 after negotiated discounts. We are doing——

Mr. BUCHANAN. So, across the board, 50 percent or something?

Dr. PINIECKI. We are doing it for nine.

Mr. BUCHANAN. Do you have any interest in coming to Florida——

Dr. PINIECKI. So probably about——

Mr. BUCHANAN [continuing]. To set up business down there?

I yield back. Thank you.

Chairman SMITH. Mr. Doggett is recognized.

Mr. DOGGETT. Thank you, Mr. Chairman, and thanks to our witnesses.

As a long-term advocate myself for greater openness, for greater transparency, I certainly support having better and more extensive data concerning health care prices. Comparative price data can be helpful to us as policy-makers and can help identify inefficiencies in cost and quality. What transparency cannot do is to fix our broken health care system that is riddled with anti-competitive behaviors, increasing consolidation, and government-approved monopolies.

It is not like shopping for a car or a television. There is very little competition among health care services, and monopolies drive up prices. Even if a consumer has complete pricing information, understands every option, and has time to shop for the best deal, health care prices are still astronomical in a broken market.

And unlike shopping for a television, health care is often an emergency item, an accident, a heart attack. There is not a chance to do much shopping, nor is the lowest price the biggest consideration at that dangerous point in someone's life.

For more than a decade, the Republicans have had as their principal health care goal repealing Obamacare and replacing it with nothing care. Now they claim that, if we have enough price information and we have these health savings accounts, we have a panacea. Well, I don't believe that that is true.

I think that health savings accounts, not unlike the junk insurance plans they have also promoted, have some serious limitations and are often very skimpy. For example, there is data that shows that the majority of U.S. households have less than $3,000 in their checking and savings accounts. But the average deductible for an HSA qualified plan is about $2,500. So, for many families who have an HSA, an emergency can still wipe out a family's savings.

And I think it is rather misleading to talk about 78 percent of families, people and families being covered by HSAs, because the data that is really significant is how many people have money within an HSA. And if you look at the 2020 data, there are only 2 million people in America who claimed a deduction for a contribution to an HSA. It may just simply mean that that 78 percent have employers that offer them little else than a high deductible plan.

Having an account doesn't mean you have much or any money in it or even a dime in it. In fact, the truth about HSAs is that they are a boon for those at the top of the economic ladder. Only 5 percent of Americans earning less than $100,000 actually had money in an HSA.

Under the guise of affordability, HSAs are really a triple tax advantage for the wealthy. They provide tax deductible contributions, earnings are tax deductible, and withdrawals are also not taxed. It is a great contrast with the flexible savings accounts that many people rely on, where you are called upon to guess how much your health expenditures will be the next year, and if you guess too high you lose those dollars. No, in this case, this is a lucrative tax shelter that grows year by year.

We need to recognize that health savings accounts are an expenditure to the people of America. They are a tax expenditure that is as real as if we went down and asked the Appropriations Committee to approve the almost $200 billion that will be spent over the next 10 years on health savings accounts, even if there are no changes made in them. Republicans are really big spenders when it comes to these tax loopholes, and that is what we have here.

I think, Dr. Gilfillan, one comment I would ask you about is your reference to Medicare Advantage. How much is the overpaying for Medicare Advantage denying us an opportunity to improve Medicare and other health care programs?

Dr. GILFILLAN. Thank you for that question, Congressman Doggett. This year estimates are between 25 and $50 million in—$1 billion——

Mr. DOGGETT. A billion.

Dr. GILFILLAN [continuing]. In over-payments to MA plans. That is projected to total almost $600 billion, just from the risk score gaming we know they do to make their populations look sicker over the next 8 years, and all subsidies combined look like about $1 trillion in subsidization over the next 8 years. That is more than enough to address the issues of housing insecurity and food insecurity that we know contributes significantly to discrepancies and inequities in life expectancy in America.

Mr. DOGGETT. Thank you very much.

Mr. Chairman, I would ask unanimous consent to include in the record a report from the Center on Budget regarding health savings accounts and their limitations.

Chairman SMITH. Without objection.

[The information follows:]

Center on Budget and Policy Priorities

Expanding Health Savings Accounts Would Boost Tax Shelters, Not Access to Care

MAY 2, 2023 | BY GIDEON LUKENS

Proposals to expand Health Savings Accounts (HSAs) often purport to help more people afford health coverage and health care, and proposed legislation in Congress would loosen restrictions on HSA contributions, withdrawals, and eligibility.[1] In reality, HSAs overwhelmingly benefit high-income people and exacerbate racial and ethnic inequities. The accounts often serve as lucrative tax shelters for people with high incomes while doing little to expand coverage and affordability. Meanwhile, HSAs already come at a steep cost to the federal government — estimated at $13 billion in 2022 and nearly $180 billion over the next ten years.[2]

Instead of expanding HSAs, which primarily benefit high-income people who already have health coverage, policymakers should target federal resources toward people who are uninsured, particularly those who have low incomes — for example, by closing the Medicaid "coverage gap" in states that have refused to expand Medicaid under the Affordable Care Act (ACA). Policymakers should also pursue policies to increase affordability, including permanently extending enhanced premium tax credits that help people afford ACA marketplace plans. Closing the coverage gap and making enhanced premium tax credits permanent would increase coverage and affordability for people with low and moderate incomes while also improving health equity.

Roughly 1 in 6 Privately Insured Adults Have HSAs

Under current law, people can set up an HSA if they enroll in a high-deductible health plan (HDHP) that meets certain standards. For 2023, this includes having an annual deductible of at least $1,500 for individuals and $3,000 for families, with a limit on out-of-pocket costs of no more than $7,500 for an individual and $15,000 for a family.[3] In 2021, 37 percent of all privately insured adults aged 18 through 64 were enrolled in HDHPs, and slightly under half of those in HDHPs had HSAs. Nearly all of the private plans that are HDHPs with HSAs are employment-based plans, with a very small fraction being directly purchased on the individual market.[4] Both individual account holders and employers are permitted to contribute to accounts for employment-based plans, but not everyone who holds an HSA makes contributions or receives employer contributions on their behalf.

HSAs Provide a Lucrative Tax Shelter for High-Income People

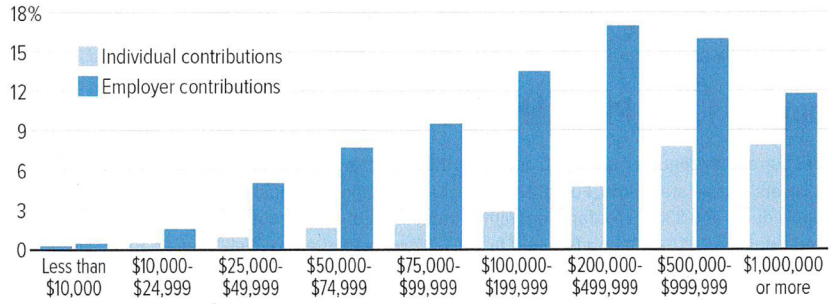
Unsurprisingly, data show that HSAs overwhelmingly benefit and are more prevalent among high-income people. A Congressional Research Service analysis of 2017 IRS data found that tax returns exceeding $500,000 in adjusted gross income were the most likely to report individual HSA contributions, and returns between $200,000 and $1 million were the most likely to report employer HSA contributions.[5] (See Figure 1.) The prevalence of HSA contributions declined as income declined, and only a small percentage of low-income tax returns showed contributions.

HSAs offer substantial tax advantages for people with high incomes. Contributions are not taxed: individual contributions are tax deductible, while employer contributions are excluded from taxable income. Additionally, contributions can be invested in stocks and bonds, accruing earnings that are tax-free, and withdrawals are also not taxable if they are used for medical expenses deemed "qualified" under federal tax rules. Because of this unique "triple tax advantage" and the fact that HSA assets can be rolled over from year to year, financial advisors widely promote HSAs as investment vehicles.[6] After years of rapid growth, total HSA assets surpassed $100 billion in January 2022, with HSA investment assets (e.g., stocks, bonds) a large and fast-growing share, according to a survey of the industry.[7]

FIGURE 1

HSA Contributions Far More Prevalent Among People With High Incomes

Percentage of tax returns reporting Health Savings Account (HSA) contributions



Note: Income is measured as adjusted gross income.

Source: Congressional Research Service analysis of Internal Revenue Service data for tax year 2017

For investors with high incomes, HSAs provide an attractive tax shelter for retirement, especially for people who have reached the contribution limit for their 401(k)[8] and other investments.[9] In 2023, the maximum annual contribution limits for HSAs are $3,850 and $7,750 for individuals and families, respectively, with an additional $1,000 available for people aged 55 and older.[10] With no income limits on who can hold HSAs, individuals with enough money can max out and roll over their HSA contributions year after year, then withdraw them tax-free in retirement to pay for their own or their family's health care expenses — and even reimburse themselves for medical expenses incurred years in the past.[11] After a person reaches age 65, HSA funds can also be used for non-medical expenses with no penalty, though withdrawals for non-medical expenses are subject to income taxes, similar to 401(k) and individual retirement account (IRA) withdrawals.

The fact that HSA contributions can be invested, accumulating tax-free earnings that compound over time, differentiates them from employer-based insurance premiums or flexible savings accounts, which are excluded from taxable income but cannot carry over from year to year. HSAs also are advantageous relative to 401(k) plans and other retirement vehicles in that both contributions and earnings are *never* taxed as long as they are used for qualified medical expenses.

Savings in retirement accounts are already heavily skewed toward people with higher earnings, and ownership rates for retirement accounts are far lower for Black and Latino people than for white people.[12] HSAs only widen these disparities, as discussed below.

HSAs Offer Little Benefit to People With Low and Moderate Incomes, Contribute to Inequities

HSAs are not a viable option for people who are uninsured and can't afford coverage, and people with low and moderate incomes benefit little from HSAs compared to high-income people. Those with low and moderate incomes are less likely to be able to afford to contribute, and these accounts are not helpful for people who can't afford to save, must use any available income for upfront medical costs, or are struggling with medical debt.

In 2022, roughly 68 percent of adults aged 19 through 64 with incomes under 200 percent of the federal poverty level (about $55,000 for a family of four) would not have been able to pay a $1,000 medical bill within 30 days.[13] In 2018, the majority of households had less than $3,000 in their checking and savings accounts and reported they had less than they needed for emergencies. The median household with an income of $20,000 or less had under $100 in their checking and savings accounts.[14] Almost half of uninsured adults aged 19 through 64 had difficulty paying or were unable to pay medical bills in the past year, and 80 percent reported financial problems resulting from medical debt in the past two years, such as an inability to pay for basic necessities.[15]

Additionally, people with low and moderate incomes receive a far smaller benefit than high-income people for each dollar contributed to HSAs because they are in lower marginal income tax brackets, and this lowers the value of the deduction and the tax-free earnings. For example, a large majority of uninsured people fall in the 12 percent or lower income tax bracket.[16] Were they to enroll in HSA-

qualified plans, their ability to deduct HSA contributions would provide them with an income tax deduction of between 0 and 12 cents on the dollar. Likewise, a married couple filing jointly and earning $80,000 — slightly more than the median household income — would fall in the 12 percent tax bracket and deduct 12 cents on the dollar for their HSA contributions.[17] In comparison, a married couple filing jointly and earning $700,000 per year would fall in the 37 percent bracket, saving 37 cents for each dollar put into an HSA.[18]

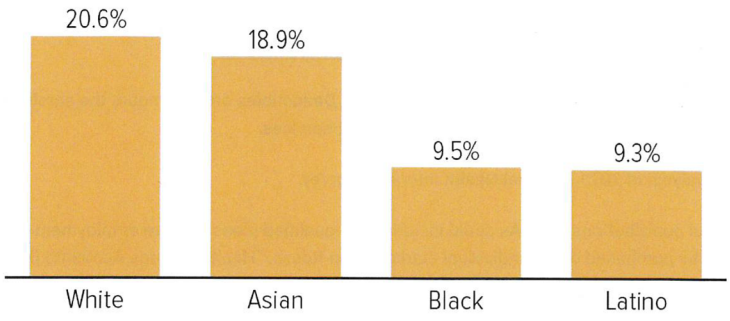
The benefits of HSAs are even more skewed toward high-income people when one considers not only the prevalence of HSA contributions, but also the dollar amount of contributions. Many workers enroll in HSA-qualified HDHPs not because they plan to accumulate savings, but because there are no other health plans available through their employers. Likewise, many employers who offer HSA-qualified HDHPs contribute little or nothing to their employees' HSAs.[19] A study of 2012 IRS data found that tax filers in the highest income quintile were far more likely to report contributions than lower income quintiles; they also reported higher levels of contributions and were much more likely to maximize contributions and take full advantage of the tax benefits.[20]

Moreover, survey data show that HSAs are distributed highly unequally across race and ethnicity. Among people with private health coverage, Latino and Black people are about half as likely to have HSAs than are white and Asian people (the data do not indicate whether or how much HSA holders are contributing). (See Figure 2.) Against a backdrop of long-standing racial disparities in wealth — a typical white family in 2019 had eight times the wealth of a typical Black family and five times the wealth of a typical Latino family — HSAs provide preferential tax treatment that is disproportionately out of reach for people of color.[21]

FIGURE 2

Black, Latino People Much Less Likely to Have HSAs

Percentage of privately insured adults aged 18-64 enrolled in a Health Savings Account (HSA) in 2021



Source: CBPP analysis of 2021 National Health Interview Survey

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Billions Spent on HSAs Could Be Used to Increase Coverage and Affordability

HSAs are not only highly inequitable, but also come at a steep cost. As noted above, HSAs are already projected to cost the federal government nearly $180 billion from 2023 to 2032. That amount is close to the ten-year cost in the President's fiscal year 2024 budget for permanently closing the Medicaid coverage gap ($200 billion) or permanently extending enhanced premium tax credits for ACA marketplace coverage ($183 billion), two policies that would each provide coverage to millions of uninsured people.[22]

Proposals to expand HSAs would only add to their costs. Instead of pursuing tax policies that primarily benefit high-income people while doing little to help the uninsured and people with low and moderate incomes, policymakers should focus on expanding health coverage, improving affordability, and increasing access to care.

End Notes

[1] For example, H.R. 107 would no longer require an HSA to be paired with a high-deductible health plan and would increase the annual contribution limits: https://www.congress.gov/bill/118th-congress/house-bill/107. Another bill would allow gym memberships and fitness equipment to qualify as HSA expenses: https://www.congress.gov/bill/118th-congress/senate-bill/786.

[2] U.S. Treasury Department, fiscal year 2024 tax expenditures estimates, https://home.treasury.gov/policy-issues/tax-policy/tax-expenditures.

[3] IRS, https://www.irs.gov/pub/irs-drop/rp-22-24.pdf. Deductibles are an amount the enrollee must pay on their own before the plan begins covering most services.

[4] CBPP analysis of 2021 National Health Interview Survey.

[5] Individual contributions to HSAs could include HSA-qualified plans that are employment-based or plans directly purchased on the individual market. Ryan Rosso, "Health Savings Accounts (HSAs)," Congressional Research Service, August 8, 2022, https://crsreports.congress.gov/product/pdf/R/R45277.

[6] Ramsey Solutions, "How to Make the Most of Your HSA Investment," December 15, 2022, https://www.ramseysolutions.com/insurance/hsa-investment.

[7] Devenir, "HSA Assets Hit $100 Billion Milestone," March 23, 2022, https://www.devenir.com/hsa-assets-hit-100-billion-milestone.

[8] The contribution limit for 401(k) plans in 2023 is $22,500, and people aged 50 and older can contribute an additional $7,500 in catch-up contributions. Over 5.1 million people (roughly 3 percent of the workforce) maximized their elective retirement contributions in 2018. See https://www.irs.gov/newsroom/401k-limit-increases-to-22500-for-2023-ira-limit-rises-to-6500 and IRS W-2 Tabulations Table 2.G: https://www.irs.gov/statistics/soi-tax-stats-individual-information-return-form-w2-statistics.

[9] Ryan Ermey, "This savings account offers a 'triple tax benefit' — but 88% of users are missing out," CNBC, February 9, 2023, https://www.cnbc.com/2023/02/09/health-savings-accounts-how-to-save-for-retirement.html.

[10] IRS, https://www.irs.gov/pub/irs-drop/rp-22-24.pdf.

[11] HSAs cannot be used to pay for expenses incurred before the HSA was established.

[12] Maria Hoffman, Mark Klee, and Briana Sullivan, "New Data Reveal Inequality in Retirement Account Ownership," U.S. Census Bureau, August 31, 2022, https://www.census.gov/library/stories/2022/08/who-has-retirement-accounts.html; U.S. Government Accountability Office, "Income and Wealth Disparities Continue through Old Age," August 2019, https://www.gao.gov/assets/gao-19-587.pdf.

[13] Sara Collins, Lauren Haynes, and Relebohile Masitha, "The State of U.S. Health Insurance in 2022: Findings from the Commonwealth Fund Biennial Health Insurance Survey," Commonwealth Fund, September 29, 2022, https://www.commonwealthfund.org/publications/issue-briefs/2022/sep/state-us-health-insurance-2022-biennial-survey.

[14] Caroline Ratcliffe *et al.*, "Perceived Financial Preparedness, Saving Habits, and Financial Security," Consumer Financial Protection Bureau, September 2020, https://files.consumerfinance.gov/f/documents/cfpb_perceived-financial-preparedness-saving-habits-and-financial-security_2020-09.pdf.

[15] Collins, Haynes, and Masitha, *op cit.*

[16] CBPP analysis of 2021 American Community Survey.

[17] Median household income was about $71,000 in 2021. Jessica Semega and Melissa Kollar, "Income in the United States: 2021," U.S. Census Bureau, September 13, 2022, https://www.census.gov/library/publications/2022/demo/p60-276.html.

[18] IRS, "IRS provides tax inflation adjustments for tax year 2023," October 18, 2022, https://www.irs.gov/newsroom/irs-provides-tax-inflation-adjustments-for-tax-year-2023.

[19] KFF, "2022 Employer Health Benefits Survey," October 27, 2022, https://www.kff.org/health-costs/report/2022-employer-health-benefits-survey/.

[20] Lorens Helmchen *et al.*, "Health Savings Accounts: Growth Concentrated Among High-Income Households and Large Employers," *Health Affairs*, September 2015, https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2015.0480.

[21] Neil Bhutta *et al.*, "Disparities in Wealth by Race and Ethnicity in the 2019 Survey of Consumer Finances," Board of Governors of the Federal Reserve System, September 28, 2020, https://www.federalreserve.gov/econres/notes/feds-notes/disparities-in-wealth-by-race-and-ethnicity-in-the-2019-survey-of-consumer-finances-20200928.html.

[22] See https://www.whitehouse.gov/omb/budget/. Similarly, in an earlier estimate, the Congressional Budget Office projected that permanently closing the Medicaid coverage gap by extending ACA marketplace subsidies would cost $180 billion from 2022 to 2031: https://www.cbo.gov/system/files/2021-12/57673-BBBA-GrahamSmith-Letter.pdf.

PDF of this report (6 pp.)

MORE ON THIS TOPIC

PRIMER

What Is a Health Savings Account?

APRIL 3, 2023

Chairman SMITH. Mr. Smith, you are recognized.

Mr. SMITH of Nebraska. Thank you, Mr. Chairman. Thank you to our witnesses.

I am—hearing the comments moments ago, I am tempted to spend my time countering so many of those things. Let me just say that I hope that we can work together to empower patients, empower patients to make the decisions, whether it is on a procedure or whether it is on the financing that we can acknowledge that way too often patients do not have the opportunity to make decisions for themselves. And I don't think it should be that the government should make decisions for them. There is lots of evidence that that hasn't worked.

But I do believe that today's hearing is an opportunity. Certainly, it reminds me, as was discussed earlier about the work, the bipartisan work that we did on medical billing, surprise medical billing, and I believe that the price transparency rules aim to address a similar underlying problem, and that is consumers face too much uncertainty and lack information about the cost of their care.

Just like with surprise billing, our goal should be helping patients avoid unnecessary, unexpected costs. The ability to compare and factor costs into decision-making can also help patients be better informed health care consumers. In order for our health care system to be as efficient as possible, and for our constituents to stretch their health care dollars—their health care dollars—people need access to accurate, accessible information to make logical direct-cost comparisons when shopping for care.

There are many upsides to providing patients the ability to shop for the care that best meets their needs. Providing a clear explanation of their liability gives people the knowledge and power to save in advance or better budget for a procedure they know they will need. This knowledge, along with planning and increased flexibility, can help people avoid large and problematic medical bills.

Part of this planning and increase flexibility should include more discussion around whether or not to choose a health care plan that includes an HSA, and examining how we on this committee can empower patients with tools to make those HSA dollars go further. As you know, HSAs allow beneficiaries to save tax advantaged contributions for further health care needs. I have worked to increase the flexibility and value of HSAs for years.

For example, earlier this Congress, I reintroduced the Home Care for Seniors Act. This would allow HSA reimbursement for qualified home care expenses. I was also pleased to introduce legislation with Congresswoman Steel, the Telehealth Expansion Act, which would permanently allow for first-dollar coverage of telehealth in the high-deductible health plans which legally must be paired with an HSA.

Mr. Short, in addition to the two pieces of legislation I just mentioned, would you say there are any actions Congress should take to help patients more effectively utilize HSAs and become more empowered health care consumers?

Mr. SHORT. Absolutely. Any way that we can allow for HSA dollars to pay for more direct payment options like direct primary care is paramount in terms of addressing this inefficient payment process that we are now faced.

We have a constant confusion when it comes to health insurance and health care. Health insurance is not health care, and so it does not matter which grouping provides the catastrophic insurance. If we don't address the underlying payment issue, we are not going to solve the problem. So, coupling that with price transparency, and allowing for direct payment options, and removing these constraints on HSA tied to high-deductible health plans will open that up and expand HSAs and health care for everybody.

Mr. SMITH of Nebraska. Thank you. I think it is really important that we focus on policies, as has been mentioned, as you mentioned, that actually bend the cost curve. And more consumer involvement, more consumerism is the best way to do that. And I think that, you know, disregarding realities in Medicare Advantage and other very directly consumer-oriented decisions, dismissing those realities is not doing the general public a service. I am very concerned about that, moving forward.

And we need to do things and pursue policies that, like I said, bend that cost curve, rather than just shifting around who pays for what. You know, the high deductible in the individual market now isn't as offensive as apparently it was for, say, the high-risk pool before Obamacare. So, I hope that we can pursue bipartisan solutions here.

You know, I represent a great number of critical access hospitals which reflect the needs of the community. I appreciate the opportunity to engage with them, to hear their concerns, and, you know, empower them to help their patients, as well.

So, again, I appreciate this opportunity. It is timely. It is important. And I hope that we can work together—work together—to empower patients across America.

Thank you, I yield back.

Chairman SMITH. Mr. Thompson is recognized.

Mr. THOMPSON. Thank you, Mr. Chairman, and thank you to the witnesses for being here today.

I am all for transparency, and I think it should include clarity in billing, as well. It is incredibly unfair that, when it comes to health care and perhaps only health care, Americans almost never know what something costs before we buy it, or how to figure out the bill after we have received the services.

Health care is not like buying a car or a refrigerator or a bicycle. If you need health care and you need it urgently, you don't go shopping or log on to Amazon. You go to the nearest hospital. If you need a transplant, you can't decide to wait a few months to see if kidney prices come down. If you are injured in an auto accident, you are transported to a hospital, not to your house so you can go online to shop for the best deal or the cheapest deal for broken bones.

So, I appreciate the chairman holding this hearing, and I hope it is a prelude to bipartisan efforts that will bring costs down.

As mentioned, so far all we have heard are years and years and years of bemoaning the Affordable Care Act and trying to discredit that. We should be and we should have been working together to deal with the underlying issue.

Dr. Gilfillan, I would like to ask about the enormous administrative superstructure you talked about, and the let-people-shop-

around approach some of the witnesses have mentioned today. I am all for empowering patients, but I am concerned that everyday folks will have a tough time navigating what we all agree is an absurdly complicated administrative financial system. Can you talk a little bit more about that?

And do we have evidence that consumers are really shopping around?

Dr. GILFILLAN. Certainly, Representative Thompson. The superstructure I mentioned has grown over the last 40 years after managed care was introduced, and through several iterations, changes. We have seen it actually grow to the point of between hospitals, physicians, and insurance companies, it is probably consuming somewhere around 25 percent of the total we spend for health care. And it is making health care harder to get, and it is distorting the actual delivery of care.

In my mind, the way to deal with the cost problem is to get at the root cause of that. And I believe one of the root causes is actually the employer-sponsored health insurance marketplace.

HR departments want everybody in their network, and when you do that, you create the reality of must-have providers, providers you have to have offered if you are giving—offering an insurance plan. Those must-have providers have the ability to just about dictate price to insurers. That is what leads to the high costs—and they are real—that we see in health care. What——

Mr. THOMPSON. Thank you, Doctor. But I want to make sure we have time because I have another question. I want to talk about hospital reimbursements.

You pointed out the huge range of profit margins in the world of hospitals. I am concerned in particular that, while some hospitals may cherry-pick profitable parts of the market, other hospitals, particularly rural hospitals, are constantly fighting just to stay open. Can you talk about the impact an across-the-board hospital payment cut would have? Are all hospitals in the same situation?

Dr. GILFILLAN. No, they are very different, as you point out. And of course, critical access in rural hospitals and safety net institutions are in the most precarious positions. They receive most of their funding through Medicare and Medicaid. The rates are lower. They have no market power, frequently, to negotiate high prices on the commercial side. And as a result, they are constantly on the edge of financial ruin.

I believe that we need to move to a different way to reimburse hospitals, that we should have common pricing as we do for Medicare, as we do for Medicaid, as is used by Medicare Advantage plans, administrative pricing that is set reasonably, that enables all hospitals in all communities serving all populations to receive adequate reimbursement and be successful.

Mr. THOMPSON. And how can we help consumers navigate this very confusing billing system that we have to deal with whenever we receive services from a hospital?

Dr. GILFILLAN. I believe we have—approaches like bundle payment, where indeed you put all the costs together, are helpful. But at the end of the day, I believe fundamental change in the way we reimburse hospitals and the elimination, frankly, of front-end

deductibles and high-cost sharing for patients is the way to make patients—give patients the opportunity to be thinking about what they need to do for their health, not what they need to do to avoid bankruptcy.

Mr. THOMPSON. Thank you very much. I yield back.

Chairman SMITH. Mr. Kelly is recognized.

Mr. KELLY. Thank you, Mr. Chairman, and thank you all for being here.

Every time we have one of these get-togethers, I am so thankful that you take a day out of your life to come and talk to us. And we give you five minutes to tell your whole life story, and then we tell you what our stump speech is when it comes to these things.

Ms. Troiano, so I am an automobile dealer. One of the things we do, because we believe our team is so valuable, is to provide health care and pension plans for them. Now, people say, "You only do that for your own good."

I say, "Yes, you know what? When they are working and they are productive, they are profitable. When they are not, if they are hurt or sick, they are not. It is just a simple business plan."

And I know that we like to confuse what we are doing. I don't know how in the hell an outfit that is $33 trillion in the red can tell you guys how to run health care. It is just amazing to me.

But we sit here, and we babble about—I have 52 people of our team, we are paying almost $600,000 a year for that health care coverage. Now, where does that cost go? It goes on the cost of every product we sell, every service we sell. We are in a very competitive business. And you know what it is like. Talent is so hard to find today. Keeping talent healthy is so expensive today.

So, I listened to everything that you have all said. And honestly, I don't know if anybody has the right answer. This isn't a Republican versus Democrat, Democrat versus Republican, where we don't care about people getting sick or ill or dying. That is crazy. That is political speech. That has nothing to do with the health of this country.

So, I thank you all for being here, but I got to tell you this is mesmerizing to me because I actually pay for this stuff every month.

I just recently had a medical incident. I have no idea what the cost of it was, by the way. Now, I wasn't in a position to bargain with anybody. So that is—you know, I am in the automobile business, and usually people come into our store. They say, "We are going to six different stores. Tell me what the best price is on this half-ton pickup. And if you are the lowest price, I will come back and get it from you." I don't think you can do that if you have some kind of a trauma experience, and you are not able to go out and compare pricing.

So, I don't really know what the answer is. I know it is a good topic for us to talk about. Do any of you have any idea of how we could solve this problem?

I don't want to attack HSAs, by the way, okay? Let's just leave that out.

Tell me what we could do. And I know you—listen, we are down to two-and-a-half minutes, and that is because I have been running at the mouth. Just, if you can, if you can weigh in, if you could

wake up tomorrow to a health care plan that made sense, what would it be?

Ms. Troiano, why don't you start? Because I know you go through this every day.

Ms. TROIANO. I do go through it every day, and I appreciate the question.

The fact of the matter is transparency would help. It would help tremendously, because we are teaching and training our employees to go out and look for health care, look for the best health care they can get, and look at the prices.

If I want to say what health care should be, it should be like it was 45 years ago, when I had my son. When I went to the doctor, I paid my doctor $25 a visit, or $20 a visit, and I had major medical coverage. So, when I went into the hospital and had him, and it was $263 for 5 days and a blood transfusion—I have still got the bill—it was covered by my medical insurance. Other than that, lab work was a few bucks here and there. I covered that. I paid for that out of pocket.

Then HMOs came along, and everybody felt that they should only have to pay $10 to go to the doctor. And it doesn't work that way. And now we are into high-deductible plans.

What we have found through Sidecar Health is that they are able to go in, and they are able to find the doctors, they find the prices, and our employees are able to shop for that care. And then they come in and they may talk to me about it. They may talk to the owner of the company about it.

But protecting the employees and protecting their wallets is so important nowadays, because everything costs so much.

Mr. KELLY. Yes, listen, we are going to run out of time, but I am just going to share one story with you because I know you have been through the same thing.

So, a new person comes on board, new hire, and you said, "Hey, listen, these are the benefits that we offer. We have health care, and we have a pension. We would like to see you sign up for our health care plan."

They say, "You know what? I don't really need a health care plan. I am young, and everything is fine. I don't have to worry about it."

Eventually, they will come in and say, "Listen, can I still get on the health care program?"

And I said, "Well, I know you got married about a year ago. When is the wife due?" That is when they want to do it. They want to get coverage after they have already experienced what it is they need to cover.

Listen, I am out of time. You guys are incredible to come here and spend your day with us. Keep—please, keep giving us the information we need to have. Everybody needs to weigh in.

So, thank you so much, Chairman. Thanks for having this hearing. I think it is good for everybody to hear what it is that we are challenged with. Thank you.

Chairman SMITH. Thank you, Representative. Mr. Larson is recognized.

Mr. LARSON. Yes, thank you, Mr. Chairman. And I want to associate myself with the remarks of Chairman Neal. With this ex-

ception, I would like to throw in the Sisters of Notre Dame, as well, for the work that they have done tirelessly. And yes, I hope there is a direct path to heaven for me, Mike, on that also Mr. Thompson's comments.

And Mr. Gilfillan, I wanted to ask you. In your seven principles—and I believe in the—you were in the process of answering Mr. Thompson's question. You indicate in one of your principles, create an all-payer payment system using administrative pricing. Could you elaborate on that, et cetera, what you mean by that?

And how would that impact everyone's concern that there be transparency, and how will that better help the health care system overall?

Dr. GILFILLAN. Certainly. By administrative pricing, I mean prices that are established by administrative edict, if you will, as we do with Medicare and Medicaid. And the largest privatized health insurance program in America, Medicare Advantage, actually uses administrative pricing from Medicare, and it is the only reason it is successful.

So—but the proposal is, rather than allow the marketplace to establish rates for paying hospitals, which is what we have experienced for the last 40 years, the result of that is extraordinarily high prices because employers insist on having certain hospitals in their networks. That just has driven up prices.

The marketplace is broken. It is not like shopping for cars. Every patient's needs are different. They occur as emergencies. They are unforeseen. The vast majority of dollars as one gets older are not related to shoppable services, but to acute events. And the reality is that is what is exposing people to these high prices.

So, I believe establishing a set of prices that are the same, whether you are a safety net provider or a provider in Bryn Mawr, Pennsylvania in a high-income community, we should not differentiate how much we pay hospitals. We should—as we do in Medicare, we should pay them according to a set fee structure. In doing that, we will significantly decrease the exposure that people have to these high prices.

And finally, as I said, I would eliminate deductibles, because they are actually causing people to avoid care. And differentially, poor people, lower-income people are actively avoiding care and well-to-do people, the limited number—only 17 percent of all Americans have an HSA—the very limited number of people that do are paying for it through their tax-exempt spending accounts.

So once again, we are asking low-income folks to shoulder the burden of shopping and going out, even when they are sick and vulnerable, to get complicated services that, as Congressman Kelly points out so clearly, often times are emergencies.

Mr. LARSON. You also said that you would continue transparency efforts to collect information on costs and outcomes, which seems to be universally agreed to with everyone on the respective panel, and outcomes of care utilizing tools like patient-reported outcome measures. What are PROMs?

Dr. GILFILLAN. Yes, it is simply calling you and asking you after you have received a service, how are you doing? Not just, were you satisfied? How are you doing physically? Are you better, as a result of your hip surgery? Are you walking more? How fast

did you recover? Those are patient-reported outcome measures. We don't do much of that, unfortunately. We tend to rely on very narrow metrics that allow people to perform by—to the test, basically, as opposed to whether or not our patients' experience and outcomes are what they expected. So that is what PROMs are.

Mr. LARSON. Keeping in mind also, the issue of transparency, I do think, Mr. Chairman, that we have to be transparent that why we are having this hearing—and while I am sure many Americans across the country are tuned in—what they are concerned about most is the fact that we are about to default on the dollar.

And we have a responsibility in this committee to deal with the debt ceiling. And we have millions of fellow Americans, 66 million Social Security recipients concerned and wondering whether or not they are going to get their check. That is what we should be focusing on. I yield back.

Chairman SMITH. Mr. Larson, there is only one chamber that has increased the debt limit. It was the House Republicans. Not one Democrat voted to increase the debt limit under the Limit Save Grow Act. We are waiting on the U.S. Senate to actually respond, or the White House. So hopefully they do not want to default.

I would love to recognize Mr. Schweikert.

Mr. SCHWEIKERT. Sorry about that, Mr. Chairman. We are trying to do some math in the background on the fly.

And this is for my brothers and sisters here on the committee. I think, actually, one of the things that always frustrates me is we sort of are mixing—is the colloquialism, "oranges and apples." When you talk about the ACA, ACA was a financing bill. The Republican alternative was a financing bill. It was who got subsidized, who had to pay.

And somehow, we take joy saying we did this for people because we handed out more subsidies. I wish the committee would actually engage in something a little more intellectually robust, and actually a discussion of not how we subsidize, but what we pay, not who pays it. And that is actually where some of this conversation could be actually much more robust and a lot more mathematically honest.

Mr.—or Dr. Whaley—and forgive me if I mispronounced your name—I have been trying to dig through some of the RAND studies and those things, so I want to walk through first some concepts, because you have one chart in here that sort of talks about—let's refer to it as subsidized cross-subsidization, transfer pricing, private markets functionally subsidizing are dramatically more expensive than government-paid-for markets.

So, I have a Medicaid Medicare population, sometimes my Indian Health Care Services, my VA—but when I look at this chart, I mean, you have some here that the private pay market, 300 percent higher?

Dr. WHALEY. That is correct.

Mr. SCHWEIKERT. And is that some—functionally, is that greed or is that an under-compensation from the government market into those populations?

Dr. WHALEY. That is actually one of the things we looked at and noted in my statement, is that that variation is actually not

tied to the share of patients that a hospital has that are, say, Medicare or Medicaid.

The large difference in prices that we see illustrated in that chart really reflect differences in negotiation power and concentration in different markets. So, some hospitals, whether through it just being the only game in town or acquiring other practices, are just really able to negotiate high prices.

Mr. SCHWEIKERT. So, you got me to the punch line I was looking for, because in here some of the RAND work was talking about one of the difficulties is sort of the collapse in competition because of consolidation.

Dr. WHALEY. That is correct.

Mr. SCHWEIKERT. Have you also worked through some of the data points of—in health care markets, as—if we dare use the word "market," and something that is—where the majority of money comes through government—what is—do we have a sense of, in highly concentrated markets, you know, single ownership, or just one or two systems compared to any samples here in the United States, where a market is—has lots of different providers, what we see in variants in the pricing just at that level?

Dr. WHALEY. One good example actually comes from the State of California. Northern California is very concentrated and dominated by a handful of providers. Southern California tends to have much more competition among hospitals. Hospital prices in northern California are roughly double what they are in southern California.

Mr. SCHWEIKERT. Say that last sentence again.

Dr. WHALEY. Hospital prices in northern California are approximately double what they are in southern California, which has a much more robust and competitive hospital——

Mr. SCHWEIKERT. So, you believe that almost 100 percent variance in cost is just because of market concentration, lack of market concentration?

Dr. WHALEY. Correct.

Mr. SCHWEIKERT. Even with what CalPERS did of actually trying to do, you know, their experiment from, what, a decade ago, when they were going broke and trying to find the best low-cost provider?

Dr. WHALEY. That is exactly right. And the CalPERS reference-based pricing model was really designed as—given the level of market concentration and lack of competition in northern California, how do you get patients out of higher-priced northern California hospitals?

Mr. SCHWEIKERT. Look, many of us on our side as Republicans, we like concepts like HSAs and this and that because we see it as empowering the individual. But some of us have actually much more, I think, disruptive visions of the thing you can blow into in your home medicine cabinet that instantly tells you you have the flu and could order your antivirals.

Has RAND or anyone out there done a study of saying, okay, here is adding competition in our health care delivery systems, but my ability to have a breath biopsy, the thing on my wrist that manages my blood glucose—if obesity and diabetes are the number-

one drivers of health care expenses in the United States, you would think our—as a group here, we would be passionate to talk about.

If 33 percent of health care is just diabetes, if maybe the number-one killer of prime age young men is obesity, we would actually talk about things like that. Have you seen anyone start to do studies of that ability to almost have your own medical lab on your wrist?

Dr. WHALEY. Not quite to the same extent, but one really good example in, I think, one of the benefits of price transparency is how it enables that type of innovation. So, for example, we have done a study of a program that developed bundled payment programs. And so, instead of kind of going across a variety of providers to get service, can everything be bundled into a single provider?

And that type of innovation and use of price transparency reduced prices for surgical procedures by about 45 percent.

Mr. SCHWEIKERT. Interesting. Doctor, thank you.

Thank you, Mr. Chairman.

Chairman SMITH. Thank you. Mr. Blumenauer is recognized.

Mr. BLUMENAUER. Thank you, Mr. Chairman. I find the witnesses fascinating. I think the purpose of this hearing is extraordinarily useful.

One of the things that is sobering is that we are paying more, a third more—excuse me, we are paying almost twice as much as typical countries, and Americans get sick more often, they take longer to get well. We have serious structural problems here.

This is a very complex issue. There are lots of results. One of them, I would suggest, is that we are subsidizing a diet that makes Americans sick, and half of the public suffers from diet-related medical conditions.

The results are sobering. We have actually lost ground in terms of life expectancy from 79 to 76 years. Black life expectancy is five to six years less. These are very sobering circumstances. But I think we have, in the course of the witnesses' presentation, we have got, I think, glimmers of hope where people can come together.

And the debt ceiling crisis that is enveloping us here and I think we end up making it more complicated than it should be, but as a practical matter, the debt ceiling and the national debt is driven by health care costs. We are going to be spending $1.7 trillion next year, and it is going to rise to 12.7 percent of the gross domestic product in 10 years. We need to get health care under control, not only because of the lack of results, but that is an actual fundamental structural weakness in our economy and our country.

I am intrigued by one little thing. Mr. Smucker and I have introduced some legislation that would promote direct primary care. The typical general practitioner sees a patient about every eight minutes, and they are lined up, and there is a huge amount of administrative overhead. A number of you have referenced that in terms of your testimony—Mr. Short, I appreciate your reference. This is an opportunity to shift so patients will pay by the year, not by the visit, and they receive incentives to use the care.

Mr. Chairman, I hope that this is an area that our committee can be involved. Direct primary care, get rid of fee-for-service for more people. It is just a minor adjustment in terms of the IRS, in

terms of what you define as insurance. Direct primary care should not be insurance. We ought to be able to make this adjustment with the legislation that Congressman Smucker and I have introduced that would be an important small step towards squeezing some of the excess costs out. It is more choice for the individuals, it is better for individual business. And it is a tangible step to be able to get more value out of the system.

Mr. Short, you referenced it. I kind of went off on not a tangent, but I am setting you up. Do you want to just elaborate a little bit on your testimony about how important being able to have direct primary care would be?

Mr. SHORT. Yes, absolutely, and thank you for support on the issue of direct primary care.

The basic concept of direct primary care is that we are taking what would be an actuarial value out of the insurance plan and pushing it directly to the health care primary care providers, may they be physicians, nurse practitioners, and physician assistants. And by doing that, you change the incentives. You are aligning up the health care provider to be incentivized to keep individuals healthy.

I referenced in my testimony that one employee at one locksmith company who was proud of the fact that he had not been to a primary care physician in 20 years, and that physician, that primary care relationship, that direct primary care physician had a duty to then get him into a physical, into a wellness exam, and discovered he was type 2 diabetic.

Mr. BLUMENAUER. Yes.

Mr. SHORT. And he was—so the physicians get the payments directly through this arrangement. There is no overhead. There is no revenue cycle management. This is critical, in terms of beginning to bend the cost curve for everybody.

Mr. BLUMENAUER. Thank you, Mr. Chairman. I appreciate your patience. This, to me is something that doesn't need to be partisan, it is very direct. It doesn't cost anything, and it improves health care. And I look forward to working with you and Mr. Smucker to see if this is a little thing that we can get across the finish line. Thank you very much.

Chairman SMITH. Thank you, sir. Mr. Wenstrup is recognized.

Mr. WENSTRUP. Yes, thank you, Mr. Chairman, and I want to thank you all for being here today. I am very pleased that we are having this hearing, and I am glad to see a practicing physician here on the panel today. I think that that has been missing very often when we get together, and it is important. And my home state of Ohio is pretty well represented here today with Dr. Piniecki and Ms. Troiano.

Thank you very much for taking the time to be here and, really, to all of you for that.

You know, as a surgeon who has seen patients, you know, I have seen the change in our health care system that I think has brought us down. Ms. Troiano, you really touched on it, what—you know, when you had a child 45 years ago.

You know, we were just talking about direct primary care. I am in favor of direct primary care, but that works well for a primary care physician. But it is harder for a specialist to operate under

that circumstance, as people aren't going to pay a fee for a specialist they may never need to see. So, we have to figure out some way to make that work better.

But, you know—and I also think it is important too, you know, that we focus on health. And Mr. Blumenauer brought that up, and if—you know, because prevention costs nothing in the long run. When you prevent something from happening, or you stay on top of things, and we focus on keeping people healthy, and it is not just what we are doing in medicine per se, but, you know, what we are doing with how we feed our nation and those types of things, we have got to address all of this if we are going to be successful and really drive down costs.

But you know, as someone else was—I think it was Mr. Thompson talking about these bills that are so high, well, I can remember—you know, as a foot and ankle specialist, you know, over a fourth of your bones in your body are right there. And so sometimes you are doing multiple procedures on one patient. And so, the standard was, when I started in practice, you bill 100 percent for your most expensive procedure, and then you do 50 percent for the second, and 25 for the third, and 25 for the fourth. And then what would happen is insurance companies, when you did that, they would take the second one that you billed at 50 percent and cut that at 50 percent. And then they would take the one that you billed at 25 percent and cut that down 25 percent more.

So, the game was starting to be played. And so, we had to start billing everything at 100 percent, stamping the claim saying all procedures billed at 100 percent. Well, that led to a lot of lack of transparency for patients, and it was just a game being played with the insurance companies. But that is why you started to see bills like that, because if you didn't bill it all that way, they were going to do it in an unfair practice. So, there are a lot of things to do.

But, you know, we passed the No Surprises Act. Unfortunately, the HHS decided to change it when we made it very clear in a bipartisan fashion what this bill was supposed to do, and that has made it more difficult for patients. But there were a lot of things in there about transparency.

We passed it in December of 2020, it required the advanced explanation of benefits—you are probably all familiar with that—a separate tool intended to improve price transparency. And this required that health insurers provide patients with basic information such as estimated price for a scheduled procedure—now, these are your non-emergent things—whether or not the medical provider or facility providing the service is in their plan—they should be able to tell them that—whether or not the patient would be subject to utilization management services like prior auth and step therapy, two things that we are trying to fix here.

You know, I would have patients say, "How much is this going to cost?"

I say, "Well, here is what I charge," but I could charge $1 million because the insurance company is going to tell us what it is, and that is a problem. So, we tried to eliminate that with this bill. We are over a year past the date, HHS has yet to even begin the rulemaking to implement these common-sense patient protections.

Dr. Piniecki, Congress did amazing bipartisan work on this. And if implemented correctly, this will serve as a meaningful price transparency tool for patients. Can you walk through how transparent pricing works for you, as a doctor, and what it means for your patients?

Dr. PINIECKI. Sure, and I appreciate the time. The important thing is, number one, you have an apples-to-apples comparison. So, I think we have made impressive steps in the transparency front to try to get prices out there from the hospital systems.

Right now, it is not apples to apples. I actually went on there a few weeks ago and looked up a CPT code for a joint replacement at one facility, and it was $1,352, or something like that. I mean, I don't know where that number came from, but I guarantee you that wasn't the price. The implant is significantly more than that alone. So, we really need to kind of drive that forward a little bit more.

And so, I would love to see a bundled price for services provided. And we have talked a little bit here about the emergency services, and that is absolutely essential and imperative.

But the vast majority of surgeries and procedures performed are scheduled elective procedures. And so, you know, hundreds and thousands of gallbladder removals and hernia repairs, you know, and foot and ankle procedures, you know, bunionectomies, whatnot. So, it can be done. The impetus is on the physicians, on me and on my colleagues, to provide that pricing for our professional services. And I think we need to push forward that with the facilities.

And we actually need, as much as we can, have a bundled price for the services provided. I know what goes into it—I have been doing this for 13 years, the hospital systems have done it a lot longer than I have and have outpatient departments. So, I would say we need to just drive that forward, and patients will benefit from that, regardless of their socioeconomic classification or political leanings.

Mr. WENSTRUP. We did well when we had our own doctors' own surgery center. It was much easier.

My time is expired, but Ms. Troiano, thank you for the transparency you are trying to bring in medicine. We will talk further.

I yield back.

Chairman SMITH. Thank you. Mr. Pascrell is recognized.

Mr. PASCRELL. Thank you, Mr. Chairman. I want to associate myself with the words of my friend from Ohio. I know we don't agree on too much, but I thought you were speaking to truth. I think that is a worthy objective. And the example you gave is a perfect example of what we are dealing with in health care. Let's be honest about it. Regardless of which subject within health care, we are dealing with those kinds of games that are played on us, and we play many times on the public to let them think we have solved the problem.

I have a question to start, Dr. Gilfillan, if you would. Welcome aboard. Great witnesses today. You note that a new report, the Center on the Budget Policy Priorities, indicates that HSAs have become tax shelters for billionaires. Can you unpack HSAs have been exploited to profit the rich and not help regular Americans?

Dr. GILFILLAN. Certainly, Congressman. It is pretty straightforward. If you have discretionary income to put into an HSA, then you benefit from the tax avoidance associated with that. And you put some money away for a potential medical rainy day, if you will. If you do not have discretionary income, you are not in a position to do that, and most employers are not doing it. That is why the number of people with HSAs has been—remains low.

So, employers liked the deductible idea, and they have proceeded with that so that almost everybody has a deductible. But that took—that saved money for employers. HSAs were a cost, funding HSAs would be a cost. So that has not caught on. And as a result, we have exactly what you have described, wealthy individuals using them to shelter their—some of their disposable income and wealth.

Mr. PASCRELL. Well, this hearing comes at a very interesting time, as you well know, everyone knows. We are staring at a financial doomsday. This crisis imperils the health of this nation. It imperils the health, particularly, of 60 million people on Medicare. So, we have days left before we fall off the cliff.

Some of the testimony today would have us believe that the American people need more information to protect our health care system. See, that is what we don't see. We are not getting enough information so that we can go from one side of the border to the other side of the border and understand what is at stake here.

But when your health is at stake, everything is at stake. That is true when we are shopping for routine and predictable needs, like selecting a primary care physician or scheduling your annual dental cleaning. But if we are in health crisis or, God forbid, your child was in pain, that is not the time to try and become an expert in medical billing.

Americans are adept at balancing value and cost. They do it every day at the gas pump and in the grocery store. Our constituents are smarter than we think, and they know the value of a dollar and stretching budgets. But when we are talking about catastrophic, once-in-a-lifetime critical care, transparency and pricing is not enough.

This committee must look at Wall Street firms bilking Medicare, another report about how they are bilking and how much they are bilking for and squeezing seniors for every dime. And I am just flabbergasted by a report which I missed—I read the report, and I didn't really focus on this part of it. This report was outstanding. The National Bureau of Economic Research Study, they found that private equity nursing home ownership resulted in the premature deaths of 20,150 nursing home residents between 2012 and 2017—not the pandemic—and that equals about 160,000 life years lost.

The study authors also found that private equity ownership increased the use of anti-psychotic medication by 50 percent—that is often a proxy for insufficient staffing, as you well know—Medicare billing by 11 percent, and the chance of death by 10 percent.

So tomorrow we are going to be talking about the pricing of Medicare. Today we are concerned about who do you turn to. And the questions and comments from both sides of the aisle I thought were excellent today, as were all the responses. We may disagree

on some things. But if we don't know what the problem is, Doctor, we are not going to solve the problem. Or maybe we will get lucky.

I yield back.

Chairman SMITH. Thank you. Mr. Arrington is recognized.

Mr. ARRINGTON. I thank the Chairman and the witnesses for their time and insight.

Health care is very complicated. I truly believe we all want to make it more affordable for our constituents, for the American people. I think we all recognize the system is failing patients. It is—we may have the best physicians and the best technology and the best facilities, but this is an embarrassment in that we can't get any of those things to function efficiently for the desired outcome—by the way, a desired outcome that we would all agree on.

I agree and disagree with you, Dr. Gilfillan. I find myself agreeing on the monopoly forces aspect to your remarks. We talk about big government being inefficient, convoluted, and making things more complicated than they should be. I personally think markets are the best way to achieve best value. If you have a healthy market with true choice, transparency, informed, empowered consumers, and real competition, among other things, competition being at the heart of it, and I think that competition is stifled by big medicine, big pharma, big insurance, big hospital.

So, I am very sympathetic, and I think I would agree with you that—I guess I would summarize it by saying we are neither fish nor fowl. We are—while I reject a government-run health care because I have seen government-run programs, and they were miserable failures, not because there weren't good intentions, but it just doesn't—it will never function the way it should for the consumer, for the customer. But today it is part government run, part private run, and we just—people are so confused, and we are just not serving anybody well. It is just—I will acknowledge that, right?

But I do think people are rational and logical. But your point is the system isn't logical or rational. And so, it makes it more difficult. I agree. But let's shine some light where there is darkness for consumers to understand what it is they are getting for their money, what other options they have, who is the best at delivering the services, et cetera, et cetera.

I think Mr. Pascrell said it well. Our constituents and the American people are so much smarter than we give them credit for, but who in the world could navigate this system?

So, I think everybody would agree that—now, I think we need not more government central planning. I think that will make it less efficient. I think we need healthy market forces, and we should unleash those market forces. And when we do—including more competition, Mr. Gilfillan, and less monopoly forces. Man, I wish we would have that conversation and that debate in here.

But on the drug pricing side, me and some of my Democrat colleagues were able to pass what we call Shop Rx, and it essentially allows for—basically, requires insurance providers to provide to physicians and patients information, as I mentioned, on the different drugs available, generic included, branded, the cost, where they can find it. I thought this was a step in the right direction, especially for our seniors. It gives them that real shopping experi-

ence right there at the touch of a smartphone and in consultation with their physician.

This is two-and-a-half years later since we passed the bill. CMS has still not promulgated a single rule to implement it. So, Dr. Whaley, I just want to ask you, I mean, is this a tool that is going to help seniors if we can actually get the government—this is why I have no confidence, by the way, in a government-run system. It is almost three years later, and we can't even implement what we think is a small step to transparency and empowering seniors, so they have real choice. Any comments?

And then I will—my time has expired.

Dr. WHALEY. So just very briefly, it is likely that we would potentially see much more patient engagement, including among seniors, for drug price transparency and price shopping for drugs than for other types of medical services.

Mr. KELLY [presiding]. Thank you, Dr. Whaley, thank you.

Mr.—Dr. Davis, you are recognized.

Mr. DAVIS. Thank you. Thank you, Mr. Chairman. You know, with Sunday being Mother's Day, I can't forget my mother driving into us the idea that an ounce of prevention is worth much more than a pound of cure.

And so, when I think of health care and transparency, I often think of prevention, and I also think of a patient's right to know. And what that really is designed to do is to give the patient a sense of feeling of assurance that I have the best understanding of health care delivery of the system and what I need to do in order to get from it what is best for me.

I don't believe that health care can be treated the same as marketplace choices. There is so much complexity. It is so difficult to know. It is so difficult to understand. But I do believe that if we put more focus on prevention, if we are really talking about reducing costs, bringing down the cost, if we put more focus on prevention as opposed to after the floods have come, you know, then we start talking about flood control. But if we prevent the flood from occurring, the idea is to save.

Dr. Gilfillan, you outlined seven principles in your testimony. I have read them carefully and looked at them. If we really wanted to get at this business of reducing costs, how do those principles align with your thinking?

Dr. GILFILLAN. Well, thank you, Congressman Davis. I think I agree, prevention makes sense. It is important.

And I also agree that primary care is critical to making the system work. I happen to think that primary care is best embedded in a larger system that is accountable for delivering better outcomes. And so, I believe accountable care organizations with primary care capitated within them, as some have proposed, is actually a great way of getting providers interested in actually doing significant preventive health care work.

The problem today with fee-for-service is no one is actually benefitting from providing preventive care. So, we need to create a structure of accountability where providers are thinking every day about what I can do to keep this patient healthy every time I see you. And I think it is correct, we don't want someone just seeing someone for 10 minutes, and moving them out so they can check

a box and get 1 payment. We want them thinking holistically about every patient and their population, and I believe that is best done through accountable provider entities, as I mentioned in the principles.

So that is the path I would take: capitate primary care within a broader accountable system of care where we hold providers responsible for improving outcomes and decreasing the overall cost.

Mr. DAVIS. You also indicated that comprehensive health insurance coverage for everyone would be a good approach. What do you mean by that?

Dr. GILFILLAN. Well, I use the term "comprehensive" by saying—to mean that we don't—we should eliminate deductibles and co-insurance. We should open the doors to people going to get the care they need, and then have primary care available readily to provide that care and to help them avoid becoming ill. So comprehensive, not with hurdles or obstacles to care is—was my intent. And we need it for everybody.

Today we actually have created a multi-tiered system where the wealthy get what they need, and lower-income families have a hard time getting the care they need, and they often—they are in communities where we haven't adequately funded hospitals or other services, and they haven't attracted the private equity that has found their way into other segments where there is more money to be made.

So, I think it needs to be comprehensive coverage for everybody at the same price so that, if I am living in an inner city or in a rural area, my provider will be paid just as well as that provider in a wealthy suburb and is able to build the structures and the care systems needed to keep me healthy.

Mr. DAVIS. Thank you, Mr. Chairman. I yield back.

Mr. KELLY. Thank you, Dr. Davis.

Thank you, Doctor.

Dr. Ferguson.

Mr. FERGUSON. Thank you, Mr. Chairman, and thank you all for being here.

Ms. Troiano, thank you. I hope I said that right. You know, being from Georgia, I can add an extra syllable with ease, so—but thank you for being here. And as a small business owner, thank you for your testimony, your insight, and thank you for fighting through and keeping on. We do appreciate that.

So, Mr. Whaley, I am going to kind of start, you know, with you and just kind of give us some insight here. Just simple questions. Right—compared to a decade-and-a-half ago, is health care—is the cost of health care in America more or less at the individual level than it has been—than it was 15 years ago? We pay—are Americans paying more now than we were?

Dr. WHALEY. Substantially more.

Mr. FERGUSON. Substantially more. Is America more healthy today than it was a decade-and-a-half ago?

Dr. WHALEY. Not to the same level at which prices have gone up.

Mr. FERGUSON. Okay. Is there data—and a genuine question here—is—does data exist that shows utilization of the system through different income groups, meaning—we talk a lot about ac-

cess to care and creating access to care. Access to care is very different than utilization to care. Are you aware of data that exists that shows that people in different income stratas, even if they have access to care, do they utilize that care?

Dr. WHALEY. We do know—not through a single data set, but through data sets that we have been able to piece together, differences in utilization and types of providers based on broad differences in income.

Mr. FERGUSON. Okay. With that, if you—and again, I am going to put my provider hat on, of having a private practice, a dental practice in which my patients, whether they were Medicaid patients, whether they were employed by one of the major employers, whether they had unlimited wealth, all of my patients got treated the same, same appointments, same access. It was just the way the way that we operated.

And what we found is that, even if someone had access to care, many times on the lower end of the spectrum, because of a variety of other issues and emergencies that they were dealing with, and the fact that they were living in the crisis of the moment, they simply didn't access the care. They didn't utilize the care.

So when we talk about price transparency—and we should, because I think it is an important—I think it is important for Americans to know the cost, the real cost of health care, I think it is important that we all understand the real cost of health care, and I think it is important that employers do, and are able to make decisions based off of that. Does transparency solve all of the world's problems? No, but it is clearly an outlet—or an inlet for us to understand cost in the health care system, as it—as patients and employers do.

But shouldn't we be looking at—shouldn't we be transparent in the data, as well, and how different groups are utilizing the system?

Because if you have a group that may have access to care, but they don't have—they are not utilizing the care, is that creating a problem in terms of still having the catastrophic events that drive cost up so high?

I mean, Ms.—again, I am sorry, but with your employees, do they all utilize the system the same way, or do you have patients—or excuse me, employees—that only go in at catastrophic events?

Ms. TROIANO. We encourage our employees—everyone who is on our health care plan has to see their primary care physician at least once a year. So, they have to turn in a biometric screening to a company, and they are required to do that.

Part of the problem is the insurance companies are a big part of this problem, because they dictate to the primary care physicians what lab work they can have done, they dictate what tests need to be run——

Mr. FERGUSON. Let me grab you, because I agree with you on that, but I have only got a few seconds here on this. But price transparency and understanding where those dollars go is, obviously, important, particularly at the hospital level and the enforcement of the rules.

But Dr. Whaley, can—again, can you provide us or be willing to work with the committee to get utilization data across the board,

and maybe work with whoever you need to so that we can understand not just access to care, but utilization of care and consistent utilization of care and the lack thereof, what is it doing to lead to these higher costs so——

Dr. WHALEY. Absolutely, and I agree that that is critically important.

Mr. FERGUSON. Thank you.

Thank you, Mr. Chairman.

Mr. KELLY. Yes, sir. I recognize Ms. Sánchez.

Ms. SANCHEZ. Thank you, Mr. Chairman, and I want to thank all of the witnesses for their testimony today.

I want to assure everybody that Democrats are committed to affordability and transparency in the health care system, and that is why now, more than ever—that is why now more Americans than ever have health care coverage. It is why America now pays no more than $35 per month for insulin after we passed the Inflation Reduction Act. And it is why we worked with our colleagues across the aisle to pass the No Surprises Act.

However, I am a little disappointed because my colleagues today are promoting transparency in the name of a patchwork of health care options that primarily benefit wealthy Americans. I didn't have time to shop for the best emergency care when my son was hit with the face in a baseball when he took a line drive at third base (sic). And sexual assault survivors don't have time to shop for forensic medical exams after they have been assaulted. In fact, that is why I worked with my colleagues across the aisle to introduce the "No Surprises for Survivors Act".

I think we can probably all agree that there should be more transparency in the health care system, particularly with the increase in consolidation and private equity investment. But claiming that patient choice will magically move the needle in affordability I think is misguided at best, and disingenuous at worst, particularly when my Republican colleagues are working to push the U.S. into default, causing a 22 percent cut to the Centers for Medicare and Medicaid and Health and Human Services.

Dr. Gilfillan, the research in Mr. Kampine's testimony shows that there is no correlation between cost and quality. In fact, when patients have been offered online price transparency tools, they actually spent more than when they did not have access to those tools. Can you explain that?

Would you say that the average patient is able to identify high-quality and cost-effective providers?

Dr. GILFILLAN. Congresswoman, quite honestly, I cannot identify high-value and high-quality providers in any way other than actually going around and talking to people who are close to the delivery of care in any particular institution. That is what I do when someone asks me for a recommendation, because the data we have is poor. It would be better to have more information, more data, more transparent data, and more structured data via registries or report outcomes I mentioned that actually give us the chance to do that.

But right now, you can go online and look at three or four different quality rating tools, and find the same provider rated high

or low on those tools. So no, there is not an ability to actually do that today.

Ms. SANCHEZ. Thank you. And Dr. Gilfillan, many of these employer-based, consumer-driven health care plans that the witnesses are highlighting are effectively high-deductible plans. Those plans don't guarantee availability of providers in their area, nor do they promise consumer protection for additional medical bills.

The majority of health care services are not even shoppable, and the facts are clear: today a quarter of Americans delaying needed health care due to the cost. It is not incumbent upon those patients to have the time and knowledge to bargain shop for their health care like shopping for a plane ticket. I don't think that we can expect working families with no health care background, no understanding of the thousands of CPT codes, conditions, and plan types to be able to navigate a system that even payers have trouble with.

I mean, when I had to switch my health care plan at the beginning of the year, it was difficult for me to figure out how to do that, and I am an educated woman.

Would increased price transparency help working families, particularly Latino and Black families?

Dr. GILFILLAN. I think the reality is, as I have said before, often times the choices of providers are limited. Transportation is limited. So individuals in minority communities who may be in a majority—or a significant number are in communities that do not have access to alternative care delivery are actually not benefitted by seeing all that information, I believe.

I think, generally, it is good for us to know. But the reality is that these—many of these additional high-deductible plans are actually mini-med plans, many major-med plans that leave individuals and families exposed to even greater bills when they actually go outside, or they actually get care from parties that are not connected to those bills.

So I think it is—I would agree with you—at times disingenuous to say that there are opportunities to decrease costs across the total spectrum of care by 30 or 40 or 50 percent. That is simply not the case. It hasn't been proven, and it hasn't happened in the 20 years that I have seen these kinds of programs promulgated.

Ms. SANCHEZ. I thank you for your testimony, and I yield back.

Mr. KELLY. Thank you. Pursuant to committee practice, we are now going to move to two-to-one questioning.

Mr. Estes, you are recognized.

Mr. ESTES. Well, thank you, Mr. Chairman, and thank you to our witnesses for being here today to discuss this important issue of transparency in health care pricing.

You know, there are so many issues in our health care system, and we have talked about several of them today. But there is no one solution necessarily that is going to solve all of them, you know, what you need for emergency care, what you need for planned procedures, what you need for preventive care, all different. And what we have to recognize is that some of those solutions do solve some of the problems, and it can't just throw them out because they don't solve all of the problems.

Last week we learned that inflation had gone up again. Americans are now paying 15.3 percent more than they were when Presi-

dent Biden took office for the same goods and services. And a lot of medical procedures, that is even higher than what it was a little over two years ago. We know what prompted this rapid increase in inflation: massive Federal spending. So, while Kansans have had to watch their spending habits, Democrats in D.C. have pushed out over $11 trillion in spending, which has brought us to the limit that the Federal Government can borrow.

As they struggle to stretch the same dollars to do more, Americans have a right to know how much the doctor is going to cost them. As we look for ways to curb Federal spending and bring the Federal deficit under control, we can look to a growing body of evidence that suggests a link between price transparency and reductions in Federal health care spending.

Health care spending currently represents 18.3 percent of our GDP. One out of every four dollars the Federal Government spends is on health care, and that figure is projected to rise to at least 35 percent over the next decade. Premiums and deductibles in private plans are rising more than wage growth, and Medicare's hospital insurance trust fund is projected to be insolvent in 2031. These numbers are troubling. But the data shows that increased health care price transparency could help reverse the trend. If transparency results in a 1 percent reduction in cost, that could eventually lead to a $4.8 billion reduction in Federal spending over 10 years.

Mr. Kampine, if these transparency rules were improved, what are the economic outcomes, and what can we expect to see in terms of costs for high-cost services?

Mr. KAMPINE. So specifically, which set of rules?

Mr. ESTES. Well, in terms of as we put in more rules around having transparency——

Mr. KAMPINE. Okay.

Mr. ESTES [continuing]. Around especially providers and——

Mr. KAMPINE. Yes, great. So, I will just give you an example.

A retail client of ours, a patient requiring a joint replacement, received a $150,000 joint replacement. This isn't 15 years ago, it is not 20 years ago, this was in the in the past year. This hospital was in the lowest 20 percent of all patient outcomes in the United States for hospitals that we score that do joint replacements. There was a hospital 30 miles down the road that does the same joint replacement in the top 20 percent of all hospitals, and they were roughly $35,000.

We have enormous differences in price and in quality for these services. Being able to navigate and being able to align the benefit design so that we reward patients for using high-value care and discourage the use of low-value care has a huge opportunity to save, not just for the employee themselves, but also for the employer plan sponsors. When we look at this data—there has been a lot of discussion so far today—roughly 40 percent of the total spend for any given employer could be shopped. Within that spend, easily half of that spend could be saved. So, there is a significant amount of money that is on the table.

What I will say is over a 20-year period we have seen utilization of our tools grow, and utilization of those higher-value providers increase, enabling those employers to incrementally grab more of

that savings that is sitting on the table. There is a ton of savings that is still there. I think that is the opportunity that is in front of us through the ability to price more of these services and align the benefit design with what we want, which is better value.

Mr. ESTES. Yes. I mean, you know, as we have talked about, at the heart of health care is people. Yet ironically, health care is one of the few systems where individuals don't know the price of services that they receive.

Dr. Whaley, while the hospital rule has shown some promise, we know that not all hospitals are the same. In Kansas we have the second most number of critical access hospitals at 82, compared to only Texas at 85. Many critical access hospitals focus on getting patients stable and then moving them to larger medical centers that are more equipped to handle complicated cases.

With compliance around these transparency rules so low, what considerations or resources are necessary to help some of these critical access hospitals come into compliance without being burdensome or one size fits all?

Dr. WHALEY. I think even for critical access hospitals, compliance and posting prices for the shoppable service is important. When we have actually looked at the types of hospitals that are actually non-compliant, it is actually not many of the critical access hospitals. It is many of the large, nationwide systems. And so, it doesn't seem like it is a resource problem with compliance, but rather an enforcement problem.

Mr. ESTES. All right. Thank you, and I yield back.

Mr. KELLY. Thank you, Mr. Estes.

Mrs. Miller, you are recognized.

Mrs. MILLER. Thank you, Mr. Chairman, and thank you, Ranking Member Neal, and thank you to all of you for being here today.

Throughout my life I have worn many different hats. Besides raising bison and many other jobs, I also handle rental property that I own. And when I rent out an apartment, I usually tell them what the rent is, what that rent entails, what they can expect from a utility bill, and what their responsibilities are and what are mine. That, to me, makes a lot of sense. Now, health care, on the other hand, we have all kind of established that nobody really knows exactly what the cost is. So, we need to work on the price. I think patients would appreciate the same kind of transparency that I give in my little business.

Dr. Whaley, through your research, would you say that currently the biggest issue in preventing the use of pricing data by patients—what is it, and what do you think the most common-sense fix would be?

Dr. WHALEY. Thank you for the question. As I said in my opening remarks, price transparency, to be clear, is not a magic wand for the health care system.

We have done several studies looking at patients actually using price transparency and trying to see where they shop. And while patients who do use these tools do actually save money, the reality is that many patients don't actually shop for care. And I think there are two main reasons for this.

One, it is complicated to shop for care, and there is a reason that doctors go to medical school and patients don't. And if you are a

patient, it is hard to navigate the system. This is also a further complexity by the coverage of insurance. So even if you do shop for care, most of the savings, in many cases, actually go to an insurance company.

And then finally, the—another reality is that many patients are directed to go to certain providers from their primary care physician, and if your primary care physician is employed by a hospital or health care system, which we have seen as a dominant trend in health care markets, then that provider often times refers you to a higher-priced hospital. And so, you, as a patient, just have little agency to actually shop for care.

Mrs. MILLER. I have had young physicians sit in my office and tell me that they have, like, $600,000 worth of debt facing them, and they are just starting out in their practice.

But to me, it would be common sense to empower patients to be good shoppers in what they are looking for. And a basic market principle is that the consumer makes the best decision when they have all the information in front of them.

One concern that I have, though, coming from a rural area of West Virginia, is that there is not a huge capacity for competition because of how few options for care patients have. So even though the patients might have the price information, there won't be an incentive for providers to have competitive prices and increase quality. So, Dr. Whaley, how can we overcome these price concerns in rural America, and prevent higher prices in areas that might not have robust competition to ensure that the patients still have good, cost-effective care?

Dr. WHALEY. If there is only one provider in town, it doesn't matter how much information the patient has, that is not going to change their decision. And so, in those types of markets I think it is important to think about why are there so few providers. Is it the fact that in certain markets other dominant providers have gobbled up the system and acquired other providers? And if so, are there anti-trust or other regulatory policies that we need to have?

If it is the case that it is just a rural area where maybe it is just kind of natural to have a single provider, then maybe there needs to be a different payment model that maybe equalizes payments across different payers for those types of providers.

Mrs. MILLER. It is sort of both of those.

I have mentioned this before in health hearings because I worry that the fear of the hidden costs might prevent folks from actually seeking care, as many of these studies have shown. Dr. Piniecki, is there something that you have seen from the provider side? Do you think that transparent prices would alleviate some of the fear that the patients might have in choosing their health care?

Dr. PINIECKI. They definitely have. Like I said, you mentioned about, you know, a lot of rural areas. I spend a fair amount of time in West Virginia a couple of times a year on average just for vacation purposes, I just enjoy the area. And so, I have got a chance to know the folks in those areas, Beckley and other areas around there.

What typically happens is, if provided the information, what we found in the last couple of years is that patients will, in fact, be good consumers. They are active consumers of their care. They will

invest the time to find out, hey, where is the best option for me, not only from a cost standpoint, but from a quality standpoint based upon the metrics that we have available right now, which are incomplete, but are getting better, and they will actually travel for that care in a lot of cases.

So, you know, it has been quite impressive just to see patients taking ownership in that, but they have to be given the tools, from a transparency standpoint, to have the resources to do so.

Mrs. MILLER. Thank you. I yield back.

Chairman SMITH [presiding]. Thank you. Mr. Higgins is recognized.

Mr. HIGGINS. Thank you very much, Mr. Chairman.

Dr. Gilfillan, how do you characterize a high deductible health plan as it relates to patient protections and patient services?

Dr. GILFILLAN. Congressman, I believe high-deductible health plans actually reflect in the employer market—actually reflect the fact that employers were frustrated with the ability of insurance companies to get adequate pricing to have lower costs, and therefore made a decision to pass on responsibility for those costs to their employees, some of whom can afford it, many of whom cannot.

Mr. HIGGINS. But doesn't that, by its very definition, discourage people from using the health care that they already pay too much for by jacking up premiums, jacking up co-pays, and jacking up deductibility? And then, when they go to use the health care that they pay too much for, there is very little underlying health care?

Dr. GILFILLAN. It has been shown, I believe, that cost sharing, whether through deductibles or high co-insurance, do result in patients avoiding necessary care and unnecessary care almost in a way that is undifferentiated. It is a truism in the industry that, if you put hurdles in the way of getting care, financial hurdles, people will access less care.

Mr. HIGGINS. So, doesn't that take us back to pre-Affordable Care Act with all the patient protections, the inability of an insurance company to deny somebody coverage because of a preexisting condition, the 10 essential health benefits that all health care plans have to provide?

It seems as though this is moving way back to a place that, you know, I think in terms of patient care, is not a good place.

Dr. GILFILLAN. Well, certainly the Affordable Care Act created the remarkable result that many more people at least have coverage, so they are not exposed to the catastrophic financial and family impacts of having no insurance.

Mr. HIGGINS. Thirty-five million more Americans have health care because of the Affordable Care Act.

And health care is delivered by professionals: doctors, nurses, specialists. And how you pay for it is a combination of private pay and public pay. Right now, the annual health care cost in America is about $6 trillion; $1.9 trillion of that is paid by the Federal Government through Medicare, Medicaid, the Veterans Administration in general tax treatment. It is a lot of money. It is about 30 percent of all health care spending paid by the Federal Government.

But doesn't it also give us leverage to knock down the cost of health care and build up the quality of health care?

Dr. GILFILLAN. I believe it can. And in some ways, it already is.

Through a variety of programs, many of which were in the Affordable Care Act, such as the shared savings program, CMS is actually making great strides towards improving the delivery of care. It is also more efficient. The reality is the cost of administering Medicare is about 2 percent compared to the 15 percent that is taken by commercial and Medicare Advantage insurers.

Mr. HIGGINS. And aren't those private payers?

If you look at the compensation scale of some of the, you know, well-known national—aren't they incentivized to cut costs, which is an incentive to deny people coverage for the insurance that they are paying for?

Dr. GILFILLAN. I think they are incented by improvements in stock prices, and everything they can do to increase stock price they do. And that includes decreasing the——

Mr. HIGGINS. Including——

Dr. GILFILLAN [continuing]. Cost of care.

Mr. HIGGINS [continuing]. Denying coverage?

Dr. GILFILLAN. Denying coverage is not so much the issue for individuals. At the level of providing a service, yes. In my experience at Trinity Health, large national insurers were denying or downgrading 30 to 40 percent of our in-patient claims. They were doing that on the backs of providers, if you will. They were insulating patients from some of that. But the fact was they were denying care, and at times obviously denying coverage for specific services.

Mr. HIGGINS. Thank you.

My time is expired. I will yield back.

Chairman SMITH. Dr. Murphy is recognized.

Mr. MURPHY. Thank you, Mr. Chairman.

I am going to piggyback on Mr. Higgins, because you are exactly right. Insurance companies get paid to deny care, period. Period. That is what we were trying to do with the No Surprises Act.

And you, Doctor, you spoke about that earlier, but we sent them, the Biden Administration, a great bill that put a balance between insurance companies and doctors, bipartisan, bicameral, Biden Administration—everything to insurance companies, everything to insurance companies.

I think we have gotten a little bit—you know, I appreciate everybody's comments today—a little bit off track. Health care is not a market economy. Why? Because the government is involved. Because the government is involved. It is—that is one of the main reasons. So, if I will, I am just going to say why are things more costly.

By the way, since the ACA has come in, insurance has cost—has doubled 129 percent from 2013 to 2019, what people pay for insurance, it is 129 percent up. Yes, there are more people covered, but it is all shifting. So to say it has saved people money is absolutely false.

Why are insurance companies—ma'am, you spoke about—earlier, about the cost when you saw this. I remember when my dad passed away we got an insurance bill—1979, in the hospital for 6 weeks, cardiac surgery complication and died. I think our bill was $25.

Why? Let's look back and see why this is, because I know transparency is an issue, but honestly, guys, that is about five percent of health care. There is monopolies, there is rural care, mostly elective surgery.

What is the number-one determinant of which doctor you want? It is whether you like him, and does he work at that hospital, and do you trust him. And if you want to shop around for a knee replacement, and you find somebody you trust, great, good to you. But that is such a minuscule amount of what we are talking about.

Why are health care costs rising? Insurance companies. Insurance companies.

Last year, in the third quarter, United made a $5.5 billion profit, $20 billion for the year. Their CEO gets close to $20 million. Government regulatory burden. There is a wonderful little chart that I show. Over the last quarter century, the growth of physicians is about that. The growth of the Administration and burden is like that. That delta is a massive provider.

The cost of technology. Everybody now has to have a robot in their hospital. I am not saying that is good, that is bad, but I think we, as physicians, have gone way too much technology, and that is cost of health care.

Extortion of Pharmacy Benefit Managers. Let's get a hold of that for the price of cost of drugs.

The explosion—and I will go back to diet. We talk about health. You can't go on any corner in eastern North Carolina and not find 15 fast food markets. And this is where diabetes, heart disease, obesity where all these things are coming from.

You can't make a patient take a prescription, buy a prescription, and do what you tell them.

And where has the cost not risen? Physician pay. Twenty-two years, twenty percent decrease, the people who are actually providing the care.

By the way, hospitals don't deliver care. They are a building. Doctors and nurses deliver care.

Let me ask you something, a real question here. I am sorry, Dr.—I can't—have a hard time pronouncing your name.

Dr. Gilfillan, one thing that drives me crazy is insurance company CEO pay, but it is also hospital administrator CEO pay. Do you think hospital CEOs should be paid any more than the physicians in the hospitals who deliver the care?

[No response.]

Mr. MURPHY. There is a yes-or-no answer to that, because if you have seen this explosion in the number of hospital administrators, where is the massive delta, and why do you see such an exodus of doctors today——

Dr. GILFILLAN. Could you——

Mr. MURPHY [continuing]. That are leaving? It is one of those reasons.

Dr. GILFILLAN. Could you just rephrase that question?

Mr. MURPHY. Should CEOs——

Dr. GILFILLAN. Just say it again.

Mr. MURPHY [continuing]. Be paid more than the physicians who provide the care in the hospital?

Dr. GILFILLAN. I think they should be paid close to what physicians make.

Mr. MURPHY. Thank you. I agree with that. I don't believe in these CEOs making $14 million, or some hospitals where 9 of the top administrators making 2, $3 million. It is just ridiculous. It is a slap in the face for the doctors and nurses who are taking the care.

Let me just end up—we will talk about the transparency issue. Medicaid—folks on Medicaid don't give a damn about it. They have a $3 co-pay, and they don't care. Medicare, there is—I don't care if I charge $175 million to take out a kidney, I am still going to pay the $175. Now, the hospital charge and everything else is different.

I absolutely believe that we need transparency in health care, but what we truly need is to go after the items that I spoke about earlier that are the true drivers of health care costs, and get the government out of health care, get our insurance companies to go back and do what they were supposed to do, insure patients, not deny care, get Pharmacy Benefit Managers back to what they were supposed to do, rather than triple-bagging now money, and get all these things out of health care. And then we would return to a system in the United States where it was supposed to be, where you don't go to Britain, you don't go to Canada, where people are denied care.

Thank you, Mr. Chairman. I yield back.

Chairman SMITH. Mr. Kustoff is recognized.

Mr. KUSTOFF. Thank you, Mr. Chairman. Thank you for calling today's hearing and thank you to the witnesses for appearing.

Dr. Piniecki, if I could with you, in your statement you talked about when you left the hospital, your prior position due in part to lack of transparency, so at your new practice, or your—the practice that you are at, you do you list on the website costs for all the procedures, from a colonoscopy to an eye muscle surgery to a toe amputation. Everything is fixed, it is transparent.

How do you determine what to charge for a colonoscopy, for example?

Dr. PINIECKI. That is a good example. One of the important tenets of doing what I am currently doing is that I feel a personal responsibility to taking the complexity whenever I can out of the care delivery model. So, for example, colonoscopy. If you operate under the normal fee-for-service process and you submit your claims, you bill for each one of those pathology specimens you take, you can kind of run up the bill really, really easily in the traditional system.

What we elected to do is say, hey, we understand there is going to be certain colonoscopies that are going to be done where no biopsies are needed. That is going to be X price to our business. And there is going to be certain cases where 10 are needed, and that is going to be, you know, a multiple of X price.

And so, we have just taken those numbers, and looked at the data to say, hey, if we amortize that out, what does our cost need to be to cover our expenses and make a small margin, assuming that we are going to take 3.2 polyps out? That way, the impetus is not on the consumer to say, hey, I don't know if I am a 10-polyp

patient, or if I am a 0-polyp patient, because my price is going to vary. We take that liability on our shoulders and say, hey, this is what we are going to charge for everyone, so that we can basically offer the service in a nondiscriminatory fashion, so everyone is kind of treated equally.

Mr. KUSTOFF. Your practice, your clinic, you have got a—you have got a number of the specialties: gastroenterology, ophthalmology. Going back to the colonoscopy just for a moment, so again, your prices are—they are transparent. Do you adjust them X number of times a month, X number of times a year? When and how are they adjusted?

Dr. PINIECKI. Since 2021 we did increase the prices probably about 4 to 6 months ago, quite frankly, due to inflation, inflationary costs. The consumables costs are still there, and the staffing costs. We have tried to do because with our model, again, we employ nurses and technicians, surgical techs that have had multiple years of experience just because we want the best of the best as far as the clinical staff, we want to make sure that we are compensating those folks well and you know, the cost of living is going up, you know, so we wanted to basically incentivize the good people that we have there to stay there and want to be with us. And so there was one price increase in the last two years.

Mr. KUSTOFF. This hearing—and I think rightly so—has been focused on the patient and his or her ability to get care, and to be—to know what they are paying. I could, though—I do want to ask you about the practitioner, because you—again, you talked about the situation that you left and where you are now.

We all talk to different practitioners in our districts. We know the frustrations, starting with the Affordable Care Act. Talk, if you can, about this model and the benefits to the doctor or the practitioner.

Dr. PINIECKI. There has been a significant number of them. There has been some wins that we have had and some losses. I will start out with some wins.

A couple of the surgeon practices across multiple specialties that have agreed to provide clinical services at our facilities, they didn't actually know what compensation they actually needed. They just didn't know. They are just used to submitting their claims, the fee-for-service model, and they didn't really know what was fair. And so, we just tried to be generous and really kind of shift—to Dr. Murphy's point, you know, most of the fee is going to the box, the four walls where the where the actual, you know, services are being provided, not to the ones that are providing the service. So, we just try to compensate the surgeons well, and they are really thankful for that.

And the other interesting part of that was, you know, they said, "Well, how do I get paid?"

And we just said, "At the end of the month, and we just write the check."

And they are like, "That is all there is to it?" And quite frankly, there is. That is all there is to it.

One of the losses that we had was during COVID we had a significant number of employed physicians associated with the hospital systems locally for us who said, "Hey, elective surgeries have

been canceled. We are not actually allowed to operate. Essentially, we have patients that need clinical services, surgical services provided, but we are not allowed to do that right now. I am thinking about taking some time off. Can I provide services at your facility for patients that need, you know, semi-urgent, but still classified as elective procedures?"

And they were told no, and couldn't participate, even though they were not actually providing any clinical services at all because all elective services have been canceled.

And so, again, these are the frustrations that we have dealt with, and that is, unfortunately, one loss that we have had in the employed physician realm.

Ms. KUSTER. Thank you.

Thank you. My time is expired. I yield back.

Chairman SMITH. Ms. Chu is recognized.

Ms. CHU. Dr. Gilfillan, you gave a very compelling argument in your testimony that the transparency in health care pricing that would allow patients to shop around for the cheapest price will not fix the problems that Americans face in obtaining health care. That is because, on top of an inefficient health care system, we have a vast financial and administrative superstructure that takes away from the actual delivery of care. These are the insurance companies, private equity firms, and Big Pharma who are working for market dominance to reduce competition.

Now, I do think there should be transparency, and that we should all know what the cost of health care is in each market. But you make the strong point that asking America's families to address the shortcomings of our health care system when they are the most vulnerable seems inappropriate, ineffective, and has failed to date. And in fact, you give the example of a woman who has just found a breast mass and the impossibility of her being able to shop around for the cheapest health care.

Can you talk further about that example, and whether shopping for health care works?

Dr. GILFILLAN. Certainly, Representative. So, it is easy to say, you know, I have got knee pain and I would—I need—my doctor says I need an MRI. And therefore, I look around for a cheaper MRI.

But how about a person, a woman, who discovers a breast mass? What lies before her and her efforts to deal with it? Is she going to look and shop for an ultrasound? Is she going to go to a primary care doc who sends her one place for an magnetic resonance imaging study? It might be different from the place that she would like to go to see an oncologist who is a particular specialist in this area, who might be centered at a hospital, an oncology specialty hospital, that may or may not be in the network of the insurer that they have, and may or may not have higher prices for one service and lower prices for another service when they go to look online.

There is only a couple of codes, frankly, in the list of 300 or the 70 required shoppable services that actually address this. So then, if she needs—if she, unfortunately, has a cancer diagnosed, where is she going to have chemotherapy? How is she going to shop for chemotherapy? How is she going to decide as she looks around at prices for these 10 or even 20 different services that occur along

the way in her cost of care, what is the trade-off in her mind between price and quality?

Does she think the lower the price, the better the quality? Does she think the higher the price, the better the quality? What is that trade off?

Is—are any of us equipped to make that kind of a trade-off? And I think the answer is no.

And that is just one example of asking someone at an incredibly vulnerable moment to go out and plot their own path not just to getting access to care, but figuring out how much it is going to cost as I get care at all those multiple stages.

Ms. CHU. Dr. Gilfillan, it was back in 2019 with the Trump Administration that there were 2 rules finalized for price transparency, and the Biden Administration continued this effort by increasing penalties for non-compliance. So, this has actually been bipartisan. But despite all that, it has been very difficult for patients to access pricing information. And it is especially difficult for those who lack health literacy, or who are limited English proficient.

So, my first question is what compliance of—what compliance rate is there of hospitals in terms of the price transparency? I know that there were four penalties imposed since the rule started. Is that a little or a lot?

And then what about the health literacy issue?

Dr. GILFILLAN. Yes, well, it is little, I would say. I think we can all agree it is a little.

And I went online, by the way, at my old employer, Trinity Health, and looked to see what their compliance was. They are 100 percent compliant. The tool is nice and, by the way, they bought a standard tool from some vendor that put that together for many hospitals. So, the industry is building that capability.

My understanding from what I have seen is that about 70 percent of hospitals are compliant with various pieces and, hopefully, they are making progress on others.

But when you look at those tools, and when I look at the tools of my fellow panelists here, they are not easy. You know, I know CPT codes. I know more about CPT codes than most doctors because of the—being in the insurance business, right? It is not easy to identify the—to find the service you are looking for, the code. And more often than not, it wasn't there. And when I looked at the prices on some of these sites, quite honestly, the prices didn't make sense, as someone else here said. They are not consistent.

So, when you go out there and look right now, health literacy is an issue, certainly, but basic—the basic data that is being provided in these third-party sites that are set up to help you shop just are not accurate.

Ms. CHU. Thank you. I yield back.

Chairman SMITH. Mr. Fitzpatrick is recognized.

Mr. FITZPATRICK. Thank you, and thank you, Chairman Smith, for holding this timely hearing on the much-needed price transparency in our health care systems and services.

As we all know, the United States of America has the highest cost of health care in the world. In 2021 the U.S. health care spending reached $4.3 trillion. And according to the Congressional Budget Office, meaningful price transparency can add leverage and

promote competition to reduce prices. And one of the goals today, obviously, was for all of us to explore this relationship between price transparency and cost savings in our health care system to better inform patients.

My question, Dr. Whaley, is for you. Currently, hospitals are the only health care providers required to post transparency data. Do you believe the requirements should be extended to other settings of care in which patients can obtain shoppable services?

And if so, which settings would they be?

Dr. WHALEY. Thank you for the question.

Hospital care accounts for about half of health care spending, or about 45 percent of health care spending, meaning that there are many other sites of care where patients are receiving lots of care.

I think if the price transparency requirements were to be expanded, there are many settings that would be natural settings, both in which patients receive lots of care, and it is also the shoppable types of care where patients are making these types of decisions. So, these environments include places like ambulatory surgical centers, freestanding imaging and laboratory test centers, and potentially physician offices.

Mr. FITZPATRICK. And providing access to price information, obviously, has been very important in my home state of Pennsylvania, and our hospitals in Pennsylvania. Every hospital has a patient advocate or a financial counselor. These individuals are available to discuss pricing with anyone in order to clarify costs.

Have you examined the benefit that a program like this can have on providing pricing information to patients?

Dr. WHALEY. Unfortunately, we have not studied patient advocates directly.

Mr. FITZPATRICK. Mr. Chairman, I yield back.

Chairman SMITH. Mr. Steube is recognized.

Mr. STEUBE. Thank you, Mr. Chairman. I think one of the things that obviously has come out through all of this is there is a significant lack of transparency in the hospital marketplace.

I had the fortunate or unfortunate situation about four months ago to spend four days in the hospital. It was a trauma-type situation, so I obviously didn't have control over what hospital I went to, and all of that. But just to give you kind of an idea of what I personally went through and have now a lot of information on this, I mean, at no point in time while I was at the hospital did anybody say, hey, this procedure is going to cost this much or, hey, if this doctor comes, it is going to cost this much. Like, there was no communication whatsoever on any prices on anything.

And then this came about, I don't know, a month or two later, and this is the bill that I got: five pages, single space, of all these things that supposedly happened to me while I was there. Like, I broke my pelvis. I had a punctured lung. I don't know why I needed an EKG. Nobody asked me if I wanted an EKG. Maybe that is—the doctors are gone, maybe that is just something they do, and they don't ask you. But, like, there was no communication with the patient about the procedures that were going to be done.

Now, I got excellent care, so I am—I don't want you to take what I am saying is I didn't get good care. But from a patient perspective, there was no communication about how much. And this was—

these four days, this was over six figures of just being in the hospital, being told, okay, this is what we are going to give you, this. At one point I was told we were taking you in for a procedure, and he kind of explained what it was going to be before I went in there. And that is significantly problematic for patients that, when you get this in the mail a few days—well, a month or so afterwards, and you look at the numbers, and you are like, holy cow, like, there was no communication about any of this. It is, obviously, challenging.

Luckily, we have health insurance, so there wasn't too much of a challenge there. You pay your co-pays. The other piece of it that was interesting that I have learned through this process is multitudes of doctors showed up during my four-day stay, and I didn't know who these doctors were. They showed up and then, on top of this bill, I got other bills for the doctors that just showed up. I didn't know who they were. I didn't invite them to come in. I didn't say yes or no, I would like you to talk to me for five minutes to give your expertise on my broken pelvis.

So, there is some significant issues that have to happen, in my opinion, on the health care side for the consumer and the patient, regardless of whether it is trauma or not trauma. I mean, I was conscious the entire time. So there could have been communication. My wife was there the entire time. There could have been communication.

So my question—and I will open it up to the panel—is what can Congress do, from a legislative perspective, to breathe in some transparency so that when a patient like myself or otherwise—Americans show up at a hospital, regardless of what the circumstances is, there is some communication between the hospital and the patient of, okay, you are here for X, so this is what we are going to do, this is going to cost X amount. If you stay one day in the ICU, that is going to be $8,000. Do you have a, you know, choice as to whether you want to do this at home or come and do an outpatient?

Like, what can—I am just asking you, because you guys are professionals. I don't know, I am just—I was a patient. What do you think that we could do to breathe some free-market transparency and some patient advocacy into the ability to be able to make those determinations?

I will open it up to anybody that wants to comment.

[No response.]

Mr. STEUBE. Don't all jump in at once.

Dr. PINIECKI. I got a couple looks over here, so I guess I will take that. [Laughter.]

Mr. STEUBE. Yes, go ahead.

Dr. PINIECKI. One of the biggest things with the transparency—I don't know if you want to call it a movement—is that the more we are able to get numbers out there, and accurate numbers, whether that be elective surgery, whether that be emergency surgery, whether that be emergent trauma care, whatever that might be, emergent imaging or elective imaging, the more we get the information out there to have comparative pricing, it is going to keep the bad players more honest. They are just not going to get away with things.

And so, I bet on that bill, if I had a chance to look over it, I could tell you from almost most of the line items, hey, this is reasonable, this is unreasonable, and that is just me. If you have transparency and actually have that data out there, and have claims out there from the person that came before you—and this is what that hospital charged—it is just going to keep that hospital honest if they are not being honest. And I don't know if they are, but it is just going to level the playing field and actually have the information available, and then the bad players will be called out for it just, you know, amongst, you know, the industry at large.

Mr. STEUBE. So, requiring—just to kind of summarize what you are stating—just requiring hospitals and providers to provide information on what X service is going to cost, put it on their website or wherever, so that when a patient does show up they know and have transparency. Like you mentioned, radiology. I had apparently 14 units of radiology, and that cost $38,000. I don't remember all of those scans. I don't remember what they were.

So, you are just saying, like, if there was some information on a website that is public and available, and when you show up you kind of have an idea, is that—am I summarizing that correctly?

Dr. PINIECKI. I think that is fair. I will give you an example. I don't know what 14 units of radiology means, but I use an example. You probably had an MRI or CT scan. The hospital—a hospital-scheduled MRI is, you know, anywhere from 3 to $5,000. You can get that for about $700, you know, with the same type of study done.

And so, when those numbers actually come out, if it were transparent, what is being charged with any given system or entity, it is—the systems will police themselves, right?

You know, at that $5,000 study, the machine cost the same as the $700 study. If there is a 400 percent margin there, there is probably a local system, You know, probably wherever you receive care, that is willing to say, hey, I will accept a little bit less margin, you know, hey, we are not going to gouge you like that guy did.

And so, I think you will start seeing some self-policing and market correction with some of these major outliers.

Mr. STEUBE. Thank you. My time is expired.

Chairman SMITH. Ms. Moore is recognized.

Ms. MOORE of Wisconsin. Thank you so very, very much, Mr. Chairman, and thank the panel for your long suffering through the Ways and Means Committee.

Mr. Gilfillan, I noticed from your testimony that you talked about the creation of an all-payer payment system. Can you sort of elaborate on that, and make the distinction between that and a single-payer system for us?

Dr. GILFILLAN. Certainly, Congresswoman, thank you. And I would say, in response to your experience, Representative Steube, I think the all-payer approach is what is needed. And you needed the EKG, I am sure, with those kinds of injuries. So, I am glad you had a good outcome from that.

But an all-payer system says you have gotten that bill, and the hospital charges all sorts of different ways, and those are charges, not payment amounts, I assume. And that is because they are kind

of free to do it their way. And every one of them, 6,000—those 6,000 hospitals will do it their way, and every insurer is going to ask to get it their way. And an all-payer system would say, you know what? We are going to do this one way. Here is a standardized way of doing this. This is the way you should submit your bills. And by the way, what I pay you is going to be based on the rates that we have established for that particular set of services.

And I don't believe shopping, you know, at the hospital bed is really a viable thing to be doing. So, I would take you out of that predicament, and simply say there is an all-payer system. Different insurers can use it—will use it, are required to use it, so we don't have this a la carte madness.

Ms. MOORE of Wisconsin. Got you, got you, thank you so much.

You talked in your testimony about the Medicare Advantage industry benefitting from government intervention, including subsidies. Many have bemoaned the fact that medical assistance is facing funding crises. So, is the Medicare Advantage system better? Is it worse? Does it have more quality? And how does it interface with the payments for medical——

Dr. GILFILLAN. Yes. Well, I think it is pretty clear. I think it is almost universally acknowledged that it costs more. How much is debatable. It is somewhere between 20 and 30 percent more, probably, or some would say 10 to 25 percent, I guess, would be more accurate. Definitely more expensive.

In terms of outcomes and quality, it is debatable. MedPAC, the organization that advises you all, Congress, on Medicare policy, has said it is impossible to determine and compare the quality of care in Medicare Advantage versus ordinary Medicare.

And I would just go back to Congressman—original point, Congressman Murphy—and say we do indeed have the worst. We have the worst of government, and we have the worst of business marketplaces coming together to create a system which is unaffordable for all.

Ms. MOORE of Wisconsin. Let me ask you one other thing. There has been a lot of discussion about health savings accounts. And is it just unavailable to people who are low-wage workers or—and I just want you to elaborate on that a little bit.

Dr. GILFILLAN. It certainly is. It is—most families in America have limited savings. Many live from paycheck to paycheck, and do not have ready—readily available disposable income. And that is why the penetration of health savings accounts has been so slow, so low.

Ms. MOORE of Wisconsin. I just have one other question. I want to backtrack a little bit on my Medicare Advantage service. There are things like, you know, exercise or swim classes or things that people on Medicare Advantage say that they get that you cannot get under Medicare, regular Medicare. Is that the case?

I mean, people prefer Medicare Advantage because they get those extra things. I just wanted you to comment on those different——

Dr. GILFILLAN. Yes, there are extra benefits that are provided through Medicare Advantage. There still are co-pays. It is sometimes deductibles and co-insurance. So, it is not free coverage, although the premium can be free. Yes, there are gym memberships. Yes, there are other services. Many of those supplemental services

actually are not very utilized because if you are a person with no disposable income and you have the inability to pay to go to see a dentist, and now Medicare Advantage plans give you coverage for half the cost of going to the dentist, you still don't have the money to cover the other half. So, it turns out that the use of those supplemental benefits is actually pretty marginal in most markets today.

Ms. MOORE of Wisconsin. Thank you so much.

And Mr. Chairman, I would yield back.

Chairman SMITH. Thank you. I will point out that 78 percent of all individuals who use an HSA make less than $100,000 a year. It is a pretty big number.

Ms. Tenney is recognized.

Ms. TENNEY. Thank you, Mr. Chairman, and thank you, Ranking Member Neal, for holding this hearing, and thank you to our witnesses, a terrific job today from various perspectives.

And almost any market, assuming there is a market, we interact with in American life functions best when we have the two necessities: we have access to clear information and transparent pricing. That is, if people really do have a choice. Without these qualities, it is impossible for the patient to know if their care is good, a good value for the price, and if they should be looking elsewhere for care.

Again, we get to the question of do they really have a choice. And I come from New York. A lack of market information and transparent pricing in our health care sector is just one of the many reasons—and there are many, as Dr. Murphy pointed out—that we have seen a rapid expansion in health care costs from premiums to co-pays and co-insurance. Our health care system is not failing because it is free market. It is because it is not a functional free market. And anyone who wants to come to New York to see among the highest health care costs in the nation, you can see how it is not working in New York.

And as a family business owner, I can totally relate to Ms. Troiano. We face enormous pressures. We had health care for our employees, which we provided without a mandate because we wanted to be competitive against our neighbors, our competitors, and also government that was providing pensions and health care, and we were trying to lure great employees and great people to come to our company.

But today we went from a rate of about 5,000 a year for a family plan to over 29,000 a year for a small family business with about 60 employees. So, we know this enormous cost is just really almost prohibitive for us to even stay in business because we can't compete against government on so many levels. So, the so-called Affordable Care Act has made it almost impossible for us to stay in business and to actually have affordable, good care for our clients, not to mention the really high deductibles that we face.

But I wanted to ask you, similar to the Clark Grave Vault, many of the small businesses I represent, as well as my own company, as I cited, have seen enormous interest in their health care premiums—seen increases in their health care premiums. In your company's switch from traditional health care insurance to the innovative Sidecar health care, how much were you able to save in premiums compared to what you were quoted for other plans?

And have you been able to provide any additional benefits to your employees?

Ms. TROIANO. So, Sidecar Health came in. Our original—United Health care was our carrier for six years. They came in with a 35 percent increase. There were three companies that would not even quote us. They did a no-quote on us. Sidecar Health came in and, actually, our premiums increased 10 percent. So, it was a palatable amount. It was amount we could absorb, and passed on very little to our employees. I think the employees' single care coverage went up $3 a month.

We offer an FSA, not an HSA. Our employees like the FSA, they—we have a lot of participation. About 68 percent of the people who are in our health care plan are in our FSA. But they like the Sidecar plan because they don't have any funds going out of their own initially. It is all funded by Sidecar up front. They know the health care, and they are very good at shopping it. They are very good at shopping.

Ms. TENNEY. So those are—provide those additional items that you couldn't provide otherwise.

Ms. TROIANO. We couldn't have provided them anything near what Sidecar has, where they don't pay anything for prescription costs.

Ms. TENNEY. Terrific.

Ms. TROIANO. Yes, which is something that is a big part of our cost.

Ms. TENNEY. Thank you for that. I appreciate it. It is a great idea.

Mr. Short, in your testimony you outlined how the subscription-based direct primary care model has been effective in improving health outcomes and reducing costs for patients. Great to hear this. These are among the facts as a core reason why I joined my colleagues, Representatives Smucker, Blumenauer, and Schneider, to introduce the Primary Care Enhancement Act. Can you describe how direct primary care model reduces costs upstream and increases the quality of life for patients?

Mr. SHORT. Absolutely. With the ability to moving the payments directly to the health care provider at the behest of the individuals, we are able to cut off a tremendous amount of overhead, and then incentivize the individual primary care physicians to actually take an additional interest in the preventive health care. And by going after preventative health care as a means to offset future health care expenditures, we are able to bring down the cost of care. And also included in that cost of care is reducing the cost of payment acquisition.

Ms. TENNEY. But would you—would you change our health care payment system now to make our health care sector more responsive for these cost-saving innovations like direct primary care?

Quickly, we have got a few seconds left.

Mr. SHORT. So, everything that is non-catastrophic we need to move down directly to the patient and the provider relationship by increasing those payment accelerations, by reducing the account receivable and the payment cost of acquisition.

Ms. TENNEY. Thank you so much.

I yield back.

Chairman SMITH. Mrs. Steel is recognized.

Mrs. STEEL. Thank you, Mr. Chairman.

Our nation's inflation problem has shifted from goods to services. The jump in medical inflation is concerning, as rising prices for services tend to decline more slowly than for goods. On top of that, according to a recent LA Times article, health care spending now accounts for almost one fifth of America's economy.

I view addressing rising medical costs involves two matters: greater health care price transparency and more competition. I believe currently, hospital price transparency doesn't work, because it is not good enough, and CMS has largely failed to hold the hospitals nationwide accountable for non-compliance. So, my question is to Mr. Kampine.

I am concerned about the quality, consistency, and usefulness of the data provided with the hospital price transparency requirements. Do you believe there is a lack of standardization and specification in reporting requirements?

Mr. KAMPINE. Yes, absolutely. Certainly, yes. That is part of the reason for some of the variability in the files that we look at. It is very difficult to work with.

Mrs. STEEL. Thank you for a very precise answer. I really like that.

And I also believe that increasing health care price transparency, paired with modernized health care options will drive value and temper the trend of rising health care costs. For example, telehealth has been life-changing for so many over the past few years, and we should remove red tape that prohibits families and individuals from having access to this option. This is why I introduced the Telehealth Expansion Act and—with Congresswoman Susie Lee and Congressman Adrian Smith and Congressman Brad Schneider.

This legislation would make permanent a waiver created by the CARES Act to allow over 34 million Americans with health savings accounts to access telehealth services without first having to meet their deductible.

I also support improving both HSA and direct primary care access, which Congressmen Brad Wenstrup and Brad Schneider have been leaders on.

So, Mr. Short, I believe telehealth access is vitally important for all of America. Last—late last year the Ways and Means Committee worked in a bipartisan manner to extend first-dollar coverage of HDHP, high-deductible health plan, HSA telehealth after it had already expired early in 2022. As we get closer to next year, I am very much concerned about this provision expiring again. We try to make it permanent, but every year we are just barely extending one year. Last year we extended two years.

What are some of the consequences of not having access to telehealth pre-deductible for the millions who have HSAs?

And secondly, how would we improve access to HSAs, moving forward?

Mr. SHORT. I think the ability to, you know, increase access, even using technology through telemedicine, is critically important because physicians are trained to know when someone is having bad Chinese food or a heart attack. And it is important that we have the ability for people to have access to care from all types of

pieces to it, which drives different types of health care outcomes, consequences if diagnosed indirectly. So, if you don't have access to telemedicine, easy access to care, you are going to see more people going to emergency rooms, which is going to increase the cost of care.

And so how can we increase HSA access to more people? Well, it is getting HSAs for all, getting people to have the ability to have more access to HSAs in—regardless of the health insurance plans that they have. That is how I would expand all of it.

Mrs. STEEL. Thank you very much. I yield back.

Chairman SMITH. Mr. Kildee is recognized.

Mr. KILDEE. Thank you, Mr. Chairman, and just a point of personal privilege, I want to thank the Chairman, the ranking member, and other members of the committee. This is my first time back to committee since my cancer diagnosis and surgery, which was successful, and I appreciate all the kind well-wishes and support during that period. It meant a lot to me personally, and I am very grateful and, obviously, grateful for the outcome, and continue to remain positive about the future. So, thank you so very, very much to all of you for that.

And to the witnesses, thank you for your testimony.

I am from Michigan. One out of ten Michiganders has some form of diabetes, and access to insulin is literally a matter of life or death for those people that I represent. For those patients there is no shopping, there is no health care shopping. They have to be able to access the medication that their doctor prescribes for them.

I do support increased transparency in the health care system for lots of reasons, but we can't expect transparency alone to rein in the rising costs of health care, particularly when there are patients that depend on insulin and don't have the luxury of selecting their treatment based on cost. It is one of the reasons that we passed the "Inflation Reduction Act", which included legislation that I helped write to cap insulin at $35 a month for seniors. Of course, we wrote it to apply to all insurances, and we will continue to work to meet that goal.

Also allowing Medicare to negotiate prescription drug prices will make a difference, taking patients out of the middle. We delivered a real promise of better health care for seniors, and millions of dollars of savings.

But obviously, our work isn't done. The focus of this hearing addresses much of that. But people are still struggling to afford insulin. Patients with diabetes are also struggling to afford the cost of supplies and equipment that are used to manage the disease. And of course, we know there has been dramatic improvement in the delivery mechanisms for insulin. Continuous glucose monitors, the insulin pump: just a couple. And that continues to evolve.

So, Dr. Gilfillan, I wonder if you, in your experience at Trinity, in which role you provided direct support to many people in Michigan that I represent, if you might comment on two things.

One, on how the cost of these important aspects of diabetes care, the equipment, how making more affordable diabetic equipment would impact outcomes for those 1 out of 10 Michiganders that I represent, but I think, important to this conversation also—and

Mr. Short, I took note of your testimony, where you mentioned the cost of untreated diabetes.

So, Dr. Gilfillan, if you might comment on the health outcomes and the cost impact of making more affordable the necessary equipment, not just insulin, but the equipment to more efficiently and effectively deliver that remedy to those patients, what impact that might have on health outcomes and on the cost to not just the Federal Government, to all those who help underwrite the cost of health care?

Dr. GILFILLAN. Certainly, Congressman. I am glad to hear your recovery is going well.

And I must tell you, I really enjoyed my five-and-a-half years in Michigan. Wonderful people and good weather for a significant part of the year. Yes, right.

I think—and congratulations again on the insulin coverage and cost. Very important.

There were stories, you know, about young type 1 diabetics who were rationing their own insulin, and who died as a result of going into diabetic ketoacidosis, the primary complication of that. It is remarkable, and I think it is probably one of the most striking points of evidence about a health care system more oriented on wealth for institutions than health for populations that we allowed pharmaceutical companies to increase the price of insulin the way they have.

I mean, it is—in any other business it would be unconscionable. But somehow, we allowed that to happen.

I think the cost of supplies—it is just—every element of the system is currently used to optimize revenue and profits for the institutions that operate. And so, they use diabetic supplies to exactly that end.

And I would suggest the way to deal with that is through a comprehensive coverage program that doesn't have these funny exceptions about DME or other ancillary services that just says straight up, you get what you need, and make a system of—network of providers accountable for delivering those services.

The costs associated with diabetic complications is extraordinary. And I don't know the percentage, frankly, of the dollars spent in commercial insurance—maybe Chris does—for diabetic complications, but it is significant, and it is probably on the order of 10, 15 percent, I would guess. So, it is a major expense. And I would urge you to get that coverage for both insulin and diabetic supplies passed for the commercial and virtually for all covered populations in the U.S.

Mr. KILDEE. Thank you for that, and I thank the chairman for allowing a little extra time.

The cost of a CGM or an insulin pump along with affordable insulin more than offsets the cost of even a single complication and could be life-changing for those people.

So thank you very much, Mr. Chairman. I appreciate it and I yield back.

Chairman SMITH. Mr. Kildee, we are pleased to have you back in the committee. And one minute is the least we could do, but we appreciate you being here.

Mr. NEAL. I think it was unanimous, wasn't it, Mr. Chairman?

Chairman SMITH. It was. It was, absolutely. We did it.

Mr. Smucker.

Mr. SMUCKER. Thank you, Mr. Chairman, and I would like to say, as well, it is great to see Mr. Kildee here.

You are looking great. Maybe better than normal. I don't know. [Laughter.]

Mr. SMUCKER. But anyway, Mr. Chairman, I would like to also thank you for holding this important hearing. And I was a small business owner myself, with about 150 employees. And I have seen the value of empowering patients to have as much say as they can in their own health care choices. And I have seen how that can help to reduce costs and improve outcomes.

And I also developed the real frustration when, you know, red tape or regulation, whatever it may be, in our health care system got in the way of the delivery of the services or got—undermined patients' abilities to make their own informed health care decisions. So again, this is a great hearing today.

I would like to specifically talk about that in the context of direct primary care, which—I appreciated Mr. Blumenauer's comments on that earlier today. It is a bill that we are working on together, and it is important to me, because I have seen the impact in my community, where different groups, whether it be business owners who are providing the services, have really used this innovative payment model to really make a difference in people's lives, better access to that primary care when needed, sometimes bringing people—or encouraging people to get care earlier, which sometimes can have a real impact, rather than letting a condition get worse.

So—and again, you know, I think folks know, but just reiterating, this is a monthly fee that is being paid to doctors for a suite of primary care services, rather than paying a fee for each service. So, patients like it because they get reliable, high-quality preventative care. It keeps them sometimes out of higher-cost sites of care like the emergency room.

They also know exactly how much they are going to pay each month for that if it is not being paid for by their employers. But employers like it because investing in that preventative care for employees helps them to be more healthy, and also they are more productive.

And I think in my community, at least, doctors like it because that monthly payment structure means they can spend less time coding for services and doing what they really want to do as doctors: spending time caring for their patients.

And so, this current IRS rule that prevents 32.5 million Americans with a health savings account from participating, from using those funds to pay for direct primary care, I think, is something that—it is a small fix that I think would benefit a lot of people, and that is why, as I mentioned, I am proud to work with Mr. Blumenauer. Ms. Tenney, I think, talked about it, as well, Mr. Schneider, on the Primary Care Enhancement Act, H.R. 3029, which would fix that gap in our tax code and expand access to direct primary care. The legislation has been favorably reported by this committee on a bipartisan basis in primary congresses, as well. So hopefully, this is the session that we can fix this.

Mr. Short, employers offering direct primary care report savings of over 22 percent, or 20 percent in some cases, and I wonder if you could just talk a little bit about that, explain how it can both reduce costs and also improve health outcomes for patients.

Mr. SHORT. Absolutely. Even in my company we offer and pay for direct primary care for that very reason: the savings we have been able to uncover by having the program in place for now over eight years. And the simple fact is we are able to incentivize the health care providers and the direct primary care physicians to act—to take an active role in the preventive medicine of our employees and their families. And by getting them actively involved, we are actually—their incentive is to keep people healthy versus a fee-for-service world, where they make money when people are sick.

We have seen the actual results come through and avoiding larger claimants, where diabetes is a great example. If we can get a hold of diabetes first, before it becomes an issue with metformin and other processes, we can save money for the plan. And we are seeing that in real life. We saw the Milliman study as well, and we are seeing it across the country.

Mr. SMUCKER. Do you see any reason why patients with HSAs should not be allowed to partake in direct primary care?

Mr. SHORT. I see no reason. It seems like common sense.

Mr. SMUCKER. Yes. And can you explain why direct primary care, it is not health insurance, and the IRS at this point is treating it as such, can you explain that?

Mr. SHORT. Yes, so direct primary care is a set of services, very, you know, focused on primary care, while insurance is a global coverage for multiple things beyond just primary care.

Mr. SMUCKER. Thank you.

Thank you, Mr. Chairman.

Chairman SMITH. Mr. Hern is recognized.

Mr. HERN. Thank you, Mr. Chairman, for having this hearing.

The first step to making health care more affordable is knowing how much things cost. No industry in America is as opaque as the health care system. It is ridiculous that Americans are in the dark about the cost of life-altering medical procedures, and I am extremely disappointed that my colleagues on the other side have turned this into a partisan issue.

The price transparency rules put in place by the Trump Administration was a good start, requiring hospitals to post prices on their websites. But unfortunately, most hospitals continue to make these tools hard to find and hard to navigate. There is no reason for hospitals to hide this information from patients. Hospitals are capable of providing helpful price transparency tools. I have seen it in several facilities across my home state of Oklahoma. The lack of price transparency is driving the trillions in spending on the health care in this country. We cannot expect Americans to get the best bang for their buck if they are unable to see the price of services that they are using.

Now I want to take some time to clear up some misconceptions that I have heard today. As we all know, over 180 million Americans have private or employer-sponsored coverage. That is more than half of the country. It is critical this committee strengthens

these health care benefits not only for the individuals using it, but to alleviate the strain on government programs like Medicare and Medicaid. These programs are ballooning in size, and the people who actually need them are suffering the most.

That is the most ironic thing about the Democratic colleagues today turning into a partisan hearing (sic). Establishing price transparency rules and strengthening the employer market helps the sick, the vulnerable, and the needy. That is why I know this comes down to one fundamental difference between the two parties. We have said it often. Conservatives believe in the consumers, and that they can do best with what money they have, not the Federal Government, who thinks they are better equipped to spend the people's money, and choose their——

[Audio malfunction.]

[Slide]

Mr. HERN. Now let's turn to this slide behind me. This slide has data from where I live in Tulsa, Oklahoma. It shows how premiums and out-of-pocket maximums are significantly lower on employer-sponsored plans accompanied with tax advantaged accounts. You can see that these premiums are roughly $77 and can be as high as $1,282 on an ACA plan. That is over $1,200 in savings per month. That means something for my constituents, especially in the area of persistent Bidenflation.

And when you look at this, you know, you have to look at this and say we are not here to discredit the ACA. We are here to—it is here to stay. And after the billions spent, Republicans and Democrats have a responsibility to come together and make it better. But frankly, I am tired of the other side saying the free market and health care just does not simply work. That is not true. This chart makes it clear that employer-sponsored care and tax advantaged accounts deliver savings to enrollees. Lower premiums, lower deductibles, and lower out-of-pocket costs are all good things for Americans, regardless of what state you are in, regardless if you are a Democrat or Republican. These savings are good and should be looked at.

So let's cut it out with the politics, and let's work together to make good policy, price transparency being one of those.

I yield back.

Devenir Research

2021 Devenir & HSA Council Demographic Survey

report release date: 07.11.2022

DEVENIR

Table of Contents

Report Methodology

The majority of this report was derived from the 2021 Devenir & HSA Council Demographic Survey. The survey was carried out in April 2022, and largely consisted of top 20 providers in the health savings account market. All data was requested for the period ending on December 31st, 2021.

Survey responses are self-reported by each HSA provider. When possible Devenir attempts to verify responses through a variety of channels, including but not limited to, press releases, annual reports, prior research, and NCUA/FDIC filings.

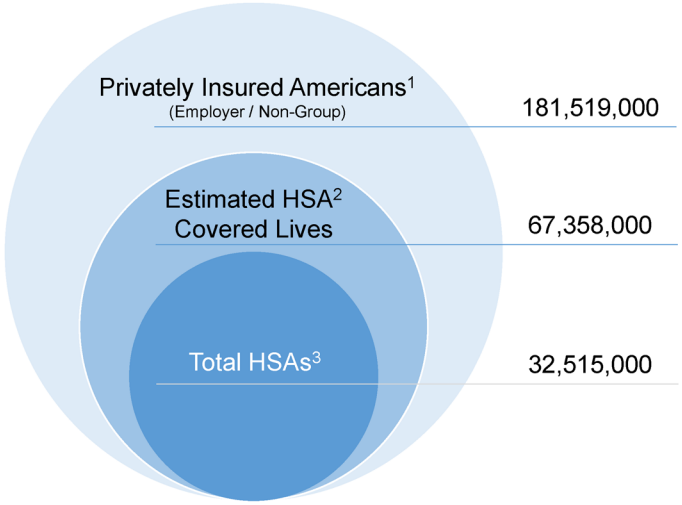
Key Findings

Over 67 million covered by an HSA. Devenir estimates that as of December 31st, 2021, there were 32.5 million HSAs, covering 67 million people.

Millennials embrace HSAs. Younger consumers have embraced health savings accounts. About 1 in 5 Americans in their 30s had a health savings account at the end of 2021.

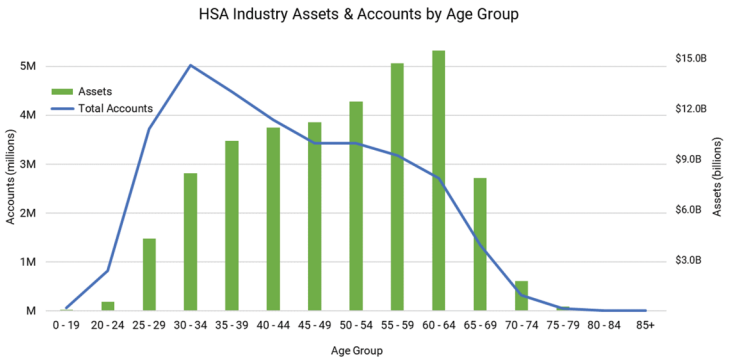
Older Americans continue to accumulate meaningful HSA savings. Accountholders over the age of 50 held almost $53 billion in their accounts at the end of 2021 (up 19% from the year prior), with an average balance of $4,758.

HSAs utilized across income spectrum. 78% of health savings accountholders have a household income of less than $100,000.

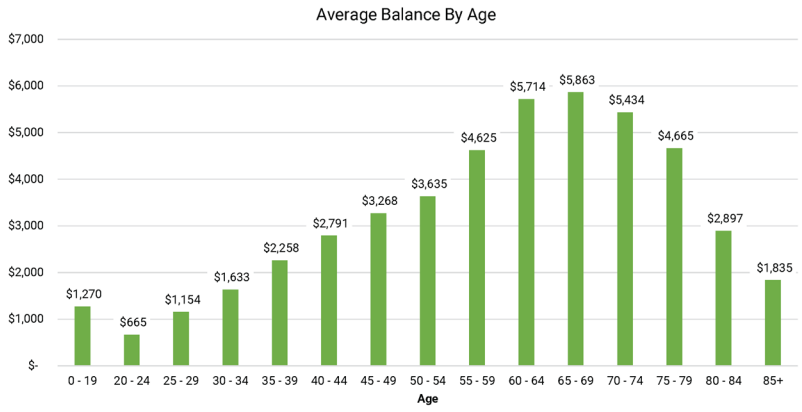


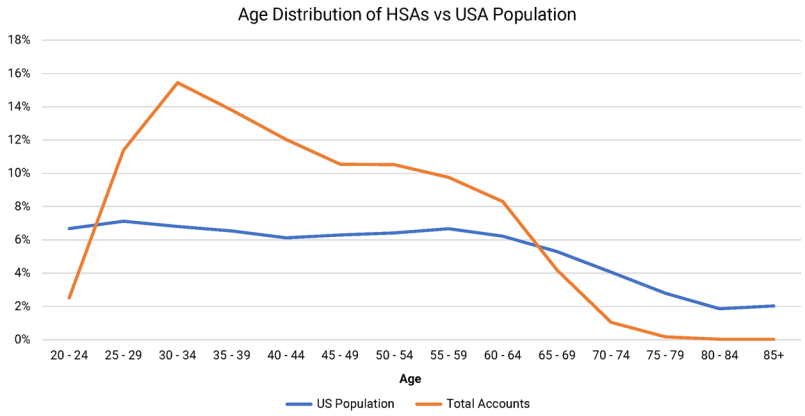
[1] Health Insurance Coverage of the Total Population | KFF
[2] Calculations from 2021 Devenir & HSA Council Demographic Survey, 2021 Year-End Devenir HSA Market Survey, & U.S. Census Bureau
[3] 2021 Year-End Devenir HSA Research Report

Age Demographics of Accountholders



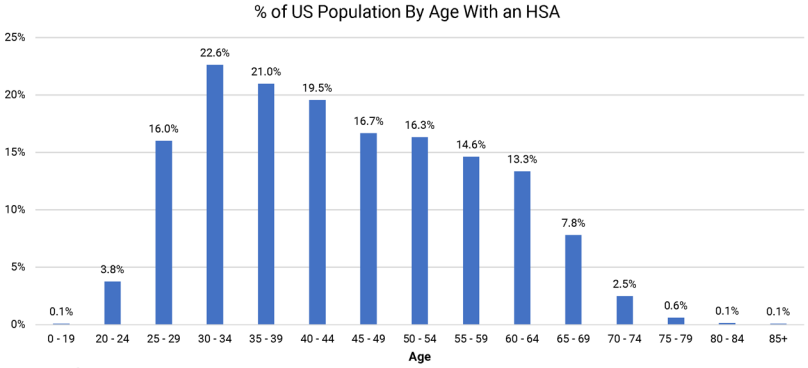
Age Group	0 - 19	20 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69	70 - 74	75 - 79	80 - 84	85+	Total
Accounts	0.07M	0.82M	3.72M	5.02M	4.48M	3.91M	3.43M	3.42M	3.18M	2.71M	1.35M	0.33M	0.06M	8K	6K	32.51M
Assets	$0.08B	$0.54B	$4.37B	$8.20B	$10.11B	$10.91B	$11.21B	$12.45B	$14.72B	$15.49B	$7.92B	$1.80B	$0.26B	$0.02B	$0.01B	$98.02B





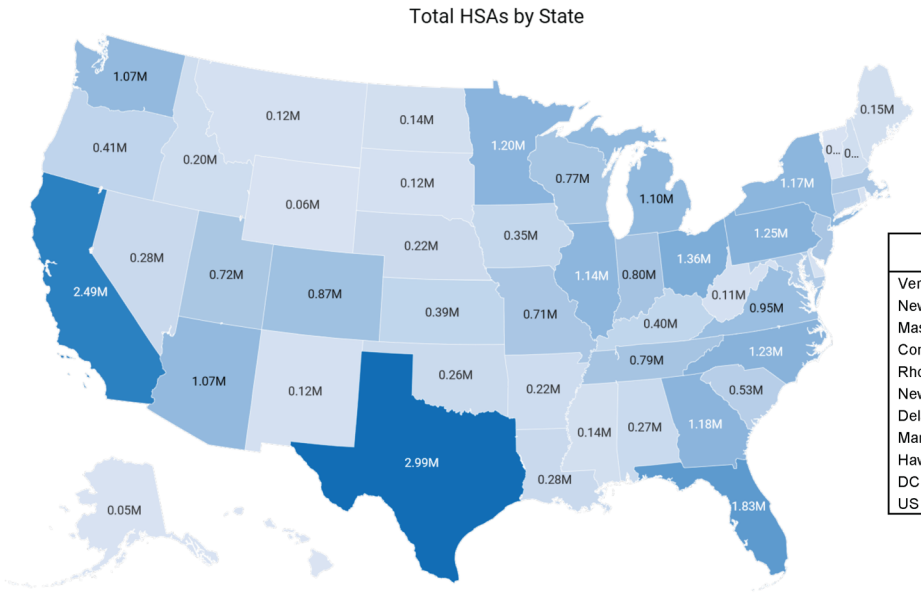
29%
of health savings accountholders are in their 30s

31%
of HSA assets are held by accountholders aged 55 to 64 years old



Factors like one individual having more than one HSA may reduce these percentages.
2021 Devenir & HSA Council Demographic Survey & U.S. Census Bureau

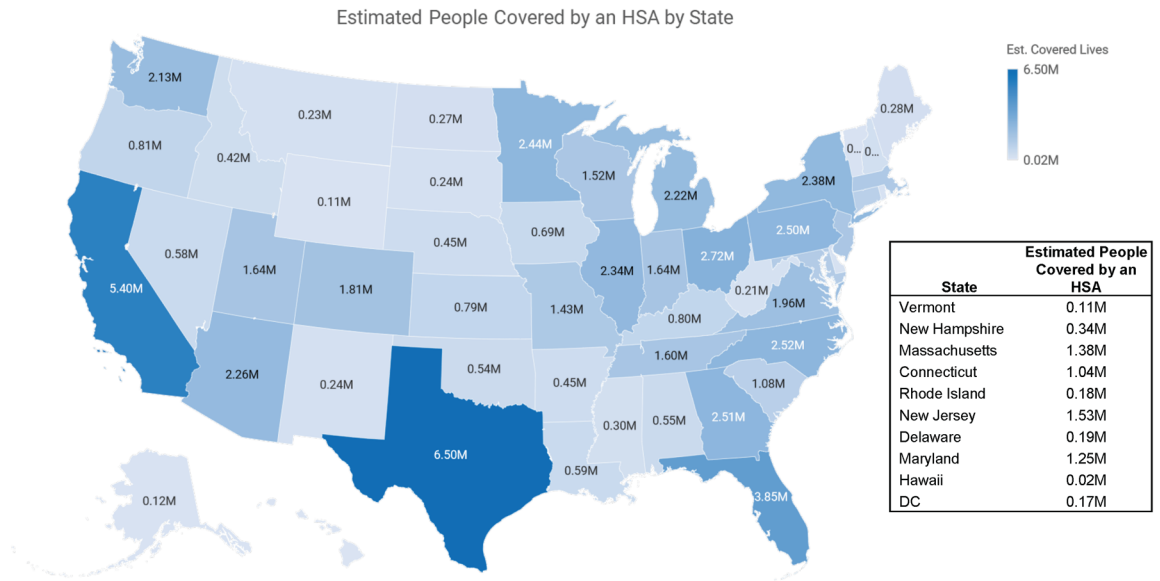
Estimated Total HSAs by State



State	Estimated Total HSAs
Vermont	0.06M
New Hampshire	0.17M
Massachusetts	0.68M
Connecticut	0.51M
Rhode Island	0.09M
New Jersey	0.74M
Delaware	0.09M
Maryland	0.59M
Hawaii	0.01M
DC	0.08M
US Territories	0.004M

2021 Devenir & HSA Council Demographic Survey

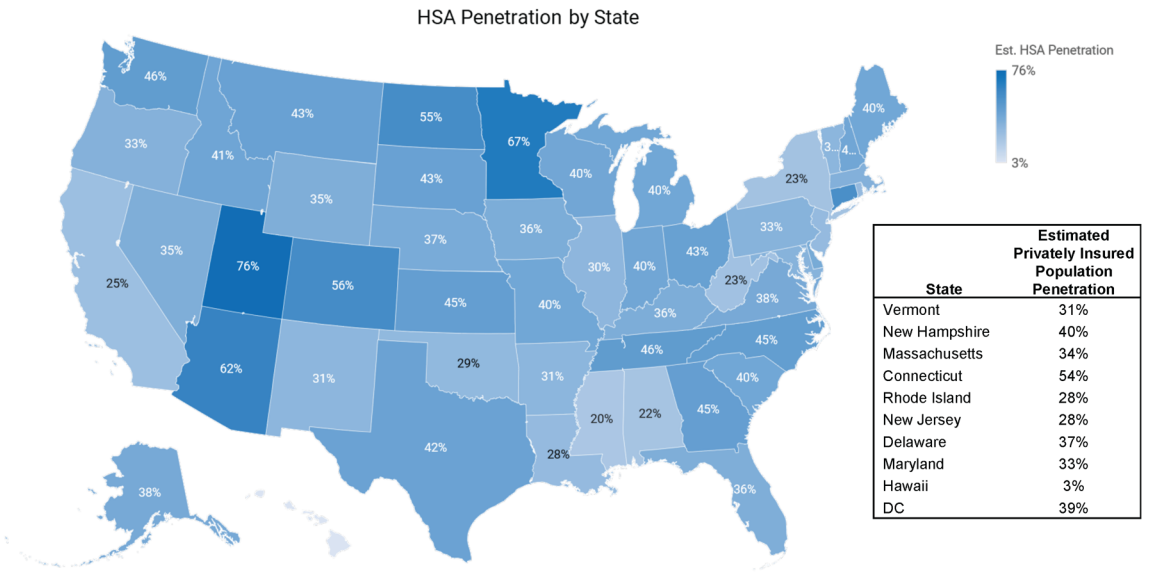
Estimated People Covered by an HSA by State



State	Estimated People Covered by an HSA
Vermont	0.11M
New Hampshire	0.34M
Massachusetts	1.38M
Connecticut	1.04M
Rhode Island	0.18M
New Jersey	1.53M
Delaware	0.19M
Maryland	1.25M
Hawaii	0.02M
DC	0.17M

2021 Devenir & HSA Council Demographic Survey & U.S. Census Bureau

Estimated Privately Insured Population HSA Penetration

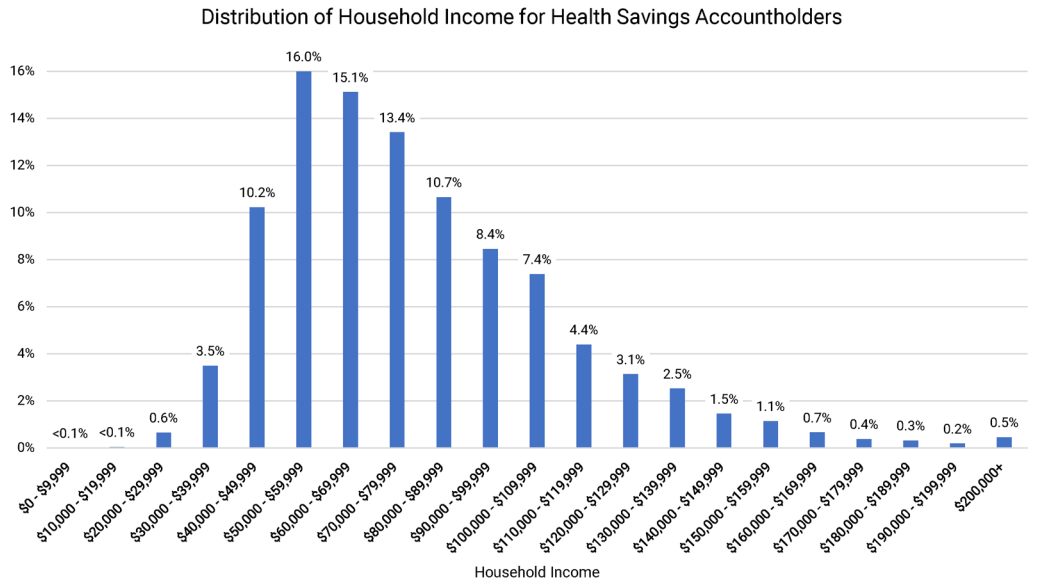


State	Estimated Privately Insured Population Penetration
Vermont	31%
New Hampshire	40%
Massachusetts	34%
Connecticut	54%
Rhode Island	28%
New Jersey	28%
Delaware	37%
Maryland	33%
Hawaii	3%
DC	39%

2021 Devenir & HSA Council Demographic Survey, Kaiser Family Foundation & U.S. Census Bureau

Health Savings Accountholder Household Income

78% **of health savings accountholders have a household income of less than $100,000**



2021 Devenir & HSA Council Demographic Survey and the U.S. Census Bureau's 2020 American Community Survey (ACS). We assume that accountholders are reflective of the community and zip codes in which they live, and we then make inference assumptions about health savings accountholders. Zip code median household incomes were derived from the 2020 ACS.

Appendix

Totals by State Table

State	Total Accounts	Assets	Average Balance
Alaska	0.05M	$0.21B	$3,855
Alabama	0.27M	$0.45B	$1,669
Arkansas	0.22M	$0.42B	$1,891
Arizona	1.07M	$2.76B	$2,579
California	2.49M	$10.29B	$4,129
Colorado	0.87M	$2.84B	$3,262
Connecticut	0.51M	$1.85B	$3,611
District of Columbia	0.08M	$0.22B	$2,629
Delaware	0.09M	$0.29B	$3,068
Florida	1.83M	$4.40B	$2,408
Georgia	1.18M	$2.93B	$2,474
Hawaii	0.01M	$0.04B	$4,577
Iowa	0.35M	$1.25B	$3,594
Idaho	0.20M	$0.54B	$2,672
Illinois	1.14M	$3.83B	$3,369
Indiana	0.80M	$2.06B	$2,562
Kansas	0.39M	$1.16B	$2,984
Kentucky	0.40M	$0.85B	$2,147
Louisiana	0.28M	$0.68B	$2,447
Massachusetts	0.68M	$2.61B	$3,842
Maryland	0.59M	$1.61B	$2,707
Maine	0.15M	$0.36B	$2,441
Michigan	1.10M	$4.00B	$3,636
Minnesota	1.20M	$4.78B	$3,973
Missouri	0.71M	$1.83B	$2,574
Mississippi	0.14M	$0.21B	$1,479
Montana	0.12M	$0.36B	$3,044
North Carolina	1.23M	$3.10B	$2,523
North Dakota	0.14M	$0.32B	$2,353
Nebraska	0.22M	$0.63B	$2,835
New Hampshire	0.17M	$0.58B	$3,388
New Jersey	0.74M	$2.71B	$3,680
New Mexico	0.12M	$0.30B	$2,585
Nevada	0.28M	$0.61B	$2,203
New York	1.17M	$3.61B	$3,077
Ohio	1.36M	$4.12B	$3,035
Oklahoma	0.26M	$0.62B	$2,383
Oregon	0.41M	$1.47B	$3,604
Pennsylvania	1.25M	$3.52B	$2,808
Rhode Island	0.09M	$0.26B	$3,034
South Carolina	0.53M	$1.16B	$2,202
South Dakota	0.12M	$0.31B	$2,615
Tennessee	0.79M	$1.75B	$2,216
Texas	2.99M	$8.11B	$2,707
Utah	0.72M	$1.84B	$2,559
Virginia	0.95M	$2.62B	$2,769
Vermont	0.06M	$0.18B	$3,148
Washington	1.07M	$4.49B	$4,211
Wisconsin	0.77M	$2.50B	$3,246
West Virginia	0.11M	$0.21B	$2,029
Wyoming	0.06M	$0.16B	$2,907
Other	0.01M	$0.03B	$4,353
Total	32.51M	$98.02B	$3,015

Other includes US territories and foreign military addresses

Totals by Age Table

Age	Total Accounts	Assets	Average Balance
0 - 19	0.07M	$0.08B	$1,270
20 - 24	0.82M	$0.54B	$665
25 - 29	3.72M	$4.30B	$1,154
30 - 34	5.02M	$8.20B	$1,633
35 - 39	4.48M	$10.11B	$2,258
40 - 44	3.91M	$10.91B	$2,791
45 - 49	3.43M	$11.21B	$3,268
50 - 54	3.42M	$12.45B	$3,635
55 - 59	3.18M	$14.72B	$4,625
60 - 64	2.71M	$15.49B	$5,714
65 - 69	1.35M	$7.92B	$5,863
70 - 74	0.33M	$1.80B	$5,434
75 - 79	0.06M	$0.26B	$4,665
80 - 84	0.01M	$0.02B	$2,897
85+	0.01M	$0.01B	$1,835
Total	32.51M	$98.02B	$3,015

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Chairman SMITH. Mr. Beyer is recognized.

Mr. BEYER. Mr. Chairman, thank you very much, Mr. Chairman and Ranking Member. Thank you for putting together this excellent hearing.

And thank you all for presenting. I have learned a great deal.

And to my friend from Oklahoma, I am confused because I think this has been a pretty bipartisan hearing, and I have heard virtually no criticism of the idea of price transparency. I think we are all in on that.

You know, eight years ago, Congressman Mike Pompeo and I sponsored legislation on site neutrality for oncology services. It didn't go very far, but it was still a good idea. And we have heard again and again today how much the absence of site neutrality has contributed to the consolidation within the health care industry and the rising of prices.

But I want to talk about All-Payer Claims Database. I introduced the act last session and again this year. And Dr. Whaley, I know you have written about it a lot. We see what it does at the state level in Virginia. APCD recently evaluated the scope of avoidable emergency room visits, and also put together a whole price and transparency report based on All-Payer Claims Database. Colorado State's insurance uses that marketplace data to figure out its quick cost in its plan finder tool.

Can you expand on All-Payer Claims Database and, specifically, the machine-readable format?

Dr. WHALEY. I think All-Payer Claims Databases are fantastic resources. For our study on hospital prices we have collected data from 11 APCDs, which I actually think is the largest collection of APCDs in a single research study.

We have been able to use data from APCDs to highlight variation in hospital prices and other provider prices across states. And with an APCD you have a lot of confidence that the findings are particularly robust and actually reflecting on the ground, the market.

As you mentioned, other states have actually gone beyond that. I think Colorado is a very good example where they have actually set up a separate agency to do studies using the APCD in addition to outside researchers, and then have used the data from that agency called Civic to actually inform many of the state policy decisions. So, when policymakers in the State of Colorado are making health care decisions, they have the most up-to-date and robust data to make those decisions.

Mr. BEYER. Great, great, thank you. I love the idea of being driven by data.

And Dr. Gilfillan, as private equity has expanded into health care, what effects have you seen about private equity ownership?

And I am thinking particularly about the emergency rooms that I too often frequent.

Dr. GILFILLAN. Yes. Well, I should note that yesterday, I believe, one of the largest private equity-backed firms in health care, Envision Health (sic), filed for bankruptcy under the ownership of KKR, one of the largest private equity entities in America. And that was because—in no small part because Congress acted in the No Surprises Act to eliminate their entire—their business model of

balance billing members who end up in an ER through no—and, through no fault of their own, end up being exposed to a non-participating doctor.

Private equity has a short-term interest—call it five years, three to five years—of creating something, driving revenue, and then flipping it and paying it to someone else or getting out. One great example of that, the result of that, was in Denver. Outside of Denver, a hospital system and private equity joined to open new mini-hospitals and local ERs. After a year—they invested, they built these places, they built them up, people started coming. They decided that was no longer their business model. They closed them. The private equity firm just said, you know what? We don't like this business anymore. We are out.

And that is the kind of short-term mentality we are introducing into health care. The SNF, or skilled nursing facility, experience mentioned earlier is another example of the model of buy something with debt, invest as little as possible, charge large management fees, get out of the business when it—you can, and flip it, and, in many instances, mortgage the actual structures and take advantage of that financing.

So, it is a short-term model. We are seeing it more and more across. We are still seeing it in physician practices. In some of the hospitals I am aware of they are still buying anesthesiologists, radiologists, ER doctors, and then going to the hospital and saying, "If you don't pay us the rates we want, we will balance bill your members, and you will have to deal with that problem."

So, there is still that endless march, if you will, of private equity because the trillions of dollars in health care are just too much for them to ignore.

Mr. BEYER. Yes. Thank you very much. And I know I have had a number of myriad doctors and nurses from emergency rooms in my office complaining that, instead of being able to provide care for their patients, they are supposed to maximize profits.

With that, I yield back.

Chairman SMITH. Mr. LaHood is recognized.

Mr. LAHOOD. Thank you, Mr. Chairman, and I want to thank our witnesses here today for your valuable testimony.

Like many of my colleagues, the cost of health care is one of the top issues I hear about from constituents back home in central Illinois. While this committee has made strides towards increasing cost transparency and empowering patients to make their own health care decisions, more, obviously, can be done.

We have an opportunity to come together on this issue and truly help our constituents afford health care services through greater transparency, innovation, and free market principles.

During my time on the Ways and Means Committee I have taken an active role in advancing health care policies that improve access, choice, and affordability for my constituents. In rural counties in my district, access and choice to options for health care services can be a significant challenge.

Additionally, the current inflation crisis underscores the need to give patients more flexibility with how and when they pay for out-of-pocket health care expenses. That is why we should look at many different options, including further support for health sav-

ings accounts or flexible spending accounts as a tool for families to make personal health decisions.

I have led and supported several pieces of legislation aimed at expanding the use of HSAs and FSAs, including the Dietary Supplement Tax Fairness Act last Congress, with our colleague, Representative Boyle of Pennsylvania, and Mr. Kelly's Personal Health Investment Today, or PHIT Act, this Congress. These bills expand the options for use of HSAs and FSAs, including for preventive care and wellness, allowing for more patient choice in how they pay for health care.

I look forward to continuing to work with my colleagues across the aisle to improve our health care system so that it serves all our constituents. When we work together, we can find common ground to create more choices, increase transparency, and bring down costs for Americans.

As to a question, Mr. Short, in your testimony you mentioned the need to address key issues in the health care—the U.S. health care system, including how to—the interaction of increased price transparency affects the utilization of HSAs. With that, can you spend a bit more time discussing the relationship between the benefits of expanding tax advantaged health care accounts and how they can support increased price transparency?

Mr. SHORT. Thank you. There is many things that I don't know, but one thing I do know: If individuals don't have the incentive to ask questions, they won't. And tax advantaged accounts, including the health savings accounts, is a vehicle by which we can actually look at an issue that we are not really talking much about, and that is the inefficiency in payment processing, which is a huge issue in the U.S. health care system.

So by expanding health savings accounts, coupling with price transparency tools, getting FSAs and HRAs also to be expanded, we will be able to give more optionality to both individuals and employers, no matter if they are public sector, private sector, and everything in between to be able to have more weapons to be able to at least ask the question of what things can cost, at least for items that are below the catastrophic deductible.

Mr. LAHOOD. And what current barriers do you believe have the most impact on patients being able to effectively utilize their HSAs?

Mr. SHORT. Well, a huge barrier, as we have talked about today, what is the price of care? What does it cost? And I think the more and more we can do in terms of price transparency to arm these individual consumers can only be a benefit in allowing for them to deploy their resources as they see fit for the care that they need.

Mr. LAHOOD. Thank you, Mr. Short.

Those are all my questions. I yield back, Mr. Chairman.

Chairman SMITH. Thank you. Mr. Moore is recognized.

Mr. MOORE of Utah. Thank you, Mr. Chairman, Ranking Member. I don't say this lightly. This is, in my opinion, the most important thing for our nation to address.

We have tried over and over, different tactics and tried different things. And like my colleague from Arizona likes to remind us all, everything we have tried is a financing bill. It is subsidizing one—

subsidizing the cost from one group to a different group to a different group. And we are sitting here 10, 15, 20 years later, and costs continue to go up. That is the fact. That is the reality. Costs continue to go up.

So, whatever anybody has tried with respect to health care, costs continue to go up. It continues to put small business in the most risky situation because they cannot care for their employees. And that is why—I mean, this is the most important thing for us to be able to—particularly why I wanted to be on Health Subcommittee so badly in this committee, because we have an opportunity to do something. And I view this as an opportunity.

I have been a little frustrated today, and I am going to turn it into a more productive way to communicate it. I cannot hear one more time that because health care is different, it is different than—a different industry. It is different than getting a—or choosing a haircut or shopping for a car. I get that. We all get that. We understand that health care is different, but that doesn't mean that we shouldn't try to improve it. That doesn't mean that we shouldn't try to actually address the issues that exist.

Health care is different. There is trauma situations. If I am hit, and I am in the back of an ambulance, no, I am not going to choose and be able to compare prices like I can to go choose a car insurance. We know that. We don't need to be lectured on that. What we need to be able to do is say what is the aspect within health care where we can actually address it? Okay, we all agree in trauma, in emergency. Yes. We are not going to.

Ms. Troiano, has your—have your employees been able to see a lower cost from making a more innovative—like, an innovative switch? Your company did it. Have you been able to see lower costs?

Ms. TROIANO. We have. Our employees have seen a lot lower costs.

Number one, all of their prescriptions are paid for. They can go through online prescription companies now. There are no networks. The insurance company doesn't tell them or tell their doctor what they can or cannot have done. So, they have seen lower costs.

Mr. MOORE of Utah. Is there a major concern among your employees about catastrophic or trauma-related care? Are they comfortable that they could be covered in that situation?

Ms. TROIANO. They are comfortable. They have an insurance card, just like everyone else. It is a digital insurance card. You walk in, you present it, and then Sidecar Health takes care of it, just like any other insurance company would.

Mr. MOORE of Utah. Wait. So, you are saying that the concept of health care is different because there is emergency medical care needed, and you are not going to be in a mental state to be able to make those decisions and choose a—one haircut place over another haircut place because it is cheaper? You can still address that?

Ms. TROIANO. You can still address that.

Mr. MOORE of Utah. We can still be innovative and reduce costs?

Ms. TROIANO. Absolutely, absolutely. And Sidecar Health is very innovative. We have been very happy with what we have been

able to do with them, and the fact that our employees' doctors are now taking care of their health care, rather than the insurance company telling the doctors what they have to do for that employee's health care.

Mr. MOORE of Utah. Dr. Piniecki, have you seen similar results being able to lower costs for your patients?

Dr. PINIECKI. Absolutely. Yes, I had the opportunity to speak at a state—Indiana State entity, the Employers' Forum of Indiana. And we had just recently entered into a contract with a company very similar to the company represented here today. It is a company that produces alloys for space shuttle parts, among other things. It is a small company, about 100 to 120 employees, I believe, over 2 sites. And the day that I presented, which was April last month, we were able to save, I think, $50,000 that Friday for that company because there was actually 6 surgeries scheduled. I think four of them were colonoscopies, two of them were ENT procedures. So, the savings is real.

Mr. MOORE of Utah. Thank you.

Mr. Kampine, have you seen an increase in utilization?

If you have improved—if you improve your data, Healthcare Bluebook, if you can improve your data are you seeing an increase of utilization from patients?

Mr. KAMPINE. Absolutely, exponential over the years. We are also seeing that—similar increases in the savings for the plan sponsors and for the individual members.

Mr. MOORE of Utah. Do you think it is worth continuing to go down this path to invest and make sure that we can continue the—to optimize the data that exists for us to be able to make consumer-based decisions?

Mr. KAMPINE. Absolutely. We are going to capture more of the dollars that are on the table, and we are going to expand the types of services for which we can capture those dollars.

We are not locked in a period not making progress. This is—we have made tremendous progress over a decade. And with the new data that is coming in and some of the new capabilities from the rules, we open this up to more services.

Mr. MOORE of Utah. We—Dr. Gilfillan, we have an opportunity, something you brought up earlier, and I agree with you. Lower-income individuals may not be—if we are worried about them being able to make these types of decisions or have access to the information, these innovative solutions can make it so lower-income people can be empowered.

So, I have to—and thank you much. I yield back.

Chairman SMITH. Mr. Panetta is recognized.

Mr. PANETTA. Thank you, Mr. Chairman, I appreciate that.

In my district on the central coast of California—I think, Dr. Whaley, you talked about the issues in northern California. Trust me, I get it. But many providers face that double threat of high government payer rates, coupled with a higher-than-average cost of care.

Dr. Gilfillan, in your testimony you mentioned the impact of payer mix and commercial reimbursement on non-profit hospital access. Obviously, that drives up the cost of private care while some providers are leaving the market or declining to offer tradi-

tional Medicare plans to new patients. How can we best address this trend to keep non-profits with a high government payer mix continuing—make them operate still?

Dr. GILFILLAN. Well, thank you, Congressman Panetta. My belief is that it is wrong, it is simply wrong to pay hospitals differently and subsidize—in effect, we have lower income employees paying for health insurance that then goes to higher rates to hospitals that are in well-to-do communities. It is a reverse subsidization going on. And I believe that we should actually come up with an all-payer mechanism that standardizes rates we pay to hospitals so that all communities and their facilities are equally supported. That can be administered through employer insurance or government insurance—and I have suggested, in addition, a public option—not weakening employer insurance, it actually would strengthen employer insurance. That is the proposal that I would suggest.

Mr. PANETTA. Great, thank you. And then, as you have heard about the PHIT Act that Representative Kelly and I are co-leading—basically, Personal Health and Investment Today Act of 2023, a bill that would allow for qualified sports and fitness expenses to be paid under health savings accounts using pre-tax income. Obviously, the purpose of this legislation is to improve healthy behaviors so people can live fuller lives and stay out of the hospital later on, hopefully.

Mr. Short, for the many people who already have an HSA, however, how would allowing this type of income to go toward a non-medical service like youth fitness classes affect people's health?

Mr. SHORT. Well, I think anything that we can do or that can be done to incentivize people to take an active participation in their health is tremendous. And using health savings accounts and other tax advantaged accounts to get there is a great vehicle to accomplish that goal.

Mr. PANETTA. Great, great.

And then, Dr. Gilfillan, you mentioned in your testimony the misguided and often counter-intuitive strategy of using patient choice as a driver of health care savings. In many parts of the country there are a limited number of health savings operating, and there is a growing trend of doctors leaving the market because of the costs of providing care, as is the case of, like I said, in California, especially northern California, combined with their cost of living. What would a situation like this mean for a patient with one of the high-deductible plans you describe?

Dr. GILFILLAN. Well, I think they are just going to face higher and higher costs. Even if they shop, the costs are going to be higher as a result of increasing market power for those institutions that are in a position to extract those higher rates.

And frankly, I think even these innovative insurance plans, I think you need to see a couple of renewals come around because there is no free lunch. The reality is those extraordinary costs are going to get passed back through to the employer, or are they going to get passed back through out-of-pocket spending for employees.

So, I think some of what we have heard today does not reflect the history of what has happened with these mini-med, minimum minimal coverage plans that actually end up coming home to roost

with markedly higher renewal rates or markedly higher out-of-pocket expenses for employees.

Mr. PANETTA. Great. Gentlemen, thank you. Ma'am, thank you. I yield back, Mr. Chairman.

Chairman SMITH. Ms. Van Duyne is recognized.

Ms. VAN DUYNE. Thank you very much, Mr. Chairman, and thank you to our witnesses. I know it has been a long day.

Today's hearing is about access to quality care for all Americans and affordable options for getting that care. Two weeks ago, I hosted a health care roundtable in my district, and I heard first-hand from our current health care model—that our current health care model lacks transparency and has caused people to second guess not only their health care, but how much they are paying for it.

And let's be honest, I mean, the fact that patients have absolutely no idea how much they are going to pay for a bill, or how much, when they start getting the bills, they are going to end up paying for it is causing that frustration. And the cost of health care has skyrocketed. And I am glad that you are experiencing some, you know, some relief of that. But it is definitely not universal.

We need to work on how our market and—how it is structured. I mean, I appreciate what Congressman Moore was saying, that, you know, health care costs are ridiculous. Here is what I found: the more Federal dollars that we put into health care, the more cost—the more costly it is, the less access people have to it, and quality is suffering as a result. So, it can't just be putting more Federal dollars in, because every single time you get more Federal dollars in you have got more reports you have to fill out, more red tape you have to go through, and less time you are actually spending with your patients.

So, I mean, I look at the costs continuing to rise. I am like, what can we do to actually help our patients? What can we do to help our constituents, understanding—and this is a big one that people tend to forget—having health insurance is not the same thing as having health care? Our focus has to be on the care, and not just providing insurance companies with more money.

So, you know, our country desperately needs pragmatic legislation to reduce these costs and to facilitate long-term savings and revamp our broken health care system. So, I am actually proud to introduce innovative and prudent bills. I would hope that my colleagues can see across party lines to adequately address the failures within today's health care system. I have introduced a number of bills which would expand HSAs for children that would add flexibility and would build on the success of HSAs.

I know Congressman LaHood had asked you a couple of questions about HSAs, but I want to get more specific, if we could. And Mr. Short, do you believe that HSA contribution limits should be updated to help families better afford health care services?

Mr. SHORT. Absolutely. I mean, the rising cost of care has outpaced inflation. So, we need to keep up with the contributions to keep up with it to allow families to be able to pay for health care.

Ms. VAN DUYNE. When was the last time that they were updated?

And do you think that the updates that they have had on an annual basis have been enough to keep up with inflation and actually costs that they are paying out of pocket?

Mr. SHORT. I believe they were recently updated here recently by a few hundred dollars.

Ms. VAN DUYNE. Yes.

Mr. SHORT. But it is not keeping up with the rising Medicare inflation—I am sorry, medical inflation we are seeing, we are experiencing.

Ms. VAN DUYNE. Do you think that they should be expanded to include, like, a children's HSA or an ability to be able to pay for adult parents, perhaps?

Mr. SHORT. Oh, absolutely. Again, any way we can allow for individuals to save and plan and use funds on a tax basis for medical care, maybe for dependents, maybe for elderly parents is absolutely important, critical, and a great step forward.

Ms. VAN DUYNE. What do you think are some of the barriers right now that are—that exist that would make them less effective than they could be?

Mr. SHORT. Oh, I think by allowing HSAs for all—let's get rid of these different insurance mandates. You have a certain type of insurance to able to have HSAs. Let's have HSA be available for all Americans in—regardless to what type of plan they have.

Ms. VAN DUYNE. Okay. So, what you are suggesting is right now you could only—they have got the high-deductible health plan. Can you talk a little bit about what that is?

Mr. SHORT. Absolutely. So today you have to have a qualified high-deductible health plan to be able to contribute to an HSA program. And that just seems counter-intuitive, that if we allow people to choose the type of plan that works for them and their families, that we can then allow for them to also contribute to the HSA, allowing anybody and everybody that has a plan or any plan or no plan to be able to contribute. It would be a powerful force into, you know, bending the cost curve in the United States.

Ms. VAN DUYNE. Do you have an idea of what you think that the HSA limit should be?

Mr. SHORT. I don't, but health care is expensive. So, the more that we can allow people to save and to be able to plan and pay for health care would be critical and important to help out everybody.

Ms. VAN DUYNE. I appreciate that.

And I yield back. Thank you.

Chairman SMITH. Mr. Feenstra is recognized.

Mr. FEENSTRA. Thank you, Chairman Smith.

Thank you all, witnesses, for coming today. I have got a bit of a conundrum that I need advice and direction on.

We all talked about how high health care cost is. I don't have to relitigate that.

My district is in Iowa. I have the largest agricultural producers in the world. With that, you might imagine that we have vast farmland, open fields, and family-owned farms dotting the roadways. I also have a tremendous amount of rural, small communities that have small hospitals. These hospitals are critical access

hospitals, and they are operating in the red, so they have to make tough decisions on what services to offer.

In March the University of Iowa published an article in the Journal of Rural Health that found that one out of every five expecting mothers weren't receiving enough prenatal care after pregnancy centers closed in their area. I wrote my dissertation on this topic and found that there is significant infant and maternal mortality rates because of the lack of maternity care in rural America.

This is the issue. When I have talked to hospitals why this is occurring, they said that they do not have the cost—in essence, when you have maternity care, it is a loss leader. They are not profitable. They operate at a loss. So, to make them work, they need same-day surgery centers and things like that. However, if we want competition, the same-day surgery center moves in and, all of a sudden, undercuts the hospital, which then has to close the maternity units.

My question is, how can we—and Mr. Whaley, if you could answer this, or advice—how can we create, you know, competition, pricing transparency, and yet not have these deserts, maternity deserts, and other rural health care deserts that are being caused by the lack of services that are non-profitable?

Dr. WHALEY. Yes, thank you for the question. I think, like—everyone else on the panel agrees that we need to keep rural hospitals in business, and those are important and critical providers for people in those communities. And it may require an alternative payment system than we currently have.

One challenge, not just for rural hospitals, but I think often for community and safety net hospitals, is that in many cases, in some sense, these are the provider groups that are left out of consolidation. And when providers consolidate, they in many cases send higher reimbursed patients and privately insured patients to the system-owned hospitals and facilities. And so, if you are a community hospital or a rural hospital, you don't benefit from those privately insured patients that you used to have.

And so, I think, by ensuring that these providers aren't left out of consolidation, by ensuring that we have competition in health care markets, then that is one way to provide additional assistance to these providers.

Mr. FEENSTRA. Yes, that is a very good point, and I am glad you said that.

So how do we handle—and this is really—I don't know what to say on this, and I am asking your advice—is when you have certificate of needs—so in Iowa we have certificate of need, meaning that you can't have competition in these small communities. What, through your research, what would you say about that?

Dr. WHALEY. One of the things we have found pretty consistently with certificate of need, while very well intentioned, many of the certificate of need advisory boards tend to be—have lots of existing providers on them. And maybe, perhaps not surprisingly, they feel that it is not worth having additional entrance and additional competition.

So, if we look nationwide, states that have certificate of need actually tend to have less competition, and this includes both with

hospitals and also places like amateur surgical centers and higher prices.

Mr. FEENSTRA. Yes, thank you. This is such a hot, big topic in rural America. I mean, we just cannot continue to lose maternity units. And like I said, I have been doing a lot of research on this, and it is scary to me.

One other question. You know, my other research while I was doing the research also centered around the cost of employees. And this is another thing that, you know, when you start looking, Whaley, at some of your research that you have done, how has the cost of employees over the last several years directly affected the cost not only of competition, but of pricing transparency, meaning that the cost of a surgery one day could be different than the next day because of a third-party price or, you know, a third pricing bringing in nurses, bringing in doctors to these rural communities? This could be quite different, am I right?

Dr. WHALEY. It could be. And I think, as a potential additional payment model, something like, say, bundled payments, where we have actually seen that the hospital knows how much they are getting, they don't have to deal with insurers, and so that saves them the hassle, and the patient knows how much they are paying can be way—one way to have—for fair and more efficient payments.

Mr. FEENSTRA. Yes, thank you so much, and I appreciate all your testimonies.

I yield back.

Chairman SMITH. Thank you. Votes have been called. We are going to recess for roughly, like, 15 minutes. There is still a couple members that will be coming back right after the votes to finish the hearing. So please be patient with us, but we will recess for 15 minutes. [Recess.]

Chairman SMITH. The committee will come to order.

Mr. Schneider is recognized.

Mr. SCHNEIDER. Thank you, Mr. Chairman. I want to thank you and the ranking member for having this hearing.

And our witnesses, thank you for your endurance in staying for the break. But this is a critically important issue.

And I think—I hope that there is bipartisan agreement that transparency in pricing would be a good thing. And as I have listened to the hearing over the course of the morning and now into the afternoon, my colleague from Florida, Mr. Buchanan, mentioned that the last decade insurance prices have gone up. Well, I had a business almost 30 years ago, and we had 8 employees. I paid—my partner and I—paid everything, but we faced—Ms. Troiano, you mentioned it—we had double-digit percentage increases year after year, and finally had to say we can't afford to do what we had done in the past. And that was—it is hard to say this—in the last century, not the last decade.

And I like the words Adrian Smith, Representative Smith, said: Our goal is to empower patients with information. And I know that is what you all are trying to do, but I will say it is somewhat difficult.

The other thing I point out is I—in business—I spent my career in business before coming here. We talked about total cost, and we have talked about cars here. You know, the lesser priced, lesser

quality car might have a lower price, but the cost of operating that car over its lifetime is probably going to be more than getting the better car. The lower-priced machine tool might save money on day one, but over the course of its lifetime we are going to spend more money on downtime or defective product defects. I think the same can be said in health care.

And often times we don't have choices. So, for example, I had a injury to my ankle, a traumatic injury to my ankle, and hard to diagnose exactly what happened. I needed a CAT scan, but not just any CAT scan, I needed a weight bearing CAT scan. I live in the Chicago area. Lots of hospitals, lots of CAT scans. Only one, though, evidently, could do the weight bearing CAT scan. So, I really don't have a choice at that. It is hard to make those choices.

I also needed an ultrasound on my ankle, which I didn't before this know you could do, but it was a very specialized ultrasound. I had to go to one specific technician who had specialized in doing this to help diagnose what had happened with my foot.

And I think about it in the context of surgeries. You know, and maybe, Dr. Piniecki, I will ask you the question. Minimally invasive surgery, for example hip surgery, my understanding, I guess, would be that minimally invasive hip surgery requires specialty operating room, special equipment. It probably costs more than traditional hip surgery. Is that a fair——

Dr. PINIECKI. That is true. There is a fair amount more equipment, not just with that specific surgery but some of the other minimally invasive procedures, too, require additional——

Mr. SCHNEIDER. Yes, I mean, I have shoulder reconstruction from 1988. That means I am old. It also means I have a really large scar, which would—today would be arthroscopic. We have come far.

But if a patient is being charged with figuring out which surgery to get, and is using their own funds, might they not go for the traditional hip surgery rather than the minimally invasive that, like that machine tool or less expensive car, is going to have a greater cost over their lifetime of recovery time, possibly follow-up? Maybe you can touch on that. How does a non-medical practitioner like me try to determine what is the best medical decision?

Dr. Gilfillan, maybe I will ask you that question.

Dr. GILFILLAN. It is hard. It is hard because the available data out there is so unclear.

And then, if you start saying, well, this procedure versus that procedure, it gets—you start rapidly getting into the question of complications and, long term, what is the meaning of it?

So, I think, frankly, that folks become reliant on a physician typically, or a nurse practitioner in some cases, to advise them on what procedure seems most appropriate. And then they talk to people in the industry to try and get kind of anecdotal guidance about what the best place is to go, because quality is awfully hard to establish.

The immediate quality—complication rate versus the long-term outcomes of, you know, is this the right—is this done well so it is going to last me a long time? It is very hard to get that information.

Mr. SCHNEIDER. So, Mr. Chairman, I wish I could ask you for another 5 or 50 minutes, because there is so much to talk about here. But I think the bottom line is, as others have said, we have to bend the cost curve. That is the challenge we face. And transparency is absolutely a piece of bending that cost curve.

But as Dr. Gilfillan, you have mentioned, there are so many other things we have to be doing, as well. There is no magic pill that is going to solve our health care challenges. But we are spending not a percentage more than other developed countries on our health care system, we are spending multiples times more, and we are not necessarily getting better outcomes.

So, I look forward to working with my colleagues on this committee and throughout the Congress to find a way to do this. But this has to be one of the most important challenges we face, and something we need to find a way to work together across the aisle to come up with ideas and provide the quality health care all Americans deserve, regardless of where they live, and that I know that our doctors and other health care professionals want to provide.

And with that, I yield back.

Chairman SMITH. Thank you, Mr. Schneider. This is just—price transparency is just a piece in the puzzle that we have to address, you are exactly right.

So, Ms. Malliotakis.

Ms. MALLIOTAKIS. Thank you very much. Thank you, Chairman, for holding this hearing today.

Transparency in health care has become increasingly important. It is an important part of the health care system, and I appreciate us exposing what can be done here to make—not only provide greater transparency but provide for a more competitive and effective market that will ultimately lead to lower prices for employers, for patients, and for the taxpayers.

An area that I have been focusing on is creating more transparency in the way of prescription—the way prescription drugs are paid for, and the conflict of interest that exists when one company is the Pharmacy Benefit Manager, as well as the health insurance and the pharmacy, as well. The opaqueness that clouds this complex system has made it extremely difficult to understand the prices we pay at the pharmacy counter.

Representative Buddy Carter and I have introduced the Protecting Patients against PBM Abuses Act, which now has bipartisan support, and it would increase transparency on data related to PBM rebates and administrative fees that will help plan sponsors, government agencies, researchers, and the public understand how rebates and fees are impacting costs.

In 2019 the Trump Administration proposed a transparency and coverage rule. It was finalized in October of 2020, and the rule initially required health insurance plans to publicly post the negotiated rates of prescription drugs with in-network pharmacies and historical net prices for prescription drugs. However, in August of 2021 the Biden Administration paused it, and has yet to carry out its implementation.

So, my first question is for Dr. Whaley. If implemented, what impact would the prescription drug requiring—requirement have on

increasing transparency in this space to create a more competitive market?

Dr. WHALEY. The Pharmacy Benefit Manager, or PBM, space is probably the most consolidated area in the health care industry, with three or four firms essentially dominating the market. And so, I think any transparency on the structure of those firms and ownership entities of those firms, as well as rebates, which are mainly confidential—but it is important for employers to know how much they are paying in rebates—would be very critical.

And so, I think transparency around rebates and Pharmacy Benefit Managers as well as patient costs for prescription drugs, where patients are actually probably likely to be consumers, would be tremendously helpful.

Ms. MALLIOTAKIS. Thank you. Would anyone else like to answer? I would like to just know if—Mr. Kampine, if you would like to add to that——

Mr. KAMPINE. I am going to weigh in because it was in my written testimony, but absolutely. Understanding NDC allocated net prices is incredibly important. If you are an employer—you know, I always say, look, the—on the medical side, the carrier network doesn't guarantee high cost or low quality. We know there is a tremendous variability in cost and quality. That same variability occurs within the formulary, as well.

It is important for employers to know what the net cost is because that helps them thoughtfully structure drugs after the rebate is accounted for that are most valuable, both from a clinical aspect and from a cost aspect, and so that they are ensuring that drugs with high price and high net costs aren't being put into favorable tiers that patients are consuming, as opposed to other medications that would be more cost effective that are in a higher tier.

And so, this information is virtually unheard of, if you are an employer, to actually be able to see this. And it would be incredibly helpful. It will also be helpful in terms of improving transparency for the consumer, as well.

Ms. MALLIOTAKIS. I find it very troubling that the Pharmacy Benefit Manager dictates to its competitors, the pharmacists, how much they can make on a drug. Does anyone else find that troubling here?

Should there be restrictions so that PBMs cannot also be the insurer and the pharmacy?

Dr. WHALEY. I think, at minimum, there needs to be transparency in what those ownership arrangements are. And if there is transparency around those ownership arrangements as well as prices, then I think employers can decide whether they are comfortable working with the PBM that owns pharmacies or whether they see a conflict of interest there.

Ms. MALLIOTAKIS. All right, thank you.

Today just 45 percent of U.S. 65-year-olds are retired, compared with 58 percent in 2000. The U.S. Bureau of Labor Statistics estimates that by 2024 a quarter of the workforce will be over the age of 55 and, of those, a third will be 65 or more. With rising inflation, higher cost of living, our seniors are certainly struggling to keep up.

Mr. Short, how would expanding eligibility to working seniors on Medicare so that they and their employers can continue contributing to their health savings accounts alleviate some of these financial burdens our seniors are facing?

Mr. SHORT. Yes. I mean, having individuals, the Medicare beneficiaries being able to contribute and have HSAs is just basic common sense. Why wouldn't we want to give more people the ability to save and plan for future health care expenditures? I think it would be a great step for Medicare beneficiaries to benefit from this program.

Ms. MALLIOTAKIS. Great, thank you very much.

Chairman SMITH. I want to thank you all for a very informative and productive hearing today.

We have received many letters of support on the topic of health care, price transparency, and, without objection, I will submit them into the record.

Chairman SMITH. I would also like to thank you all once again for your over four hours of questions and answers and testimony on something that appears to be extremely bipartisan. But hopefully, we can get some things done. Getting things done in this building is a little bit more difficult than just asking questions in a hearing.

But please be advised that members have two weeks to submit written questions to be answered later in writing. Those questions and your answers will be made part of the formal hearing record.

With that, the committee stands adjourned.

[Whereupon, at 2:27 p.m., the committee was adjourned.]

MEMBER QUESTIONS FOR THE RECORD

September 1, 2023

Honorable Mike Carey
Congress of the United States
House of Representatives
Washington, DC 20515

Congressman Carey,

Thank you for taking time to speak with me on May 16, 2023, regarding the cost of Healthcare in the United States. I appreciate the time you spent with me and your gracious offer for further discussion.

In response to your letter dated May 30, 2023, the answers to your questions follow:

Question: You mentioned in your testimony that your premiums increased drastically with just one large claim. Can you elaborate a bit on that?

Answer: We paid close to $700,000 annually in premiums to our healthcare provider. Prior to 2023, we had been a client of theirs for six years. We did not have a large claim (any claim over $50,000) in those six years. In 2022 the spouse of one of our team members was diagnosed with an aggressive form of cancer. Her treatment was expensive, and she spent several weeks in the hospital for a total cost of approximately $500,000 (that is an estimate because the health insurer does not provide us with actual costs. Our team member estimated this cost). We also had two claims between $20,000 and $30,000 that affected our rates even though these are not considered large claims.

Unfortunately, the spouse of our team member passed away in December 2022. In past years and with other providers, if a large claimant passed away, that claim was not used as part of your claim history and did not affect increases. This provider decided that they would use that claim and the other two claims and increase our premiums by 36%. We asked them to reconsider, and they refused. A 36% increase was not feasible for us because our company pays an average of 74% of the annual premium. We could not absorb that increase and we could not pass it on to the team members. When our provider issued a 36% increase, the other providers chose to give large increases (because they go by the increase of your current provider and cannot view claims) with the lowest increase at 23%.

As you are aware, due to ACA, we are required to keep our premiums affordable and not more than 9.12% (lower than 2022 which was 9.61%), and a large increase would not allow us to remain affordable. We cannot go outside of the rules of the ACA, so we had to search for a provider that was affordable for both us and our team members.

We chose Sidecar Health with a 10% increase in premiums which allowed us to increase single premiums by $3 per month, with the company absorbing the remaining balance. With Sidecar Health, we feel we have a chance of keeping our premiums affordable because we shop for our services. This puts the team members in control of the costs associated with their healthcare. We know we are not going to have any premium increase from Sidecar Health in 2024. That is a win-win for the team members and the company.

Question 2: You also mentioned in your testimony that you're able to get access to pricing for doctor's visits, labs, hospitals, and other providers. I assume this also includes services related to imaging and more extensive services. Could you elaborate on what kinds of price differences you see on items outside of basic doctor visits or checkups?

Answer: Sidecar Health has a Radiology Assistant on their website which allows a member to look for Radiology Services like mammograms, MRI, etc. It considers your home zip code and looks within the radius you assign. I can look up where to get a mammogram annually and know that my reimbursement rate is $255. When I look at the website, I know there are several places I can go for less than $255 – for example, I can go to OSU and get a mammogram for $100 as a cash paying customer. Now I have the choice of where I go for my services. I can choose to receive my services for the benefit price of $255, go to a provider under the $255 price, or one over the $255 price and pay the difference. As a note, differences can be paid through my pre-tax FSA. If I choose to use OSU for my mammogram, I bank $155 in my Sidecar account.

Sidecar also has an assistant option for Colonoscopies. You can insert your zip code and find a provider that will offer the service for one price. Our members were paying over $4,000 with our prior provider, and the cost through Sidecar is approximately $2,500. If a member needs an MRI, they can choose the place they want to go for an MRI. This can vary between hospitals, stand-alone facilities and in some cases, doctor's offices. The members choose who they want to go to and the price they will pay. They tell the provider in advance that they are paying upfront, or they are a cash paying customer.

We recently had a team member with an emergency visit to a hospital. We understand that you cannot shop for prices prior to an emergency. He was in the hospital for 24 hours and received several tests including radiology, and his bill was over $18,000. When he arrived, his spouse provided them with his Sidecar card. They invoiced Sidecar who negotiated the invoice down to $6,000. He was notified by Sidecar about the amount he owed (he had not met his deductible) and what they were paying. It was a simple process and no different that any other medical insurance provider. He was very happy with the ease of the process and the outcome of the situation.

All the providers on the Sidecar website have been used by other members and reviews are available if people choose to read them. It is a simple process and allows members to see the actual cost of healthcare without the insurance markups that other insurance providers negotiate. Paying up front saves the provider money because they are not spending time billing an insurance company and negotiating a contract with them.

I hope this answers your questions. I appreciate the time you took to review the testimony and ask follow-up questions.

Kindest regards,

Kendy A. Troiano
Human Resources Director
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PUBLIC SUBMISSIONS FOR THE RECORD

Statement for Hearing on
"Health Care Price Transparency: A Patient's Right to Know"

House Committee on Ways and Means

May 16, 2023

AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. We appreciate the Committee's attention to the issue of price transparency in health care and encourage the efforts to increase transparency and accessibility of actionable, personalized information, including a consumer's financial responsibilities.

Commitment to Price Transparency
AHIP and our member health insurance providers fully support the goals of providing consumers with information about the cost and quality of health care services to enable consumers to make better-informed, decisions that take into consideration cost and value of health care. We are also fully committed to providing personalized, accurate information on enrollees' estimated out-of-pocket costs, all while protecting patients' personal privacy and the security of their personal health information.

Health insurance providers have demonstrated their commitment to price transparency by providing meaningful cost estimates through tools that help consumers shop for affordable services. Ahead of regulatory deadlines in June 2021, 94% of commercial health plans were providing patients with access to meaningful price transparency by offering cost estimates through Internet-based self-service cost calculator tools.[1]

These tools can estimate costs of complex medical services and procedures including elective outpatient surgery/procedures, inpatient surgical services, inpatient non-surgical services, physician services, outpatient laboratory services, radiology services, prenatal care, and delivery and postpartum care. They are also the best source for general estimates of not only the service cost, but the specific obligation of the enrollee based on their benefit structure (e.g., deductible, out-of-pocket maximum, or other patient cost sharing features). Moreover, many of these tools offer quality and other information that can be helpful in shopping for services.

[1] https://www.ahip.org/documents/202206-AHIP_IB_Price_Transparency.pdf

Health insurance providers are working on building awareness among consumers about these tools. In fact, nearly half of enrollees (48%) have created credentials to log-in to the member portal, website, or app where cost estimator tools can be accessed.[1] That said, of those enrollees with log-in credentials, only a fraction – on average 1 in 10 - accessed the tools. Health insurance providers continue to work to increase consumer awareness and engagement with tools by employing several tactics from member portal messages to employer outreach to leveraging agents and brokers to text messaging campaigns.

Managing Machine-Readable Files

Health insurance providers successfully implemented machine-readable files (MRFs) by the enforcement deadline, making information on in-network rates and out-of-network allowed amounts publicly available. Machine-readable files are extremely complex files, and health insurance providers invested significant resources to develop, build, and publish these files. They also continue to make significant investments annually to support updates to these files.

Health insurance providers were deeply engaged with federal regulators to ensure these files could be successfully posted and usable. For example, raising concerns about potential large file sizes and recommending changes to file formats to reduce file sizes 85-90%, which were adopted by the Tri-Agencies prior to implementation.

As Congress examines these regulations and contemplates whether legislative action may be needed, it is important to note that changes or additions to the existing requirements would result in significant new costs and administrative burden. Furthermore, because of the complexity of these files, we are concerned that attempting to address technical issues through legislation could have unintended consequences such as increasing file size or file complexity or creating privacy risks. We look forward to working with the Committee on this issue to ensure that the information is provided in a way that is most valuable to the consumer.

Implementing Advanced Explanations of Benefits

Health insurance providers are fully committed to providing consumers with information about their potential costs prior to seeking health care services through advanced explanations of benefits (AEOB), which allow consumers to request a precise estimate of their expected out-of-pocket costs before a scheduled service. An AEOB will provide personalized, accurate cost information based on the particular provider, at a specific site (e.g., hospital inpatient or physician's office), based on a set of tailored billing codes, and reflective of that individual enrollee's benefits. Thus, AEOBs have the potential to be the most valuable transparency tool for consumers.

Currently, there is no infrastructure for providers and issuers to share information needed to request, calculate, or disseminate an AEOB. Implementing AEOBs will be extraordinarily complex, including identifying and building technical standards, building an infrastructure for exchanging information between providers, and ensuring issuers have accurate, complete

information to provide enrollees with timely cost estimates. While the AEOBs hold great promise, work cannot begin until technical standards are first identified.

It is critical that technical standards are built intentionally and thoughtfully to ensure the accuracy of information that will be delivered to patients. Consumers will use information in AEOBs to make decisions that will impact their health and finances. This is why AHIP has been working for over two years—including coordinating with standards organizations, hospitals, and providers—to develop recommendations for implementation of AEOBs to provide a smooth process for consumers and ensure AEOBs include complete, accurate information about costs. AHIP has suggested building from HIPAA X12 transaction standards and supplementing with Fast Healthcare Interoperability Resources (FHIR) standards where needed to progress the delivery of AEOBs. However, the federal government has not yet issued proposed rulemaking to establish the regulations, identify the standards, and name the implementation guides necessary to operationalize the policies.

Once rulemaking is complete, health insurance providers will need adequate time to build out the infrastructure, conduct testing, tackle challenges, and roll out member education. These steps are key to ensuring consumer trust, reducing burdens and duplication by stakeholders, and improving the end products.

Conclusion

Every patient deserves access to a reliable estimation or explanation of their health care costs. Health insurers have already demonstrated their commitment to transparency by successfully implementing machine-readable files and cost estimator tools and will continue working with legislators and regulators to develop a reliable and accurate framework for delivering advanced explanations of benefits to patients among other strategies to support price transparency. Through meaningful collaboration with the Committee, we believe we can achieve such a framework and empower patients to make well-informed health care decisions aided by transparent information.

Statement of the American College of Surgeons
To the Committee on Ways and Means
United States House of Representatives
RE: Health Care Price Transparency: A Patient's Right to Know
May 16, 2023

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The American College of Surgeons (ACS) welcomes the growing focus on transparency, and we agree that the current environment makes it difficult for patients to find useful, actionable information when it comes to their health. This lack of transparency extends beyond price to include a lack of actionable data on quality, which is equally necessary for patients to make choices based on value. As a scientific and educational association dedicated to improving the quality of care for the surgical patient, we have more than a century of experience in developing more meaningful quality measures. Through this experience we have learned that safe, high-quality care can often be more affordable care as well. Improved price transparency, coupled with meaningful measures of quality, will help to prove this and help patients find care aligned with their goals and values. Price information in the absence of quality information is not sufficient for patients to make informed decisions and could lead to higher prices for patients and higher overall costs for purchasers.

Achieving meaningful price transparency for complex care will be tricky. Current efforts are in essence attempting to make available perfect information, with accurate pricing for each individual billed service, provided by every physician or facility, with the exact price paid by each payer. Achieving this might make it possible for a savvy patient with a simple, non-urgent health need to compare options for a consultation, a test, or an imaging study. However, for more complex care such as a major surgical procedure, care for a chronic condition, or cancer treatment, producing a perfect up-front estimate would be akin to shopping for a car piece by piece without knowing exactly what parts you need. For example, if a patient recently diagnosed with breast cancer were to request a good faith estimate (GFE) from his or her physician or wished to compare prices for different hospitals through a shoppable services portal, it would be nearly impossible to provide estimates that encompasses the full course of treatment without additional guidance on how to meet this congressional goal. There would be a great deal of uncertainty as the care pathway has multiple decision points which can lead to drastically different prognoses and care requirements. Even if the exact care pathway could be determined at the time of scheduling care, it is still unlikely that the full team of ancillary providers involved would be known. The uncertainty of this pathway furthermore might require different or additional team members with significantly higher or lower cost than originally foreseen.

Align and Streamline Data Sources

There is a wealth of information becoming available as hospitals post charges and shoppable services online and as insurer machine-readable files (MRFs) are released, creating the potential for valuable insights. However, this information is currently difficult to decipher even for sophisticated researchers. Furthermore, the multitude of competing requirements for price measurement and reporting across transparency efforts and payment programs runs the risk of adding unwelcome and unnecessary confusion. Hospital Price Transparency, Transparency in Coverage, and requirements for GFEs and advanced explanations of benefits (AEOBs) are all intended to improve price transparency but lack uniformity in what information is made available. A unified strategy with standardized definitions for price information conversely has the potential to reduce some of the complexity and mystery often experienced by patients shopping for or undergoing care.

Furthermore, a unified strategy would be less burdensome to implement than having different requirements and definitions for each application.

There have been several positive developments recently that represent incremental steps toward better transparency. These include the announcement from the Centers for Medicare & Medicaid services that they would be stepping up enforcement on hospitals out of compliance, as well as the introduction of bipartisan legislation in the House of Representatives to expand price data availability, accessibility, and utility. If successful, the amount of useful price information available to consumers and researchers would be greatly expanded. However, truly meaningful price transparency will remain elusive for many with complex care requirements unless additional action is taken to allow convenient analysis of care the way that it is actually experienced by patients. Specifically, standard definitions of episodes of care should be adopted that allow for real charges to be grouped and analyzed, and a comprehensive patient specific estimate produced.

Price Estimates for Complex Care

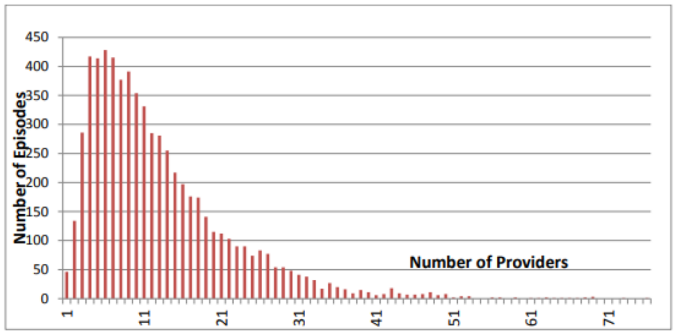
To understand the shortcoming of current transparency efforts, consider the example of requirements for GFEs for uninsured patients. Upon scheduling an item or service to be furnished, the No Surprises Act requires that providers and facilities compile a GFE with the expected billing and diagnostic codes for the patient including the expected charges for furnishing such item or service along with *any item or service that is reasonably expected to be provided in conjunction with such scheduled or requested item or service or reasonably expected to be so provided by another provider or facility*. This requirement for including the price of services reasonably expected to be provided with the core service is both vitally important and nearly impossible to meaningfully implement in the fee-for-service (FFS) environment without first settling on definitions for what constitutes the episode of care and having the ability to group services using such definitions.

The GFE for uninsured and self-pay individuals essentially requires advance knowledge not only of what services will be provided during the course of the patient's care, but also of which specific physician or provider will be delivering each service. For a care encounter such as a wellness visit, diagnostic test, or a simple procedure in the office, this might be straightforward. However, treatment for many diagnoses and conditions, such as cancer or a major surgical procedure, might involve the skill and expertise of a large team and may occur across multiple sites of service.

A retrospective look at colon resection procedures among Medicare patients shows that a surprising number of distinct parties are involved in the provision of care for a single beneficiary[1]. Typical colectomy episodes will include surgeons, anesthesiologists, pathologists, radiologists, and other consultants along with multiple locations of care such as imaging centers, lab sites, hospitals, and operating suites. While the total number of billing taxpayer identification numbers (TINs)/national provider identifiers (NPIs) for the episodes included in this analysis was typically fewer than 15, a significant number of patients experienced episodes of care involving teams of 20, 30, 40 or more.

[1] https://aspe.hhs.gov/sites/default/files/private/pdf/255906/ACSReportSecretary.pdf#page=36

Figure 1. Distribution of Providers in Colectomy Episodes



Even in the best of circumstances, care will vary from patient to patient and delivery system to delivery system based upon the unique needs of the patient and the capabilities, personnel, and resources of the system. This variation means that advance estimates for fee-for-service patients lack the level of precision necessary for them to make confident decisions about care. On top of this, each payer may have different contracted rates with each physician or facility, or even multiple rates with each depending on the insurance product.

Episodes of Care for Price Transparency

ACS agrees that price disclosure can inform and empower consumers whether they shop for items and services individually or as part of service packages (i.e., individual shoppable services, explicit or implicit items within bundles, or episodes of care), and we believe that out-of-pocket cost, in addition to total cost of care, are important types of price information for patients. ACS continues to assert that the episode of care (rather than each individual service) is the appropriate unit of comparison for complex healthcare. Further, the definition of the episode and which services are included in the analysis should be the same for purposes of price transparency, for patient cost estimates such as the GFE and AEOB, and even for assessments in payment programs such as episode-based cost measures. The use of standard definitions of what services are associated with a given diagnosis, in combination with an episode grouper, would create a groundwork for estimates and comparisons which could then be used to provide patients with a typical base price and a range of what patients with similar circumstances (such as health status and insurance plan) have actually paid for their care.

While there are multiple episode groupers available, ACS feels that the episode definitions and grouper logic maintained by the PACES Center for Value in Healthcare[2] are clinically validated, the most functional and complete for this purpose. The PACES grouper would be run on claims data to establish the complete list of services and charges associated with each episode and subcategory. This grouper was designed to count each dollar only once and to assign charges to either the most relevant episode or divide them across all concurrent episodes assigned to a patient for which that service could be plausibly provided. For the purpose of a shoppable services tool or GFE, it would be more logical to assign the full cost of the surgical procedure, the facility, anesthesia, pathology, and "any item or service reasonably expected to be provided in conjunction with the scheduled procedure" to the estimate in order to provide the most realistic price. An added benefit of using the PACES grouper to derive this estimate is that the list of items and services generated would be based on objective evidence (past claims) and therefore likely more comprehensive than lists generated on the fly by overburdened Convening Providers or Convening Facilities or by patients trying to make sense of the massive amounts of pricing data on their own.

PACES could be used with the relevant payor database or on standardized MRFs in the future to run the episode logic and its business logic to determine the overall price variability for a given condition or procedure. This information could be used to provide an expected range of estimated prices to better inform the patient of what they might expect depending on how their condition progresses. Such estimates can also be risk-stratified to better reflect what the patient might expect based on his or her underlying characteristics and comorbidities. Ultimately, providing patients with a risk-stratified range of prices based on historical, insurer and provider specific data from publicly available MRFs (including the mean and median cost) is much more actionable than trying to build a "perfect" estimate code by code.

Conclusion

The ACS thanks you for convening this important hearing on Health Care Price Transparency: A Patient's Right to Know and we look forward to being an active partner in achieving a more transparent and patient-centered heath environment. Price transparency for complex care such as surgery is different than for simple services or single encounters. Streamlining and coordinating the format and content of the different data sources related to the current price transparency programs is a critical prerequisite to achieving transparency but is not enough in isolation. Once this is accomplished, an episode grouper or similar tool can be used to generate patient-specific, risk adjusted price estimates with a range of prices as experienced by similar patients. This is far more actionable for patients than trying to "build the car from parts" by adding up the total price of each item or service related to their health care on their own. Please contact Amelia Suermann with the ACS Division of Advocacy and Health Policy at asuermann@facs.org if you would like to learn more about our efforts to increase transparency and availability of information on both price and quality of care.

[2] https://www.pacescenter.org/

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Statement

of the

American Hospital Association

for the

Committee on Ways and Means

of the

U.S. House of Representatives

"Health Care Price Transparency: A Patient's Right to Know"

May 16, 2023

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, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to submit this statement for the record as the House Ways and Means Committee examines issues related to health care price transparency.

The AHA appreciates the Committee's interest in the implementation of price transparency regulations. Hospitals and health systems are committed to empowering patients with all the information they need to live their healthiest lives. This includes ensuring they have access to accurate price information when seeking care. Our members are working to comply with both state and federal price transparency policies.

Over the past several years, the AHA has engaged in substantial member education and engagement on the patient financial experience, including for the Hospital Price Transparency Rule and No Surprises Act transparency provisions. This includes:

- Establishing a CEO-level Price Transparency Task Force that helped guide the AHA in developing policies and sharing best practices with respect to price transparency and patient billing;

- Conducting member education through multiple member webinars, bi-weekly "office hours" with AHA and Healthcare Financial Management Association technical experts, issue briefs, member case studies and podcasts;
- Providing an implementation guide for members, including implementation checklists and FAQs;
- Conducting a three-part member webinar series on health care consumer expectations and experiences with the consulting firm Kauffman Hall;
- Hosting a multi-stakeholder intensive design process, which included providers, payers, patient advocates, technology vendors and others, to develop solutions to improve the patient financial experience of care;
- Supporting Centers for Medicare & Medicaid Services' (CMS) efforts to establish voluntary sample formats that hospitals may use to meet the federal requirement to make certain standard charges publicly available through a machine-readable file by connecting the agency with experts from the hospital field; and
- Updating the AHA's Patient Billing Guidelines, which include a focus on helping patients access information on financial assistance.

HOSPITAL PRICE TRANSPARENCY RULE

Under the federal Hospital Price Transparency Rule, starting Jan. 1, 2021, hospitals are required to publicly post via machine-readable files for five different "standard charges": gross charges; payer-specific negotiated rates; de-identified minimum and maximum negotiated rates; and discounted cash prices. The rule also requires hospitals to provide patients with an out-of-pocket cost estimator tool or payer-specific negotiated rates for at least 300 shoppable services.

Enforcement and Compliance

CMS has in place procedures to ensure hospital compliance with the Hospital Price Transparency Rule through an internal audit process and by responding to public complaints and reviewing third-party compliance assessments. When these reviews idenfify potential violations, CMS engages in a multi-step enforcement process, prioritizing their actions based on the size and scope of the potential violation. Until recently, CMS issued a warning letter first, which required hospitals to respond to and/or correct the violation within 90 days. If the violation remained, CMS then required the hospital to submit a corrective action plan (CAP) within 45 days and complete the CAP within 30-90 days. If the CAP was not submitted or completed, CMS could then issue a civil monetary penalty (CMP). CMS can fine hospitals up to $2 million per facility for violations and publishes online a list of hospitals that receive CMPs. To date, CMS has issued 730 warning letters and required 269 CAPs. CMS has imposed CMPs on four hospitals; the remainder of the hospitals under review have worked with CMS to correct any issues raised or are in the process of doing so.

Under this review process, CMS found that in 2022, 70% of hospitals complied with both components of the Hospital Price Transparency Rule, including the consumer-friendly display of shoppable services information, as well as the machine-readable file

requirements. This is an increase from 27% in 2021. Moreover, when looking at each individual component of the rule, 82% of hospitals met the consumer-friendly display of shoppable services information requirement in 2022 (up from 66% in 2021) and 82% met the machine-readable file requirement (up from 30% in 2021).

These numbers show significant progress on the part of hospitals and health systems — while acknowledging the work that remains — in implementing these requirements. The lower compliance rate in 2021, however, should not be interpreted as a lack of hospital commitment to transparency. Instead, it reflects the incredible challenges hospitals were experiencing in 2020 and 2021 in addressing the most acute phases of the COVID-19 public health emergency, which strained hospitals' staff and required the diversion of personnel and financial resources. As the pandemic phase of COVID-19 winds down and hospitals have been able to resume more standard operations, they are able to dedicate the resources necessary to build the full suite of price transparency tools.

In addition to the CMS report on compliance, we would draw your attention to a recent report from Turquoise Health that found about 84% of hospitals had posted a machine-readable file containing rate information by the end of first-quarter 2023, up from 65% the previous quarter.

Unfortunately, several third-party organizations repeatedly have claimed various rates of hospital compliance with federal price transparency policies that simply are not based on the facts. One such third-party — Patient Rights Advocate — released a paper that misconstrues, ignores and mischaracterizes hospitals' compliance with federal regulations. These groups ignore CMS' guidance on aspects of the rule, such as how to fill in an individual negotiated rate when such a rate does not exist due to patient services being bundled and billed together. In this instance, CMS has said a blank cell would be appropriate since there is no negotiated rate to include. In spite of this, some outside groups still count any file with blank cells as "noncompliant." This is a fundamental misrepresentation of the rules and creates a stream of misinformation that is inaccurate and distracting to these important discussions and work.

Recent Updates to the Oversight Process

CMS recently released updated guidance on its process for monitoring and enforcing the Hospital Price Transparency Rule. The new guidance makes three changes to the enforcement process:

1) **CMS will no longer issue warning letters to hospitals that do not appear to have made any attempt to comply with the rule and instead will go straight to requesting a CAP.** In other words, if CMS cannot find a machine-readable file or a shoppable service file/price estimator tool on a hospital's website, CMS will request a CAP as the first enforcement step, significantly shortening the timeline for the hospital to come into compliance.

2) **CAPs will now need to be completed within 45 days.** Previously, CMS allowed hospitals to propose a completion deadline (typically between 30-90 days) in their CAP.

3) **CMS will automatically impose CMPs if CAPs are not submitted or completed by their deadlines.** Going forward, CMS will impose a CMP if the agency has not received a requested CAP within 45 days. In addition, CMS will actively review hospital compliance at the 45-day deadline following CAP submission and, if the violation(s) cited in the CAP request still exists, will impose a CMP.

Recommendations

Hospitals and health systems are eager to continue working toward providing the best possible price estimates for their patients. We ask Congress and the Administration to take the following steps to support these efforts, including:

- Review and streamline the existing transparency policies — including the Hospital Price Transparency Rule and the No Surprises Act — with a priority objective of reducing potential patient confusion and unnecessary regulatory burden on providers;
- Continue to convene patients, providers and payers to seek input on how to make federal price transparency policies as patient-centered as possible; and
- Refrain from advancing additional legislation or regulations that may further confuse or complicate providers' ability to provide meaningful price estimates while adding unnecessary costs to the health care system. We would encourage the Committee to review the recent modifications CMS made to the compliance process before making additional legislative changes to the Hospital Price Transparency Rule.

CONCLUSION

Thank you for the opportunity to share the hospital and health system field's perspective on health care price transparency with the Committee. We look forward to continuing to work with you to address these important issues.

POWER to the PATIENTS

Full Committee Hearing on Health Care Price Transparency: A Patient's Right to Know

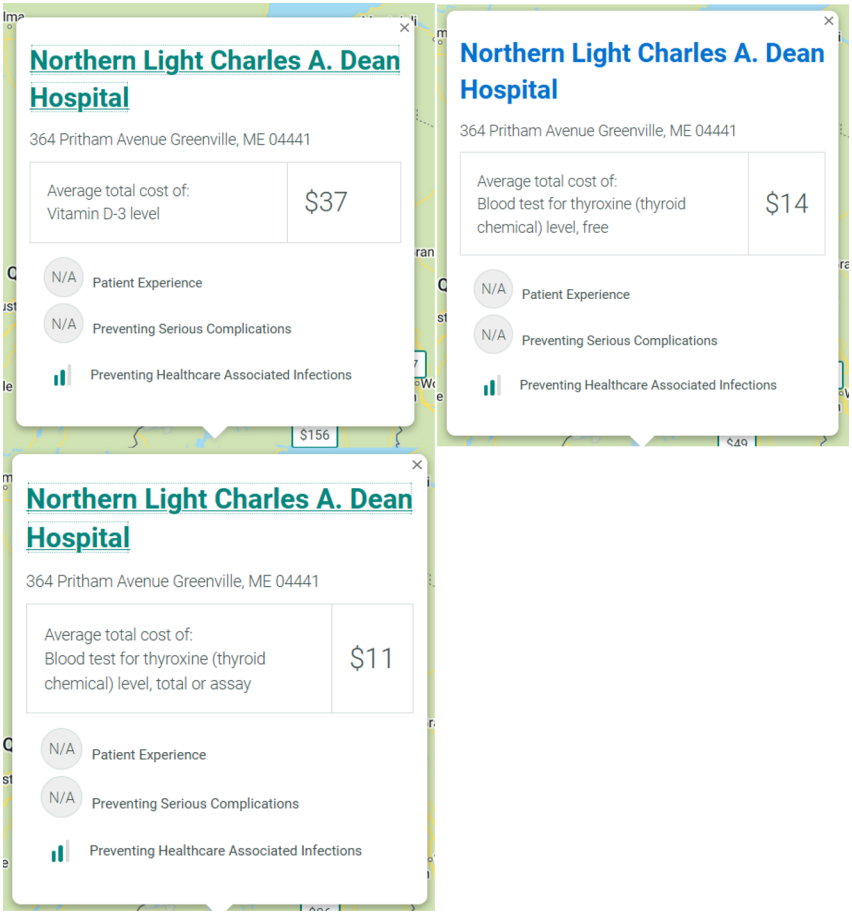
Hearing Information
Tuesday, May 16, 2023 at 10:00 AM.
1100 Longworth House Office Building

Billed price did not match website listed price. Now he's in collections.

Daniel B. recently had routine blood work done at a lab associated with Northern Light Charles A. Dean Hospital, in Greenville, Maine. After he got the bill, he went to the hospital website and saw that his lab tests should cost under $100. But his bill was for over $800, and after insurance negotiated the price down, he still owed over $600.

One test for Vitamin D was listed as costing $37 on the website. On the final bill it was $214. The thyroid tests were $14 and $11 each. On the final bill they were $187 and $225 each. (See images below.) When he contacted the hospital billing department, they said, "The website never has correct pricing."

The initial bill did not have the billing codes. During the phone call with the billing department he was referred to another department to get the actual per item billing. That department had to get the billing codes from yet another department, and it took a month to receive them. Once he had the billing codes he drilled deeper down into the website and did indeed find an excel spreadsheet where he found prices that did match his bill, but this wasn't what was presented and accessible. The Excel spreadsheet also was only useable once you have the billing codes. "It felt like bait and switch. If I had known the real costs, I would have shopped around." Now he is fighting the bill, and the hospital has sent him to collections."


Northern Light Charles A. Dean Hospital
364 Pritham Avenue Greenville, ME 04441
Average total cost of: Vitamin D-3 level
$37
N/A
Patient Experience
N/A
Preventing Serious Complications
Preventing Healthcare Associated Infections
$156
Northern Light Charles A. Dean Hospital
364 Pritham Avenue Greenville, ME 04441
Average total cost of: Blood test for thyroxine (thyroid chemical) level, free
$14
N/A
Patient Experience
N/A
Preventing Serious Complications
Preventing Healthcare Associated Infections
Northern Light Charles A. Dean Hospital
364 Pritham Avenue Greenville, ME 04441
Average total cost of: Blood test for thyroxine (thyroid chemical) level, total or assay
$11
N/A
Patient Experience
N/A
Preventing Serious Complications
Preventing Healthcare Associated Infections

[redacted]

HCI # 711 2

C A DEAN MEMORIAL HOSPITAL
43 WHITING HILL RD
BREWER, ME 04412-1006
207 695-5200
FEI # 04-3341666

PAGE NO. 1

TYPE OF BILL	DATE OF BILL	DATE OF PREV.BILL
	10/30/22	

RPAUDD

[redacted] HOSP.NO.

T	R	PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
		[redacted]	[redacted]			10/13/22		

GUARANTOR NAME AND ADDRESS [redacted]

C.O.B.	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	[redacted]		
2	[redacted]		

AMOUNT OF PAYMENT $

DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS.CO. NO. 1	EST. COVERAGE INS.CO. NO. 2	EST. COVERAGE INS.CO. NO. 3	EST. COVERAGE INS.CO. NO. 4	PATIENT AMOUNT
DETAIL OF CURRENT CHARGES, PAYMENTS AND ADJUSTMENTS								
10/13/22	70170147 001		29.00	29.00				
	BLOOD DRAW/LAB							
10/13/22	70400049 001		187.00	187.00				
	T3 FREE							
10/13/22	70472154 001		214.00	214.00				
	VITAMIN D 25/LAB							
10/13/22	70970363 001		225.00	225.00				
	TSH/LAB							
10/13/22	70998778 001		181.00	181.00				
	FREE T4/LAB							
10/18/22	50001411 001		29.00-	29.00-				
	CA BLOOD DRAW AUTO AD							
10/28/22	99901589 001		621.39					621.39
	ELECTRONIC DEDUCTIBLE							
10/28/22	11001401 001							
	ZERO PAYMENT							
10/28/22	11090297 001							
	HARVARD PILGRIM PMT							
10/28/22	50090216 001		185.61-	185.61-				
	CA HARVARD PILGRIM CO							
10/28/22	99901589 001		621.39-	621.39-				
	ELECTRONIC DEDUCTIBLE							
SUMMARY OF CURRENT PAY/ADJ			214.61-	836.00-				621.39
SUMMARY OF CURRENT CHARGES								
LAB		30	836.00	836.00				
SUB-TOTAL OF CURR. CHARGES			836.00	836.00				
T O T A L S			621.39					621.39

PATIENT NUMBER [redacted]

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS STATEMENT WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

PAY THIS AMOUNT 621.39

C A DEAN MEMORIAL HOSPITAL
BREWER, ME

1310 G Street, N.W.
Washington, D.C. 20005
202.626.4800
www.BCBS.com

May 16, 2023

The Honorable Jason Smith
Chair
House Committee on Ways and Means
Washington, D.C. 20515

The Honorable Richard Neal
Ranking Member
House Committee on Ways and Means
Washington, D.C. 20515

Dear Chairman Smith and Ranking Member Neal:

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to comment on critical issues impacting health care price transparency and affordable access to care. BCBSA is committed to advancing commonsense solutions to lower health care costs and enable patients' ability to be effective health care shoppers. We appreciate your leadership in holding today's hearing, "Health Care Price Transparency: A Patient's Right to Know."

BCBSA is a national federation of 34 independent, community-based and locally operated Blue Cross and Blue Shield (BCBS) companies (Plans) that collectively cover, serve and support 1 in 3 Americans in every ZIP code across all 50 states, the District of Columbia and Puerto Rico. For more than 90 years, BCBS companies have offered quality health care coverage in all markets across America—serving those who purchase coverage on their own as well as those who obtain coverage through an employer, Medicare and Medicaid.

Our mission is simple: We want every American to have affordable access to high-quality care. To help advance that mission, we support transparency done the right way—by providing consumers with secure, meaningful and actionable data that is relevant to their health care decision-making. Effective tools can help consumers with what they most care about—understanding their own-of-pocket costs, the quality of care provided by their doctors and whether their doctors, hospitals and other clinicians are in their network. Using this information, consumers are able to make more informed decisions on how to receive the care that is right for them.

We believe consumer transparency should focus on shoppable services to provide what health care consumers seek, without the noise of additional complicated health services for which consumers cannot meaningfully shop. Prior to the introduction of the Transparency in Coverage (TiC) tool, all BCBS Plans provided members with consumer-focused cost tools, including tools with mobile access, tools focused on prescription drugs costs, tools focused on finding the right provider and resources that were integrated with their plan design and benefits. The price comparison tools most closely aligned to the goals of the TiC tool are offered by all Plans and enable members easily compare the cost and quality across 1,600 health care services based on their individual benefit plan. For example, federal employees enrolled in

the Blue Cross and Blue Shield Federal Employee Program® (FEP®) can utilize the Healthcare Cost Advisor planning tool to get access to personalized cost data, including understanding current and past costs and out-of-pocket spending. Members can estimate potential out-of-pocket expenses based on expected or anticipated life changes or events as well as get help calculating annual health care budget. Based on Blue experience building and maintain these tools, we know that more than 80% of consumer searches are for only 50 services.

BCBS Plans across the country continue working every day to offer these cost tools, in tandem with TiC tools, to provide more targeted information that help consumers more effectively navigate and estimate the range of costs for specific shoppable services across providers in their communities. Plans' existing tools provide estimates within the context of the member's benefit plan and the likely course of services for a specific condition that are tailored to the services members are most likely to receive (e.g., a full knee replacement, including surgical costs and subsequent physical therapy).

Furthermore, BCBS companies are committed to compliance with the machine-readable file (MRF) requirements established by CMS. These existing structures are reasonable standards for the layout and design of the files based on the parameters established by the transparency rule. BCBS companies have invested significant resources to ensure alignment with these standards. We appreciate the thoughtful work done by CMS following the finalization of the rule to establish standards that are both actionable and reflective of the complexities intrinsic to the files.

We believe the regulatory pathway continues to be the best way to provide patients with the most valuable and usable price information. It allows for more flexibility to adjust the tools and requirements to reflect industry advancements (e.g., new reimbursement approaches, technologies for communicating costs). We recommend not codifying these requirements in statute and retaining the agility of the standards to best support our shared goal of transparency.

Additionally, BCBSA provided the Departments of Labor, Treasury, and Health and Human Services with our response to the Advanced Explanation of Benefits Request for Information in November of 2022 and our response to the Transparency in Coverage Notice of Proposed Rule Making in January of 2020. As part of these responses, we provided additional details and recommendations on how to work toward our shared goal of greater price transparency for consumers. We would be happy to provide them should the committee find them helpful.

As you continue your critical work to lower health care costs this Congress, we look forward to working closely with you and other members of Congress to advance solutions that deliver real results for every American and every community. If you have any questions regarding our affordability solutions, please contact me or my colleague, Keysha Brooks-Coley, vice president of advocacy, at Keysha.Brooks-Coley@bcbsa.com. Thank you again for your leadership on these critical issues.

Sincerely,

David Merritt
Senior Vice President, Policy and Advocacy
Blue Cross Blue Shield Association

Health Care Price Transparency: A Patient's Right to Know

Jonathan Ingram, *Vice President of Policy and Research*
Hayden Dublois, *Data and Analytics Director*

America's health care system is built upon a lack of transparency. In most states, it is nearly impossible for individuals and families to compare the cost of health care services and procedures like they would when shopping for gas, groceries, or housing. This intentional lack of transparency confuses consumers, hides true costs, and drives up prices.[1]

In the past several years, the U.S. Department of Health and Human Services has updated several federal regulations that require hospitals and insurers to provide more transparency, introducing accountability into America's health care system.

Unfortunately, the Biden administration has done little to monitor compliance with these transparency requirements and has even unlawfully stopped enforcement.

State-level transparency reforms led to federal action

The Foundation for Government Accountability (FGA) has worked in more than a dozen states on health care transparency efforts for many years.[2-3] These states' experiences paved the way for—and helped inform—eventual federal action on transparency.[4-5] Indeed, FGA research on those experiences was relied upon in evaluating and proposing transparency rules.[6-7]

The Biden administration is not enforcing transparency requirements

In 2022, FGA conducted an independent review of more than 6,400 hospitals, revealing widespread non-compliance with those transparency requirements.[8] Altogether, more than 63 percent of hospitals were not complying with the transparency rule.[9] Some of these hospitals refused to disclose cash prices, negotiated rates with private insurance plans, prices for some services, or even any prices at all.[10] In some states, non-compliance is even more pronounced. In Maryland, for example, just five percent of hospitals were complying with federal transparency requirements.[11]

Unfortunately, the Biden administration has done little to enforce these requirements. It took nearly a year and a half after the rule became effective for Centers for Medicare & Medicaid Services (CMS)

to issue the first fines.[12] But even these actions were little more than a minor slap on the wrist. The only fines issued so far have gone to two hospitals in Georgia's Northside Hospital System.[13] However, the fine amounts levied after nearly 18 months of non-compliance totaled less than 0.1 percent of the hospital system's annual gross revenue.[14] Put another way, these fines represented just 40 minutes of the hospital system's annual revenue.[15]

Worse yet, the Biden administration is stonewalling efforts to shine light on its lack of enforcement. In March 2022, FGA filed a Freedom of Information Act (FOIA) request with CMS seeking information on warnings, corrective action plans, fines, and other penalties issued in relation to the hospital price transparency rule.[16] Although federal law gives agencies just 20 business days to respond to FOIA requests, the Biden administration refused to produce any records associated with the rule more than five months later, despite repeated follow up attempts.[17] This stonewalling led FGA to file a lawsuit against the Biden administration in federal court, forcing them to produce the relevant public records.[18-20] The federal court ordered the Biden administration to stop evading FGA's records request, though the litigation and related document production remains ongoing.[21]

Further, the Biden administration has issued unlawful guidance to actually block the enforcement of health care transparency rules, including transparency requirements for drug prices.[22] In March 2023, FGA filed suit in federal court to challenge these unlawful actions.[23-24]

FGA thanks the Subcommittee on Health for its commitment to making the health care system more transparent and accountable to the American people.

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The Heritage Foundation

CONGRESSIONAL TESTIMONY

Health Care Price Transparency: A Patient's Right to Know

Testimony Submitted to
The Committee on Ways and Means

United States House of Representatives

May 17, 2023

Robert Emmet Moffit, PhD
Senior Fellow, Center for Health and Welfare
The Heritage Foundation

My name is Robert Emmet Moffit. I am Senior Fellow in Health and Welfare Studies at The Heritage Foundation. The views I express in this testimony are my own and should not be construed as representing any official position of The Heritage Foundation.

Chairman Smith, Ranking Member Neal, and distinguished Members of the House Ways and Means Committee. I thank the Committee for the opportunity to submit testimony on health care price transparency and to suggest ways to increase patient knowledge, engagement, and personal health savings.

A Bipartisan Opportunity. Rendering health care prices transparent and broadly accessible should be neither controversial nor partisan. Several state-level hospital-price-transparency policies, such as those adopted in 2017 in my home state of Maryland, have enjoyed strong bipartisan and popular support.[1] At the federal level, the Trump Administration's groundbreaking hospital and health insurance transparency rules unveiled in 2019 were embraced by the Biden Administration in 2021; and, despite some early problems with hospital compliance, the process of implementation is well underway. The federal health insurance rules are scheduled to enter the third phase of implementation in 2024.

The appropriate legislation is now in order. The details of implementation and enforcement will require careful consideration in the crafting of such measures. Happily, recent congressional proposals reflect a continuation of the bipartisan spirit that has characterized earlier efforts to improve health care price transparency. Representative Cathy McMorris Rogers (R-WA) and Representative Frank Pallone (D-NJ), for example, are sponsoring the Transparent PRICE Act (H.R. 3281), a major bill to promote, among other things, hospital and insurance price transparency by codifying federal transparency rules.[2]

The true test of success, however, will come when the real prices of medical services are fully transparent, easily accessible, and easy for ordinary

[1] See Robert E. Moffit, Marilyn Moon, François de Brantes, and Suzanne F. Delbanco, "The Next Chapter in Transparency: Maryland's 'Wear the Cost,'" *Health Affairs Forefront*, October 19, 2017, https://www.healthaffairs.org/do/10.1377/forefront.20171023.671259/full/.

[2] See H.R. 3281, The Transparent PRICE Act, https://www.congress.gov/bill/118th-congress/house-bill/3281?s=2&r=3.

Americans to understand, compare, and act upon in hospital and health insurance markets.

A Major Challenge. Today, accessing health care pricing data, acting on it, and securing personal savings, constitutes a major set of challenges for patients. The reason: Price opacity in health care is structural. Major health care decisions about health plans, financing, and benefits are not made by individuals, seeking the best value for their dollars, but by government bodies and large private-sector organizations. American health care financing itself mostly consists of a series of negotiated agreements between third-party players—a mix of large managed care corporations, insurers (public and private), employers, and large hospital systems and provider organizations—in state, local, and regional areas around the country. Individuals and families, as health care consumers, exercise little economic power. As the Congressional Budget Office (CBO) has observed,

> The prices that commercial insurers pay are determined through negotiations with providers. Those negotiations often lead to higher prices because of providers' market power (the ability to command higher prices than would prevail in a perfectly competitive market) and because of the lack of price sensitivity among insurers, which reflects insensitivity to prices among consumers and employers who select their plans.[3]

Not surprisingly, health insurers and medical professionals and hospitals have routinely tried to keep the substance of these price negotiations confidential.[4]

During the crafting of legislative provisions, various analysts will doubtless suggest a wide range of technical improvements to existing federal rules, such as stronger enforcement of transparency requirements, standardization of reporting, measures to ease and improve provider compliance, or the best way to include quality metrics with pricing information. Congress should not neglect the valuable work of several states in their efforts to improve pricing transparency, it should learn valuable lessons from those state experiences. Congress should ensure that any federal legislation *complements* those state accomplishments and does not undermine them. The same is true for the development of health care quality metrics; good work is already being done in the states and by private-sector organizations.

Patient Engagement. Of all the goals of an improved price-transparency policy, securing active patient engagement and personal decision-making is, or should be, the most important objective. Knowing the price of a medical service or procedure offered by a hospital, clinic, or medical professional, is pointless if the individual patient cannot act on that knowledge. Within the private sector most Americans are enrolled in employment-cased health insurance. When confronted by a variety of medical specialists, or a range of care delivery options, if a group insurance enrollee chooses the most cost-efficient option, the savings of that decision will not directly return to the patient, but to the patient's employer.

While full patient empowerment in the health care markets would require some substantial market reforms, including a robust liberalization of the health insurance market, Congress can nonetheless take certain steps to incentivize patients to make cost-efficient choices in their medical care and reap the financial rewards of doing so. In this connection, I suggest two changes to improve current policy in our health insurance markets, as well as the existing policy governing health savings accounts. Congress should:

1. **Create Incentives to Use Price Information by Encouraging a "Shared Savings" Model.** Making data on the different prices charged for medical services transparent and accessible is a necessary precondition, but not the complete

[3] Congressional Budget Office, "Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services," September 2022, https://www.cbo.gov/system/files/2022-09/58222-medical-prices.pdf. Hereafter cited as: CBO, "Policy Approaches."

[4] Maanasa Kona and Sabrina Corlette, "Hospital and Insurer Price Transparency Rules Now in Effect But Compliance Is Still Far Away," *Health Affairs Forefront*, September 12, 2022, https://www.healthaffairs.org/content/forefront/hospital-and-insurer-price-transparency-rules-now-effect-but-compliance-still-far-away.

solution. Patients also need to have incentives to act on that information and health plans need to have incentives to encourage enrollees to incorporate price information into their decisions. Put simply, the availability of actionable information will make little difference absent incentives to act on the information.

Congress can help to create the right incentives by enacting targeted reforms that enable health plans to implement "shared savings" programs. The basic concept is that a health plan would offer to share with an enrollee the savings that accrue to the plan due to the enrollee choosing a more cost-effective treatment or provider option. Operationally, a health plan would offer its enrollees user-friendly tools for comparing provider price information—and potentially quality information—on "shoppable" medical services. The plan would tell its enrollees that when they choose a better-value provider, it will share the resulting savings directly with the enrollee.

Congress could encourage the adoption of such private-sector shared-savings arrangements by making three modest changes. First, Congress should make shared-savings payments from health plans tax free to enrollees. Second, for those with health savings accounts (HSAs) Congress should specify that any shared-savings payments they receive and deposited in such accounts will not count against the annual limit on tax-free contributions to an HSA. Third, Congress should clarify that under the medical loss ratio (MLR) requirement, imposed on insurers by the Affordable Care Act (ACA), shared-savings payments made by plans to enrollees would count as "payments for medical care," not as "administrative costs." These three, modest changes would incentivize health plans and enrollees to partner in using the growing amount of transparent price information to optimize savings from consumers shopping for "shoppable" medical services and procedures.

2. **Increase Personal Savings Through a Liberalization of Health Savings Accounts.** Any codification of federal hospital or health insurance transparency rules should be combined with an expansion of HSAs. Today over 32 million Americans have saved over $100 billion in HSAs.[5] According to a major report from the American Academy of Actuaries, "[c]onsumers with high deductible health plans (HDHPs), which have a significant up-front deductible that applies to almost all services, are very price-sensitive and may be avid users of new transparency tools."[6]
To secure maximum personal savings, Congress should allow *anyone* with insurance, regardless of its benefit design, to have such an account, clarify that funds in the accounts can be used for direct primary care, and expand the level of tax-free contributions for individuals and families up to the catastrophic limits for individuals and families in the ACA health insurance exchange markets. Current law restricts tax -free employer and employee HSA contributions to $3,850 for individual coverage and $7,750 for family coverage. If, instead, the ACA out-of-pocket limits were the standard set for allowable HSA contributions, this year individuals would be able to contribute $9,100 for their coverage and families would be able to contribute up to $18,200 for family coverage.[7]

Savings Potential. Controlling costs and slowing the growth of health spending is a widely shared policy goal. While there is little doubt that a highly

[5] Greg Iacurci, "Consumers Have Saved More Than $100 Billion in Health Savings Accounts," *CNBC,* March 29, 2022, https://www.cnbc.com/2022/03/29/consumers-have-saved-more-than-100-billion-in-health-savings-accounts.html.

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restrictive system of price controls or payment caps will sharply curtail health care spending, there is also no doubt that such policies would also broadly reduce patient access to health care services.

Unfortunately, there have been relatively few studies that have focused on the potential of price transparency policies to reduce health care spending. Acknowledging this fact, the CBO has offered its own estimates for this policy, among others, and reports that a price transparency policy would yield only modest results, no more than 1 percent reduction in national health care spending. The CBO concedes, however, that the real impact of such a policy remains highly uncertain and would be heavily dependent upon the specific details of its scope and implementation.[8] Likewise, Rand Corporation analysts estimate that price transparency would yield modest results, ranging only between $8.7 billion to $26.6 billion, with the largest savings generated by employer-driven decisions.[9]

Also noting that existing research on price transparency has been relatively limited, Professor Stephen Parente, a health economist at the University of Minnesota, has undertaken a comprehensive analysis based on two large sets of all-claims databases—representing the entire commercially insured population covering more than 200 million lives. Publishing his results in *Inquiry: The Journal of Health Care Organization, Provision and Financing*, Parente concludes that a comprehensive price transparency policy— "assuming a robust set of tools"—could achieve "significant" system-wide savings. He estimates that the United States could experience a wide range of nationwide savings, from a low of $17.6 billion and potentially climbing to more than $80 billion in 2025. The national result would translate into a 6.9 percent reduction in medical spending for all Americans enrolled in private health insurance, including a 7.4 percent reduction in medical expenditures for persons with incomes below 100 percent of the federal poverty level (FPL).[10] Echoing analysts with the American Academy of Actuaries, Parente observes: "Consumers may have strong incentives to shop with the rise in the use of high deductible health plans and health savings accounts. How the potential savings are to be shared by consumers, employers and health plans has yet to be determined."[11]

CBO analysts likewise insist that the effectiveness of any price-transparency policy would depend on the details of its implementation. They also observe that, "If more consumers started using price information to choose lower-priced providers, then, over time, those changes in price sensitivity might pressure providers to accept negotiated prices that were *much lower* than they would be under current law."[12] (Emphasis added.) The challenge is to secure patient engagement.

A Word of Caution. In crafting legislative provisions, various analysts will doubtless suggest a wide range of technical improvements to existing federal rules, such as stronger enforcement of transparency requirements, standardization of reporting, measures to ease and improve provider compliance, or the best way to include quality metrics with pricing information.

In crafting their legislative proposals, Members of Congress should not neglect the valuable work of several states in their efforts to improve pricing transparency in hospital and health insurance markets, learn the valuable lessons from those state experiences, and ensure that any federal legislation *complements* those state accomplishments, and does not undermine them. This is especially true if Congress wishes to combine price and quality information. Members should not overlook or pre-empt state or private-sector development of health

[8] CBO, "Policy Approaches." p.13.
[9] Jodi Liu, Zachary M. Levinson, Nabeel Qureshi, and Christopher Whaley, "Impact of Policy Options for Reducing Hospital Prices Paid by Private Health Plans," Rand Corporation *Research Report*, January 2021, https://www.rand.org/pubs/research_reports/RRA805-1.html.
[10] Stephen T. Parente, "Estimating the Impact of New Health Price Transparency Policies," *Inquiry: The Journal of Health Care Organization, Provision and Financing,* February 17, 2023, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9940230/.
[11] Ibid.
[12] CBO, "Approaches," p. 19.

care quality metrics; excellent work is already being done, especially by private-sector organizations.

Conclusion. Today, American "health care markets" are not driven by personal choices based on accessible information on price, let alone an educated understanding of the quality of medical goods and services. In contrast to other sectors of the economy—even in those sectors where services and transactions are complex (such as financial planning)—price opacity in health care is an anomaly. Moreover, individuals and families, as consumers of health care, often have little or no say over major health care decisions, such as what kind of health plan they get, which medical treatments or procedures will be available to them under that coverage, or what they will pay in terms of insurance premiums, co-payments, or deductibles. Quality is uneven and inconsistent, depending on the coverage and care available. In short, individuals and families, as a rule, control neither the dollars nor the decisions in American health care; they are controlled by employers and corporate benefits managers, by health-insurance and managed-care executives, and increasingly by government officials.

Patient-driven choices, with some notable exceptions, are limited; and medical professionals' responses to patients' preferences and needs is too often influenced by public-sector and private-sector third-party payment rules. Actionable information, based on sound price and quality information, coupled with incentives for both plans and consumers to act on that information, can improve economic efficiency as well as the quality of patients' medical care. By promoting patient-friendly information on health care pricing and provider performance, and facilitating patients' ability to act on that information, Congress can improve the financing and the quality of American health care delivery.

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Pete Slone
Senior Vice President, Public Affairs

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MCKESSON

May 30, 2023

The Honorable Jason Smith
House Committee on Ways and Means
1139 Longworth House Office Building
Washington, DC 20515

RE: HEALTH CARE PRICE TRANSPARENCY: A PATIENT'S RIGHT TO KNOW

Dear Chairman Smith:

On behalf of McKesson Corporation ("McKesson") I am pleased to respond to your request for information related to "Health Care Price Transparency: A Patient's Right to Know". At McKesson, **we believe the "patient comes first" and we agree with the Committee that transparency is foundational to empowering the patient.** We applaud your leadership and commitment to developing bipartisan solutions that will improve patient access and increase prescription drug affordability and medication adherence.

As a diversified healthcare leader, McKesson's solutions help patients access life-changing therapies, make a real difference for patients with cancer, and equip pharmacies, health systems and clinics with technologies to operate more effectively. We work with biopharma companies, care providers, pharmacies, manufacturers, governments and others to deliver insights, products and services that make quality care more affordable.

Pharmacy spend is the fastest growing segment in healthcare. In each of the below examples "cost" was most often associated with the inability to access prescription medication.

- **13+ million** Americans annually fail to have at least one prescription drug filled
- **One-in-three** patients extended their medication by taking it on a modified schedule other than prescribed
- **17 percent** of patients have stopped buying or filling medications completely
- **40 percent** of patients said insurance barriers were the top reason they experienced a delay in accessing their medications in the past year

When we provide greater visibility and expand the exchange of information, the patient is empowered to make better healthcare decisions. Transparency remains elusive, contributing to a deterioration of individual health and increased costs. Each year, low medication access and adherence results in an estimated $100 billion in preventable medical costs, 125,000 preventable deaths, and accounts for as many as two-out-of-every-three hospital admissions. These statistics and the health outcomes associated are avoidable by **allowing all patients** access to real-time benefit tools and giving them the right to access and share their health information.

McKesson shares in the Committee's desire to strengthen the healthcare system, empower patients and providers, get the right data into the right hands at the right time, improve access and outcomes

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through adherence, reduce costs, and encourage market competition. As such, we offer the below recommendations.

We look forward to working with the Committee and please feel free to contact Damon Porter, Vice President, Federal Affairs at damon.porter@mckesson.com if you have any questions or require further information.

Sincerely,

Pete Slone

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MCKESSON

McKesson Recommendations to Improve Price Transparency

Medicare Part D Transparency Leads the Way, But Needs Improvement to Benefit All Patients

In accordance with the Consolidated Appropriations Act of 2021, the Centers for Medicaid and Medicare Services required Medicare Part D plans to implement real-time benefit tools (RTBTs) for prescribing physicians and patients alike. RTBTs are intended to give insights into the patient's pharmacy benefit coverage, including which drugs are covered and what cost obligations have been, or need to be, met for the patient to access a prescribed medication before they even get to the pharmacy counter. Notably pharmacists do not have access to RTBTs despite being the patient's most accessible and trusted medication expert. At the same time, RTBTs are only required to capture benefit and cost information for the patient's plan, while lower cost, clinically appropriate treatment alternatives may be available off-formulary and/or through pharmaceutical manufacturer assistance programs. Also, RTBTs often lack applicable utilization management requirements, such as prior authorization. Filling these data gaps will enhance RTBTs in Medicare Part D. Given their value, RTBTs should be further extended to other government sponsored programs, including Medicaid and the Federal Employee Health Benefit Program, among others. RTBTs provide necessary upfront information, helping to stave off medication abandonment and resulting emergency room visits by improving medication adherence and most importantly, patient outcomes.

Recommendation: All patients, healthcare providers, and pharmacists, across all payers should be granted access to RTBTs and data captured within RTBTs should be expanded to include off-formulary options and all prior authorizations requirements.

Data Exchange Barriers Hinder Access, Harm Outcomes

Improving data sharing across the entire healthcare ecosystem will achieve greater price transparency and reduce costs. The 21st Century Cures Act established standards for "supporting secure, seamless, and timely data exchange". Currently, health plans are the only entity with complete visibility to a patient's entire, detailed health record. Yet health plans and payers are not subject to information blocking requirements that further enable patient data access and control.

Through the HITECH Act, Congress has provided the statutory right for individuals to compel health plans to share electronic protected health information (ePHI) with third parties – such as providers, health technology companies, and others supporting their care. The HITECH Act accomplishes that by requiring any "covered entity" that "uses or maintains an electronic health record with respect to protected health information of any individual" to comply with that individual's request to "direct the covered entity to transmit such copy directly to an entity or person designated by the individual, provided that any such choice is clear, conspicuous, and specific." Congress should support the full scope of value-based care coordination and require health plan data - including patient claims, benefit and cost sharing information - apply to any covered entity that uses or maintains an electronic health record with respect to protected health information of any individual.

Recommendation: Prevent information blocking among health plans and enhance patient ability to access and direct their ePHI to other providers in the patient's care continuum and/or third parties.

Statement for the House Ways & Means Subcommittee on Health

May 16, 2023

Health Care Price Transparency: A Patient's Right to Know

Submitted by
National Association of Benefits and Insurance Professionals

I am writing on behalf of the National Association of Benefits and Insurance Professionals (NABIP), formerly NAHU, a professional association representing over 100,000 licensed health insurance agents, brokers, general agents, consultants, and employee benefits specialists. The members of NABIP help millions of individuals and employers of all sizes purchase, administer, and utilize health plans of all types.

The health insurance agents and brokers that NABIP represents are a vital piece of the health insurance market and play an instrumental role in assisting employers and individual consumers with choosing the health plan or plans that are best for them. Eighty-two percent of all firms use a broker or consultant to assist in choosing a health plan for their employees[1] and eighty-four percent of people shopping for individual exchange plans found brokers helpful -- the highest rating for any group assisting consumers.[2] During the 2023 open enrollment period, agents and brokers assisted 71 percent of those who enrolled through HealthCare.gov or a private direct enrollment partner's website. Additionally, premiums are 13 percent lower in counties with the greatest concentration of brokers.[3] Consequently, the NABIP membership has a vested interest in ensuring that consumers enjoy affordable health coverage that is the correct fit for their clients.

NABIP believes the principle of transparency is critical to lowering healthcare costs for Americans. The purchase of healthcare drives one-sixth of our economy, yet most consumers make related decisions with minimal regard to price and quality of care. In some cases, people make decisions without considering the actual necessity of the purchase. Since most individuals have health plan coverage with a predetermined network, their care selection process has become more about which providers and facilities are in their system rather than which people and institutions are proving high-quality services for the best price.

The Consolidated Appropriations Act of 2021 set the foundation for transparency in care. Now is the time to build on those actions to create an educational foundation so consumers can access the data needed to determine the quality of care and the cost associated with it.

One way that consumers mitigate costs is by combining a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), which allows patients to pay for certain medical expenses with money free from federal taxes. However, while HSAs were created nearly 20 years ago, regulations on how individuals can use their HSA dollars have not kept pace in today's changing benefits landscape. One vital change to consider would be to provide pre-deductible coverage for primary care.

Access to a primary care physician can drive down costs and increase patient utilization of preventive care. While we want as many consumers as possible to have access to a primary care physician, there are some barriers to care in the current system. When it comes to primary care, there are three options:

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[1] Kaiser Family Foundation. Employee Health Benefits Annual Survey. October 2013.
[2] Blavin, Fredric, et al. Obtaining Information on Marketplace Health Plans: Websites Dominate but Key Groups Also Use Other Sources. Urban Institute. June 2014.
[3] Karaca-Mandic, Pinar, et al. The Role of Agents and Brokers in the Market for Health Insurance. National Bureau of Economic Research. August 2013.

direct primary care (DPC), traditional primary care and concierge medicine. Under current rules, consumers are able to utilize their HSA, HRA, or FSA healthcare accounts towards traditional primary care and concierge care. A traditional primary care provider's main source of revenue is third-party reimbursement billed through each patient's health insurance issuer. "Concierge providers" bill a patient's health insurance issuer for payment for services rendered as well; however, concierge doctors also charge patients an annual fee (typically in the $2,000 to $3,000 range) for expedited access to the provider. Finally, the DPC model involves a fully independent provider who does not accept any type of third-party reimbursement. Instead, DPC payments all come directly from individual patients or families.

Direct primary care is not currently defined as an insurance product under IRC §213(d) and therefore consumers are not able to use an HSA or HRA towards their monthly membership fee, which limits access to this avenue of care. Effective primary care, including direct primary care, is well-known to be one of the critical components of overall personal wellness. The DPC model has gained popularity over the past 10 years, with both individual patients and employers interested in helping employees gain access to higher quality care and a patient experience that exceeds what is typically available through traditional primary care practices. From 2017 to 2021, the number of active DPC clinicians per 100,000 people increased by nearly 160 percent – compared to a 6 percent increase overall in primary care providers per 100,000 people.[4] Since DPC providers maintain a much smaller patient load than the average primary care practice and have a much lower administrative burden due to the elimination of third-party reimbursement, they can spend more time on patient relationships and service. DPC providers focus on each person's comprehensive health so they can often eliminate the need for unnecessary tests and better target the need for specialty care and services. Patients in DPC practices typically have better overall healthcare utilization rates and less frequently use the emergency room or experience inpatient hospital admissions.[5]

Another outdated restriction on the use of HSAs is the ability for seniors over age 65 to contribute to an HSA. Seniors are now working longer than ever and deserve to be able to access the tax advantages of contributing to an HSA. Under current rules, Medicare beneficiaries may use funds from an HSA created prior to going on Medicare; however, beneficiaries may not open or continue to contribute to an existing HSA. This is a form of discrimination against working seniors and creates a barrier for them to be able to use pre-tax dollars to pay for out-of-pocket medical expenses or for dental and vision care which are not currently covered under Medicare. Since HSA funds remain in the account and are not "use it or lose it" type programs like flexible spending accounts, the use of HSAs encourages seniors to continue to save funds in an interest-bearing account for future healthcare expenses. NABIP has supported the chairman's Health Savings for Seniors Act in the past and would encourage continued bipartisan support for seniors to be able to contribute to an HSA.

Telehealth is another area that needs to be permanently addressed in the rules for HSAs. Due to the pandemic, rules related to all aspects of telehealth were loosened, resulting in an immense increase in the use of telehealth services, enabling cross-state care which has been critical to underserved areas and rural communities. One of the most crucial telehealth flexibilities were for those covered by HDHPs. The Coronavirus Aid, Relief, and Economic Security Act created a safe harbor allowing a HDHP to cover

[4] Hint Health. Trends in Direct Primary Care 2022. 27 April 2022.
[5] Eskew, Philip. In Defense of Direct Primary Care. *Family Practice Management.* October 2016.

telehealth and other remote care services without a deductible, or with a deductible below the minimum annual deductible otherwise required by law. Telehealth and other remote care services also are temporarily included as categories of coverage that are disregarded for the purpose of determining whether an individual who has other health plan coverage in addition to an HDHP is an eligible individual who may make tax-favored contributions to their HSA.

While this safe harbor originally expired on December 31, 2021, it has since been extended on two occasions – most recently in the Consolidated Appropriations Act of 2023, where it was renewed for plan years 2023 and 2024. However, NABIP recommends making this safe harbor permanent. NABIP also recommends taking this logic one step further and allowing individuals covered by HSA-qualified HDHPs to receive primary care before application of the deductible. Enacting both reforms would result in decreased costs for rural patients, as well as any patients covered by HDHPs and the employers who offer them.

When it comes to the impacts of inflation and high healthcare costs, rural communities have suffered the most and have the most to gain from increased health care access through telehealth. Since 2005, 190 rural providers have closed; of those 190 providers, 136 of them closed between 2010 and 2021.[6] The patient-to-primary care physician ratio in rural areas is only 39.8 physicians per 100,000 people, compared to 53.3 physicians per 100,000 in urban areas,[7] so those who live on farms, ranches, and reservations often travel long distances to reach a provider. Greater distances between hospitals also result in longer wait times for rural emergency medical services. For specialists, the data is only starker; for example, as of 2022, fewer than 50 percent of rural counties have a healthcare facility with an obstetrical unit.[8] In addition to the lack of providers, compared with urban areas, rural populations have lower median household incomes, a higher percentage of children living in poverty, fewer adults with postsecondary educations, more uninsured residents under age 65, and higher rates of mortality.[9]

One method to address these rising costs and increase price transparency while ensuring a more competitive market is enacting site-neutral payment reform. Currently, providers that own multiple facilities can charge different amounts for the same care depending on where care was received. For example, the price of an X-ray or MRI in a free-standing facility can differ substantially from the price of the same test in a hospital-based outpatient department (HOPD), and a test received in a HOPD can differ substantially from a test received in a physician office – even when the same entity owns all providers in question.

The lack of site-neutral payment reform to ensure that prices remain the same regardless of where the service is received results in higher healthcare costs for patients and employers. Recent research indicates that employer-based insurance is typically paying three times more for clinical lab tests when billed by HOPDs compared to identical tests billed by physician offices and independent labs. In seven

[6] The Cecil G. Sheps Center for Health Services Research. Rural Hospital Closures.
[7] Hing, E, Hsiao, C. U.S. Department of Health and Human Services. State Variability in Supply of Office-based Primary Care Providers: United States 2012. NCHS Data Brief, No. 151, May 2014.
[8] Frankhauser, Margaret. Health Disparities in Rural America. *JSI.* 16 November 2022.
[9] The Cecil G. Sheps Center for Health Services Research. Rural Health Snapshot (2017). NC Rural Health Research Program. May 2017.

states, the markup for lab tests in HOPDs was over six times the median price for the same tests in physician offices. Overall spending on clinical lab tests in HOPDs has grown over 30 percent from 2016 to 2019, due almost solely to price growth.[10]

It is also common for hospitals to charge "facility fees" when patients receive care at a facility that the provider owns, even if the facility is a great distance from the hospital. Facility fees are believed to be the primary factor in the rapid growth in emergency healthcare costs that we have seen over the last two decades. On average, from 2004 to 2021, facility fees increased a staggering four times faster (531 percent) than professional fees (132 percent) for emergency department evaluation and management services.[11]

Additionally, an analysis released this year found that private health insurance premiums and out-of-pocket payments would decrease by over $152 million over the next ten years if site-neutral reform were passed.[12] NABIP supports site-neutral rules to deter these facility fees and location-based gaming of coverage; enacting site-neutral payment reform will help increase competition and decrease healthcare costs for Americans.

While Congress has already taken some action to address transparency under the Consolidated Appropriations Act of 2021, this is a foundation that needs to be built upon. In order to increase transparency in healthcare ensuring that providers comply with existing price transparency regulations. As of January 1, 2021, all hospital systems are required to keep on their websites clear, accessible pricing information about the items and services they provide. This pricing information is required to be stored in a machine-readable format as well as an easy-to-read, consumer-friendly format. The goal of these requirements is to enable patients to compare prices and promote competition in healthcare markets. However, as of February 6, 2023, only 24.5 percent of providers have complied fully with this rule.[13] Though the majority of hospitals have posted files, most hospitals' files are not considered compliant because they are incomplete, illegible, or the prices posted are not clearly associated with both payer and plan.

Last month, CMS released further guidance on hospital transparency rules in an attempt to enforce the rules on the over-75 percent of hospitals that are not in compliance. While this is a step in the right direction, more needs to be done to enforce the rules that are already on the books and to protect the ability of patients and consumers to choose quality healthcare at an affordable price.

We appreciate the opportunity to provide these comments and would be pleased to respond to any additional questions or concerns of the committee. If you have any questions about our comments or if NABIP can be of assistance as you move forward, please do not hesitate to contact me at either (202) 595-0639 or jtrautwein@nabip.org.

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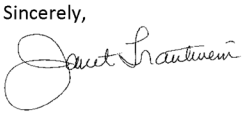
[10] Morning Consult. Coverage and Reforming the System. February 2023.
[11] Schwartz, Hope, et al. How do facility fees contribute to rising emergency department costs? *Kaiser Family Foundation*. 27 March 2023.
[12] Ellis, Phillip. Estimated Savings from Adopting Site-Neutral Payment Policies for Medicare. February 2023.
[13] Patient Rights Advocate. Fourth Semi-Annual Hospital Price Transparency Report. 6 February 2023.

National Association of Benefits and Insurance Professionals
NABIP
Shaping the *future* of healthcare

Sincerely,



Janet Stokes Trautwein
CEO, National Association of Benefits and Insurance Professionals

Testimony for the Record
Submitted to the
U.S. House Committee on Ways and Means
for the Hearing on
Health Care Price Transparency: A Patient's Right to Know

May 16, 2023

Cynthia Fisher
Founder and Chairman
PatientRightsAdvocate.org

Chairman Smith, Ranking Member Neal, and members of the Committee, thank you for devoting your time and attention to one of the most pressing issues impacting our country today: the rising and oppressive costs of healthcare.

Americans spend nearly twice as much on healthcare as the next developed country yet have worse outcomes. While healthcare costs have soared, U.S. life expectancy has declined steadily and is now the shortest it has been for two decades. This decline is not for lack of medical expertise. Unfortunately, Americans' fear of the unknown price of healthcare is a driving factor in this decline. More than 100 million Americans are burdened with medical debt, and 56% of Americans report that they delay medical care for fear of the unknown cost. Delayed medical care worsens health outcomes, allowing minor conditions to progress to the point where they are far more serious – and expensive – to treat.

We are encouraged by the committee's interest in ways to enable true, systemwide healthcare price transparency, which would reverse this negative trend and create a functional, affordable, and accessible healthcare system. As confirmed in repeated, respected national surveys, healthcare price transparency enjoys wide bipartisan support. Fully, 89% of Americans want systemwide health-care price transparency, and 88% believe hospitals should be required to post actual, upfront prices, not estimates. Moreover, 60% report having been overcharged by a hospital or medical provider.

The Hospital Price Transparency Rule and the Transparency in Coverage Rule were solid first steps. However, without robust enforcement, the rules are insufficient to effect the transformative change desperately needed by American healthcare consumers. Since the hospital rule took effect in January 2021, we have seen meager compliance by most U.S. hospitals:

- According to our organization's most recent semi-annual Hospital Price Transparency Compliance Report issued on February 6, 2023, only 24.5% of 2,000 of the nation's largest hospitals reviewed were fully complying with the rule.

- According to the *Journal of General Internal Medicine*, as of Jan. 27, 2023, only **35.9% of hospitals were in compliance.**

- According to the *Journal of General Internal Medicine*, as of Jan. 17, 2023 only **19% of hospitals were in compliance.**

- According to *JAMA Network Open*, as of Jan. 5, 2023, **"despite the steeper penalties, compliance rate remains low."**

While we want to ensure that any new legislation does not roll back progress made through existing law, we look to the Committee to fortify and strengthen existing rules as you draft truly meaningful, transformative legislation. As you consider potential legislation, we encourage you to reflect on the following ways to close loopholes in the current law and impose effective enforcement.

Require Transparency from the Agency Enforcing Price Transparency

The Centers for Medicare and Medicaid Services (CMS) offers little transparency into its efforts to implement and enforce price transparency requirements. CMS does not publish the methods it uses to audit compliance. While it does publicly report the Civil Monetary Penalties (CMPs) hospitals have been asked to pay (only four to date), it does not make public which hospitals have received warning notices.

Because Americans deserve to know which hospitals are falling short or have received warnings, consider drafting provisions into a bill that:

- Would require CMS to make public all information about its compliance reviews and enforcement efforts.

- Establishes a timely schedule for compliance review of every hospital.

Increase Compliance Through Stronger Enforcement

Because the current CMS rule lacks cost-effective, self-enforcement mechanisms to ensure compliance, leading to only 24.5% of hospitals fully complying with the rule, please consider drafting provisions into a bill that:

- Prohibit non-compliant hospitals from participating in the Medicare program.

- Prohibit non-compliant hospitals from adverse credit reporting, debt collection or lawsuits against any patient. (Similar to this Colorado state law.)

- Increase CMPs and shorten time periods for enforcement.

- Require hospital executives to attest to their hospitals reports and certify that all price data is complete and accurate (similar to hospital's submission of Medicare cost reports).

Require Pricing Data Standards So Consumers Can Easily Compare Pricing Data:

Consumers still struggle to access real prices due to hospitals' hiding prices behind estimator tools and to complicated, prohibitively large pricing files with no required data standards. This barrier is largely because the current rule fails to require that hospitals and insurers post prices in a standardized format. As CMS has no mandated standards (only recommendations), many hospitals post files that contain formulas, blanks, or N/A's instead of prices. These prove difficult for consumers and technology companies to parse. Consider drafting provisions into a bill that:

- Require hospitals to upload price data files directly to CMS into a centralized cloud-based publicly accessible data repository.
- Mandate a standardized data structure for hospitals' machine-readable price files.
- Mandate that hospitals provide prices (for each payer and plan) for a set of standardized service packages (care bundles) to enable true apples-to-apples comparisons.

Close the Loopholes

Hospitals that are reluctant to comply with the rule are using several loopholes that exist under the current regulatory structure to evade price disclosures. To remedy that, consider drafting the following provisions:

- Eliminate the price estimator tool and require hospitals to post all prices by payer and plan, in a consumer facing format, in addition to the machine-readable standard charges file.
- Require hospitals to post all prices in dollars-and-cents. If, for example, a price is determined by a percent of some other price or dollar amount, then the price data file must display the result of the calculation in the price field. (Information on the method used for determining the price (e.g., percent of) would also be included as part of the standardized file structure requirement noted above.)
- Limit the use of N/As. Currently many hospitals place large amounts of N/A's (in many cases thousands) into their price files. Mandate that, where variable pricing exists, hospitals must make full disclosure of the complete pricing information available.
- Increase the frequency of file updates. Hospitals have no trouble billing patients at current prices, yet existing regulations require only annual updates to a hospital's price data files. To reconcile that, mandate that hospitals update their files no less frequently than every six months and also upon any payer contract renewal that involves any changes to its prices.

- Expand price transparency to include all other facilities that hospitals or health systems own, including ambulatory surgical centers, imaging centers, urgent care clinics, labs, physician practices and more. The current regulation applies only to hospitals. Hospital-owned entities should also be subject to the price transparency rule.

Expand Opportunities to Promote Competition in Health Care

Once fully realized, systemwide health care price transparency will unleash competition, which will lower costs and curb consolidation. However, additional pro-competition provisions could build on this effort by also increasing competition in the payer-provider contracting process and opening up closed provider networks to competition that can lower prices. To that end, please consider drafting provisions into a bill that:

- Ban price discrimination by hospitals. Hospitals practice price discrimination when they negotiate different prices for each commercial payer and plan, extracting the highest possible prices from each. By comparison, most businesses must sell their goods at the same price to any customer that walks in the door. The Price Transparency Rule currently requires that hospitals disclose their lowest negotiated rate for each item or service; this bill provision would enable any commercial payer to access the lowest commercial price on offer at each hospital. Over time, for each of its services, a hospital would set one price applicable to all commercial payers. Comparing commercial rates across hospitals will then become easier for patients and families. For health plans, the cost of establishing and managing new provider networks will fall, and more competition and innovation will evolve in the health-insurance industry.

- Ban anti-tiering and anti-steering provisions in payer-provider contracts. Prohibit contract terms that restrict health plans from placing an expensive provider on a less favorable tier of an employee's plan or from otherwise incentivizing plan members to use fair-priced providers.

- Ban all-or-nothing clauses in payer-provider contracts. Prohibit contract terms that prevent plans from excluding one or more high-priced hospitals within a larger system from a plan's 'in-network' providers.

- Ban gag clauses in carrier and third-party administrator contracts. Prohibit contract terms that prevent a plan's access to and sharing of information, data and claims relating to its members' utilization and experience on the plan (essential for cost and performance and comparative plan procurement).

- Mandate a "Patient's Right to Save." If patients can identify providers that save money for themselves, their employers and for the system, they should not face any barriers to using such providers. However, typical out-of-network insurance benefit structures prohibit this. A Patient's Right to Save provision (or bill) would mandate that if a patient sees a provider whose fees are lower than their carrier's lowest in-network price, then the carrier must fully apply the amount paid by the patient to the patient's deductible. And if the deductible has been met, the carrier and patient could share the savings.

In conclusion, Congress has an opportunity to lead on healthcare price transparency to transform the healthcare system, lower costs, and protect all Americans. Legislation would counteract inflation by enabling consumers to compare prices and shop within and across hospitals, providers, and plans. Such competition would improve access and affordability, while eliminating inequities in care. Finally, it would lower government spending on healthcare, and protect patients from overcharges, price-gouging, and ruinous medical debt. As patients lose their fear of seeking needed health care, outcomes would improve, and Americans would live longer, healthier lives.

Thank you again for your continued leadership on this issue and for the opportunity to provide recommendations on lowering the costs of healthcare through price transparency. Our team would be happy to speak with you further about our recommendations.

Statement for the Record

Pharmaceutical Care Management Association

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Submitted to the

United States House of Representatives
Committee on Ways and Means

"Health Care Price Transparency: A Patient's Right to Know"

May 16, 2023

Introduction

The Pharmaceutical Care Management Association (PCMA) appreciates the opportunity to provide this statement about the role pharmacy benefit manager companies play in the market for prescription drugs, focusing on how they benefit patients and taxpayers. PCMA is the national association representing America's pharmacy benefit companies, which administer prescription drug plans and operate home delivery and specialty pharmacies for more than 275 million Americans with health coverage through public and private employers, labor unions, Medicare, Medicaid, the Federal Employees Health Benefits (FEHB) program, and the exchanges established by the Affordable Care Act (ACA).[i]

Pharmacy benefit companies work closely with health plans and health insurance issuers to secure lower costs for prescription drugs and achieve better health outcomes for patients and a wide range of health plan sponsors. Our comments to the Committee review the policies that PCMA members support to encourage competition as the most effective way to lower prescription drug costs for patients and the private sector and government entities that provide or arrange for prescription drug coverage. We then highlight some of the ways pharmacy benefit companies currently work to improve care, lower costs for patients, and reduce health benefit costs for employers. We conclude with an explanation of how our industry supports meaningful, actionable transparency to provide patients needed information on their drugs benefits and further enhance market competition, while detailing the numerous disclosure requirements with which pharmacy benefit companies, also referred to as pharmacy benefit managers (PBMs), already comply.

Any attempt at understanding the factors driving drug costs must include a look at the entire supply chain including drug companies, Pharmacy Services Administrative Organizations (PSAOs), wholesale distributors, employer benefit consultants, pharmacies, and others that impact the cost of prescription drugs. We encourage the Committee to review all these entities as it assesses transparency in the prescription drug market.

Pharmacy Benefit Companies Support Policies to Encourage Competition as the Most Effective Way to Lower Prescription Drug Costs

PBMs work to improve prescription drug affordability by providing prescribers with information about more affordable generic alternatives, by setting performance standards for pharmacies to encourage generic substitution and promote medication adherence, and by ensuring patients and prescribers are aware of lower-cost therapeutic alternatives. Due in large part to these efforts by PBMs, 90 percent of prescriptions are filled with generics.[ii] Pharmacy benefit companies also support increased uptake of biosimilars by preferring both brand and biosimilar products to ensure patients and providers have the incentive to choose lower cost options yet can still choose to continue with a drug from which they may be reluctant to switch. Our industry supports policy proposals to increase biosimilar uptake, which include eliminating the interchangeability designation to reduce costs and confusion, calling for an end to abuse of the patent system by drug companies, and making it easier for Medicare Part D plans to update formularies as new biosimilars enter the market.

PCMA supports numerous pieces of legislation that have been introduced and advanced in previous Congresses that would address common drug company tactics that undermine competition in the pharmaceutical market. We also support policies to address drug companies' abuses of the patent system that allow them to extend monopoly pricing well beyond their products' original patent expirations. Drug companies are responsible for setting and increasing

prices. To sustain their ability to set high prices, they often block competing brands and lower-cost generic and biosimilar products through patent litigation. Cracking down on this abuse will help lower costs for patients, employers, and taxpayers. To effectively drive down the costs of prescription drugs in the U.S., we encourage the Committee to consider these and other proposals to improve competition in the prescription drug market.

Pharmacy Benefit Companies Improve Care for Patients

Pharmacy Benefit Companies Simplify the Patient Experience

People with health insurance filled more than 6.4 billion prescriptions in retail pharmacies in 2021,[iii] amounting to almost 17.5 million prescriptions each day, underscoring the criticality that patients can obtain their prescriptions as quickly as possible at the pharmacy counter (or at home via mail delivery) to establish and maintain medication adherence. PBMs perform many essential functions that combine disparate information and expertise, as well as advanced technology, to facilitate and streamline getting a prescription filled as seamlessly as possible.[iv]

PBMs optimize the patient's experience of filling a prescription. Once the pharmacy enters the prescription into its system, the PBM electronically verifies the patient and prescription information against the patient's insurance benefit, as well as the patient's medication history for any errors or possible harmful drug interactions. Technology allows real-time, almost instantaneous access to a patient's prescription drug records, and because the PBM can see all a patient's prescriptions processed through insurance across pharmacies – whether home delivery, local or out-of-town, it is positioned to support patient safety. The PBM uses this information to determine if there is any reason that a patient should not take a prescribed drug and can alert the pharmacist to any potentially dangerous interactions before the patient receives any medication and pays any associated cost sharing. All of this happens rapidly, seamlessly, and behind the scenes to improve patient safety and care.

To support beneficiaries in Medicare Part D, plans and the PBMs that administer Part D plans must offer real-time benefit tools (RTBTs) to give patients and prescribers transparency with respect to cost sharing and benefits information at the point of prescribing.

Pharmacy Benefit Companies Lower Drug Costs for Patients

Pharmacy benefit companies, working with those providing insurance, encourage patients through formulary design and cost-sharing incentives to use the most affordable drugs, which are usually generics. For brand drugs, PBMs negotiate directly with drug manufacturers, who compete for formulary placement by offering a type of discount called rebates.[v] For drugs on the preferred tier of a plan's formulary, patients typically have lower cost sharing – flat dollar copays instead of percentage-based coinsurance.[vi] As competing products enter the market, PBMs can leverage competitor products to negotiate deeper drug discounts for patients and employers.[vii] PBMs also negotiate price concessions with pharmacies as they create plan networks.

The Medicare Part D program, where older Americans and those living with disabilities can choose among private plans to get their drug benefits, is a notable example of the value PBMs provide. Pharmacy benefit companies support Part D plans by negotiating rebates and discounts and promoting better pharmacy quality, passing 99.6 percent of manufacturer rebates, along with pharmacy price concessions, to the Part D plans, which in turn use rebate dollars to enhance drug benefits and keep premium costs reliably low for beneficiaries.[viii]

PBMs Save Taxpayers Money and Improve the Efficiency of Government Programs

Pharmacy benefit companies play an important role in federal health coverage programs, providing prescription drug benefits to approximately 67 million people across Medicare Part D, TRICARE, and the FEHB program. Pharmacy benefit companies save the Part D program an average of $2,026 per Part D beneficiary per year and will save the program over $430 billion over the next 10 years.[ix] In addition to drug savings, pharmacy benefit companies provide important clinical services that help patients lead healthier lives. For example, over the next 10 years, PBMs will prevent one billion medication errors.[x] Across the three federal programs, pharmacy benefit companies facilitate affordable prescription drug access to enable better health outcomes.

The Medicare Part D program covers 49 million Medicare beneficiaries through private prescription drug plans and offers different coverage options. For 2023, beneficiaries enrolled in original Medicare could choose from 801 standalone prescription drug plans (PDPs),[xi] while those with Medicare Advantage (MA) have their medical benefits and prescription drug benefits (MA-PDs) integrated into one of nearly 4,000 available plans.[xii]

PBMs help control costs in Part D. The Part D program has grown both in terms of the number of prescriptions filled and expenditures since its inception in 2003. However, despite its growth, during its first ten years in operation, according to the Congressional Budget Office (CBO), total Part D spending was 50 percent lower than expected.[xiii] Again in 2023, CBO found that spending in Part D has been much lower than anticipated.[xiv]

One major driver of lower spending has been the steady increase in the generic utilization rate among patients participating in the Part D program. Across MA-PD plans, the generic dispensing rate was just 63 percent in 2006, yet climbed to 90 percent by 2016.[xv] Nationally, when a generic alternative is available, the generic version is substituted for the branded drug 97 percent of the time.[xvi] As academic research confirms, "Part D plan formularies are designed to encourage the use of generics rather than their brand name counterparts."[xvii]

In addition to the increased use of generics, lower-than-predicted Part D net spending – after discounts and rebates – was also in part due to rebates negotiated by pharmacy benefit companies. The average net price of a prescription drug, after all pharmacy benefit company-negotiated discounts and rebates, fell from $57 in 2009 to $50 in 2018.[xviii]

Additionally, the Government Accountability Office (GAO) found that rebates negotiated by pharmacy benefit companies kept Part D spending seven percent lower than it would have been without rebates. And, according to the GAO, pharmacy benefit companies do not keep rebates in Part D. Rather, they pass 99.6 percent of rebates through to plan sponsors that use these rebates to improve the Part D benefit. This can often mean keeping premiums affordable for beneficiaries.[xix]

Beneficiary premiums in Part D have been relatively stable since 2010,[xx] and the average monthly premium declined by 1.8 percent to $31.05 in 2023.[xxi] GAO found that "downward pressure [by rebates] on premiums is one reason that premiums remained relatively unchanged between 2010 and 2015, according to the Centers of Medicare and Medicaid Services (CMS), even though total gross Part D drug costs grew about 12 percent per year in that period." The Medicare Payment Advisory Commission (MedPAC) agrees, finding that growth in rebates has helped keep the average premium affordable for beneficiaries.[xxii]

PBMs Support Meaningful, Actionable Transparency to Enhance Market Competition

Transparency that helps patients and payers is necessary across the entire prescription drug chain. PBMs support and practice actionable transparency that empowers patients, their physicians, those sponsoring health coverage, and policymakers, so that each of these actors can make informed decisions that can lead to lower prescription drug costs. Actionable transparency encourages consumers to shop for coverage that best fits their health needs and budgets, and once covered, use the most cost-effective, highest-value health care goods and services. It enables prescribers and patients to avoid pharmacy-counter surprises and helps ensure that physicians can prescribe drugs that are affordable for patients.

To that end, PBMs provide patients and prescribers with RTBTs, which provide real-time information on exactly where the patient is with respect to progressing through a deductible or another benefit phase, what drugs are on the patient's formulary, and exactly what cost sharing a patient should expect for a given drug at the pharmacy. PBMs also provide patients with information on in-network pharmacies, premiums, general cost-sharing, and benefits for their prescription drug coverage.

PBMs also provide health plans, including Part D plans and employer plan sponsors, with a broad array of accurate, actionable information on price and quality to make efficient purchasing decisions. Beyond this extensive information sharing, PBMs' customers have the ability to set their own terms for the transparency and information they want to receive, as well as their audit rights as part of their contracts.

In recent years, Congress has added more requirements for PBMs to report to federal agencies, as well as public reporting of aggregated information, in both cases with appropriate protections for confidential data to avoid encouraging tacit collusion among drug companies that drive drug prices higher. These are efforts that the pharmacy benefit industry supports. As we lay out below, this reporting includes aggregate information for Part D plans on rebates and pharmacy payments to the Health and Human Services (HHS) Secretary, as well as drug-specific information to the Secretaries of HHS, Labor, and Treasury.

Exposing Proprietary Pricing Information Can Raise Drug Prices

In February, the Department of Justice (DOJ) announced the withdrawal of three policy statements that had provided guidance and safe harbors for information exchanges explicitly focused on the health care markets.[xxiii] The withdrawal has suggested that information exchanges that were historically considered pro-competitive may actually have some anti-competitive impacts and will likely attract antitrust scrutiny in the future.[xxiv]

In a speech by Principal Deputy Assistant Attorney General Doha Mekki of the DOJ's Antitrust Division, the DOJ made it clear that it is concerned that information exchanges facilitated market participants' increasing application of sophisticated data analytics tools, such as machine learning, artificial intelligence, algorithms, and other advanced tools could lead to information exchanges and the distortion of free market competition, thus reducing competition through tacit coordination.[xxv] Attorney General Mekki noted that "Courts have long recognized that the exchange of competitively sensitive information can subvert the competitive process and harm competition," and spoke of the United States Supreme Court's concern that sharing current pricing information risks greater harm than sharing old, stale information.[xxvi] Mekki went on to say:

> *Courts also have looked at the degree to which the exchanged data has been aggregated. These decisions considered how, in light of the facts and market realities at the time, the information could facilitate and result in the type of behavior that the antitrust laws condemn. The Second Circuit explained in Todd that "[p]rice exchanges that identify particular parties, transactions, and prices are seen as potentially anticompetitive because they may be used to police a secret or tacit conspiracy to stabilize prices… Courts prefer that information be aggregated in the form of industry averages, thus avoiding transactional specificity." But facial aggregation of data alone has been held to be insufficient to save otherwise problematic information exchanges. In Todd, the Second Circuit looked beyond data that appeared to be somewhat aggregated to conclude that the defendants had the ability to effectively disaggregate it, raising serious antitrust concerns.*[xxvii]

For these reasons, it is important to carefully protect data that helps to maintain a competitive market and ensure it is never released publicly. As Mekki warns, such information sharing would likely damage the private market, "A softening of competition through tacit coordination, facilitated by information sharing, distorts free market competition in the process."

Tacit collusion, sometimes called conscious parallelism, is the process by which competing firms set their prices at a profit-maximizing, supra-competitive level after recognizing their shared economic interests and interdependence with respect to price and output decisions without an implicit or explicit agreement between the competing firms. Examples cited include, "airline tickets, gasoline, cellular phone text messaging and roaming rates, interest rates on bank accounts, credit card interchange fees, movie tickets, recorded music, breakfast cereals, real estate and travel agent commissions, electricity prices in deregulated markets, and air cargo fuel surcharges."[xxviii]

In an environment where the DOJ feels compelled to pull back 30-year-old guidance because of increasing concerns about the anti-competitive impact of information sharing in the health care industry (including via tacit collusion), it seems imprudent to mandate increased information disclosures that could create the kinds of anti-competitive harms that the DOJ has identified, including tacit collusion amongst the drug companies.

In 2004, the Federal Trade Commission (FTC) spoke out against over-exposing information about private business dealings because such an approach is deeply damaging to a competitive marketplace, stating, "If pharmaceutical manufacturers learn the exact amount of the rebates offered by their competitors (either because the safeguards on subsequent disclosure by purchasers and prospective purchasers are insufficient or because the mandated disclosure to prescribers provides sufficient information for pharmaceutical manufacturers to calculate these amounts) then tacit collusion among manufacturers is more feasible. Consequently, the required disclosures may lead to higher prices for PBM services and Pharmaceuticals."[xxix] Likewise, in 2009 the FTC noted that there are limits to the benefits of transparency and unintended consequences can result.[xxx] And again in 2014, the commission noted it had conducted numerous reviews on state laws mandating transparency to evaluate their likely effect on competition. At that time, staff noted two main concerns, "(1) mandatory disclosure requirements may hinder the ability of plans to negotiate an efficient level of disclosure with PBMs; and (2) if such disclosures publicly reveal previously proprietary and private information about discounts negotiated with PBMs, disclosure may result in less aggressive pricing by, or even collusion among, pharmaceutical manufacturers."[xxxi]

Additionally, the CBO has framed the transparency and disclosure considerations clearly in this often-quoted statement:

> *The disclosure of drug rebates could affect Medicare spending through two principal mechanisms. First, disclosure would probably make rebates less varied among purchasers, with large rebates and small rebates tending to converge toward some average rebate. Such compression, for reasons discussed below, would tend to reduce the rebates that PDPs received and thus would raise Medicare costs. Second, for a range of medical conditions, drugs appropriate for treatment are available from only a few manufacturers; disclosure of drug-by drug rebate data in those cases would facilitate tacit collusion among those manufacturers, which would tend to raise drug prices.*[xxxii]

PCMA encourages the Committee, as it reviews how to improve the prescription drug market to help lower costs for patients, taxpayers, and businesses, to focus its efforts on actionable transparency and information disclosure that reduces drug costs, rather than the over-exposure of the type of proprietary information that raises drug costs.

PBMs Already Comply with Numerous Disclosure Requirements

Pharmacy benefit companies already operate under federal transparency requirements and adhere to myriad contractually required transparency provisions mandated by their own business and government partners.

PBMs are subject to regulations promulgated by HHS, the Department of Labor, the Department of Treasury, the Office of Personnel Management (OPM), and states. PBM practices are overseen by state Medicaid agencies, state-based consumer protection agencies, private accreditation organizations, and their own clients – health plan sponsors. PBMs are also directly regulated by state departments of insurance or other state agencies.

PBMs serving exchange plans must report data on numerous administrative processes, such as coverage determinations and prior authorization, in a manner by which potential enrollees can access and understand them. They must also report data confidentially to CMS regarding generic dispensing rates for retail and mail-order pharmacies; aggregate amounts and types of rebates, discounts, price concessions, and service fees; total prescriptions covered; and the difference between the amount the health plan pays the PBM and the amount that the PBM pays retail and mail-order pharmacies.

Medicare Part D plans must make available to enrollees and potential enrollees all relevant aspects of their benefit design and must report confidentially to CMS the same information required of exchange plans through annual reporting. Part D plans also submit Prescription Drug Event (PDE) data, which is a summary of Part D claims activity with additional data elements including pharmacy dispensing fees. As part of the bid and reconciliation processes, PBMs (via the Part D plans) must also report estimated pharmacy and manufacturer Direct and Indirect Remuneration (DIR), including rebates and other price concessions.

It is important to note that government reporting by PBMs is not static but an ongoing, evolving construct. Indeed, CMS routinely updates required Part D filings to encompass more information, including with respect to PDE and pharmacy direct and indirect remuneration (DIR) filings. For example, under new pharmacy DIR rules taking effect on January 1, 2024, the negotiated price for a Part D covered drug must reflect the lowest possible reimbursement a network pharmacy

will receive for the drug and must also include all pharmacy price concessions. CMS has already issued detailed guidance on how these changes are to be included in PDE and DIR filings, including changes related to the calculation of beneficiary cost sharing, taking into account the application of pharmacy price concessions at point-of-sale.[xxxiii] Also, CMS has several other major expansions underway to the PDE submissions for 2025 related to Inflation Reduction Act implementation, and we expect to see more for 2026.

Moreover, reporting is not limited to federal health care programs and the health insurance exchanges established by the ACA. For commercial plans, the Departments of Treasury, HHS, and Labor, and OPM require PBMs to report a host of data related to spending and pricing for brand prescription drugs, as well as rebates and fees received from manufacturers, and the effect of these payments on out-of-pocket costs and health plan premiums.

The Departments must biannually issue a report based on the data, but otherwise, must keep the data confidential and may not release proprietary information.

Conclusion

Pharmacy benefit companies exist to reduce drug costs for plan sponsors, and most importantly, for the patients for whom those health plan sponsors provide coverage. In doing this work, PBMs generate tremendous value, estimated at $145 billion annually for society,[xxxiv] and, when taking Medicare savings into account as well as other programs and the commercial market, save payers and patients an average of $1,040 per person per year.[xxxv] Much of this value is generated by the savings PBMs negotiate with pharmaceutical companies and pharmacies. PBMs also lower prescription drug costs by promoting the use of generic medications, encouraging better pharmacy quality, and offering services like home delivery of medications. Through their work, PBMs lower the cost of health coverage, reduce drug costs, and support better and more affordable prescription drug access for patients – which means more people can get on and stay on the medications they need. For many years, evidence has shown a return of 10:1 on investments in PBM services for their private sector and government partners.[xxxvi] As a result, PBMs will lower the cost of health care by $1 trillion over ten years.[xxxvii]

PCMA looks forward to working collaboratively with Congress and other stakeholders to build on the existing private market framework to address prescription drug affordability challenges and improve functionality for patients. As this process moves forward, we welcome the opportunity to work with you to minimize unintended consequences that would lead to higher costs for employers, patients, and taxpayers.

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Submitted May 25, 2023

Written Testimony of Bradley Hahn, CEO, Solidarity HealthShare

Before the Committee on Ways & Means

Healthcare Price Transparency: A Patient's Right to Know

May 16, 2023

Chairman Smith, Ranking Member Neal and members of the Committee. Thank you for convening this hearing on the very important topic of transparency in healthcare pricing and the impact transparency – and the lack thereof – has on patient. I am Bradley Hahn, founder and CEO of Melita Christian Fellowship Hospital Aid Plan d/b/a Solidarity HealthShare ("Solidarity HealthShare"), a Health Care Sharing Ministry (HCSM) whose sharing guidelines are developed in accordance with the moral and ethical teachings of the Catholic Church.

Solidarity HealthShare was established to provide an option to protect the conscience rights of consumers who did not want to pay for health insurance that covered products or services that violate their conscience beliefs. While we are first and foremost an option to protect the conscience rights of our members, Solidarity recognized at its inception that the healthcare system is severely broken. While there are many factors contributing to this problem, one driver is the lack of meaningful transparency in pricing to provide consumers with information they need to make wise choices for themselves and their families.

Our ministry has strived since its founding in 1977 to be an authentic community that bears the healthcare cost burdens of fellow members while also caring about and praying for their health and well-being. Because our members are cash-paying members, we seek to do what we can as a single organization to try and address the brokenness of the system by helping our members be good stewards of their resources. One way we have sought to do so is by using a reference-based pricing approach to inform the expenses our members share in.

This approach is fairly simple. Our members can see any provider. When members receive a bill, they submit it to Solidarity. We then thoroughly review each bill using an industry-leading review program and then negotiate a fair and reasonable price with the provider. Our system looks at Medicare as a baseline and offers payments above Medicare rates informed by attributes such as the level of specialization or acuity of the case, geography, and other factors that typically inform prices in any rational market.

We strongly believe that all consumers – including those who have traditional health insurance or those who are cash-paying individuals – benefit from having access to easily accessible and meaningful healthcare pricing information. By this, we mean information that can be obtained from provider websites and via phone inquiries without undue burden and that is presented in a manner that can be fairly easily understood and compared, similar to what all of us can do right now if we are looking to buy a car or plane ticket or a hotel stay.

Submitted May 25, 2023

Solidarity has supported rulemaking to drive forward meaningful access to healthcare pricing data including payer-specific negotiated rates for shoppable services. We have also supported the applicability of the No Surprises Act to cash-paying consumers, especially the requirement for providers to issue good faith estimates to cash-paying consumers. Ultimately, we believe access to meaningful pricing information helps patients make informed decisions about their healthcare.

Members of Solidarity understand the importance of price transparency because our members are cash-pay consumers. They know the value of obtaining multiple estimates when possible as the difference between a fair and reasonably priced estimate and a widely inflated estimate is money out of their and other community members' pockets. This same benefit should be widely available to help educate American consumers about the true costs of healthcare.

To appreciate the importance of Medicare data as a piece of this picture, let me share a little perspective. For 2022, the average billed charges of sharing requests submitted by our members was 459 percent of what Medicare would pay for those same services. Through our repricing efforts, we were able to negotiate with providers so that the average amount shared by Solidarity members for those same bills was about 140 percent of Medicare. Perhaps it's not surprising that when broken down by size of bill, as the amount of the bill increased so did its average percentage above Medicare. For example, bills submitted that were between $25,000 to $50,000 averaged 586 percent above Medicare, those between $50,000 to $100,000 averaged 677 percent above Medicare and those $100,000 and above were averaging 760 percent above Medicare.

Congress may also find interesting the variation based on whether a bill was for the medical professional's work or if it was from the healthcare facility. Professional bills were on average about 300 percent greater than what Medicare pays, an amount that Solidarity was able to negotiate down by more than half to 127 percent of Medicare. But facility bills were more than double the amount paid by Medicare, 610 percent exactly, an amount we were able to reduce to 150 percent.

I share these inputs to underscore the importance of having Medicare payment data continue to be part of any discussion around improving healthcare pricing transparency. As the committee considers potential policies in this area, I urge you to consider the following:

- Continue supporting policies, both via legislation and via rulemaking, to provide consumers with accessible and meaningful healthcare pricing information and to conduct appropriate oversight over parties who are not complying with any laws and regulations. By meaningful information, this should include pricing information for shoppable services and the rates negotiated with various payers, not chargemaster or other largely meaningless data.

- Consistent with the examples shared, consider ways to ensure Medicare payment rates for services are more accessible. Medicare is the country's largest payer of healthcare and informs the policies of other payers. As such, it is very important that Medicare payment

Submitted May 25, 2023

data be part of any transparency program because it provides very useful context to charges put forward by a provider.

- Adopt policies to incent access to an array of healthcare products including traditional insurance and entities like health care sharing ministries. For healthcare sharing ministries, this should include enabling taxpayers who are members of qualifying sharing ministries to be able to deduct those expenses just as taxpayers can do to today for various medical expenses and for their health insurance premiums. Specifically, I urge the committee to consider and advance H.R. 3426, sponsored by Congressman Mike Kelly, that would update the Internal Revenue Code so that expenses for HCSMs are qualified medical expenditures.

Thank you, again, for holding this hearing. Solidarity HealthShare strongly supports policies to improve healthcare price transparency and we stand ready to help you advance additional policies to further this aim.

Comments for the Record
U.S. House of Representatives
Committee on Ways and Means
Hearing on Health Care Price Transparency:
A Patient's Right to Know
Tuesday, May 16, 2023, at 10:00 A.M.

By Michael G. Bindner
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Chairman Smith and the Ranking Member Neal, thank you for the opportunity to submit these comments for the record. Aside from my personal experience where pricing is not available, these comments restate those made to the Finance Committee in March regarding Pharmacy Benefit Managers and the Prescription Drug Supply Chain.

My personal experience is as an uninsured individual during the time when I was married and adding me to my wife's insurance would have been cost prohibitive. Worker and child policies were much cheaper than family policies.. During that time, I never saw an upfront price, except when I tried to take advantage of the Affordable Care Act's right to a colonoscopy. Apparently, unless you have insurance, it is not a right. The initial consultation was made before that little detail was ironed out. Needless to say, no procedure was completed.

During that time period, my primary care physician ordered a stress echocardiogram with my cardiologist because there had been a problem with an EKG (mostly due to getting a lead seated). On the initial visit, they ran another EKG with no issues, but did the procedure anyway - but with no pricing provided. Because I previously had my adrenal gland removed and my high blood pressure had resolved and my heart muscle was actually in better shape than a few years before. Then I saw the bill. It went on my tab.

When I was hospitalized at a later date, INOVA waived hospitalization charges. They did not waive added consultations and testing. There had been no disclosure on what was not covered or any opportunity to request that it be added to the free care side of the ledger. That was also added to my tab.

This mythical tab existed in the computer systems of various collection agencies and group practices that had never quoted me a price. When the value of the condominium we purchased at the top of the market in 2006 was half of our debt - and because we both lost jobs when the debt deal led to budget cuts in training for government personnel (leading to job loss), we stopped paying our mortgage and this resulted in Chapter 13 bankruptcy.

Because the marriage was ending, no further payments were being made during that period - which is not allowed, so we shifted to Chapter 7, turned in the keys and started divorce proceedings. My "tab" was settled in bankruptcy. Had there been disclosure before service, some pricing would have been changed or free care insisted upon. The unwillingness of doctors to do so simply resulted in the true costs being shifted to other payees. Whether cost shifting or price shifting is a more interesting question. There is a lot of margin built into private healthcare.

The next comments rely on my experience as a member of the Cost Management Systems project of what was then called Computer-Aided Manufacturing – International, now the Consortium for Advanced Management – International. The project produced *Cost Management for Today's Advanced Manufacturing*. I created a handbook based on the project, the *U.S. Air Force Orientation Guide to Advanced Cost Management*.

A key concept in cost management, supply chain management and cost accounting is non-value added cost. Pharmacy Benefit Managers are a non-value added cost. While they do have an impact on the price manufacturers can charge, they are the primary, if not the sole, beneficiaries.

As I learned as a proposal manager in the public sector contracting world, price and costs are different things. Healthcare is not a cost problem, it is a pricing problem and the lack of transparency means the problem must be faced by the uninsured or by employers.

The answer to this problem is some form of single payer healthcare, whether it be through Medicare for All, an expanded Public Option (to replace Medicaid) or having employers pay for medications, healthcare workers (and education) and specialist/hospital care either directly or as a part of the organization. Please see our Single Payer Attachment for more on this issue.

The other significant driver of drug prices is the question of funding orphan drugs. The answer is easy. Keep control of orphan drug intellectual property in the hands of the National Institutes of Health. Let them, and other agencies such as the National Science Foundation, fund grants and research contracts to generate breakthroughs, as well as to manage clinical trials for FDA approval (if appropriate for the population that needs the drug). When the drug is approved, NIH can then contract for its manufacture and distribution.

This methodology will get more done faster, without relying on profiteering to do what is necessary to help our most vulnerable patients.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

Attachment: Single Payer discussion from HHS Budget FY 2022

We address the funding of the Affordable Care Act, the need for an immediate COLA for retirees,funding the Social Security Administration's non-fund costs and the idea of cost savings for Social Security.

So far, the Administration has not yet addressed changes to the **Affordable Care Act,** at least not publicly. We suggest that the Committee ask the Secretary about any such plans.

At minimum, the individual and employer mandates, with associated penalties, that were repealed must be restored. The President campaigned on restoring and perfecting the Act, adding a public option. We agree, although the public option need not be self supporting. It must be subsidized through a broad based consumption tax. Such a tax burdens both capital and wage income.

The current funding stream seems to have been designed to draw opposition from wealthier taxpayers. It is an open secret that the Minority does not oppose most of the Affordable Care Act (which was designed by their own Heritage Foundation as an alternative to Mrs. Clinton's proposals). Broaden the tax base to fund the program and the nonsense on repeal will end.

The current funding stream from student loan initiation and interest, which was included in the baseline, should also be ended. Graduates (and non-graduates) with student loan debt cannot afford both their loan payments and insurance payments under the Affordable Care Act. When they apply for lower loan payments, which are always granted, they face either a balloon interest payment or capitalized interest, which makes their funding situation worse. No one should have to retire with student loan debt, yet quite a few soon will (or already have).

Forgive capitalized interest and apply any overpayments to principal. There should not be a one-size-fits-all subsidy. Also, when payments are deferred, return to the practice of deferring interest (or allow debts to be discharged, at least partially, in bankruptcy).

To deal with these issues, whatever is budgeted for analytical support in the Department should likely be doubled.

The following analysis comes from the Single Payer attachment that has previously been provided. Because of the President's preference for establishing the public option, we will repeat those analyses here. Aside from a broader base of funding, other compromises are necessary to enact a public option.

To set up a **public option** end protections for pre-existing conditions and mandates. The public option would then cover all families who are rejected for either pre-existing conditions or the inability to pay. In essence, this is an expansion of Medicaid to everyone with a pre-existing condition. As such, it would be funded through increased taxation, which will be addressed below. A variation is the expansion of the Uniformed Public Health Service to treat such individuals and their families.

The public option is inherently unstable over the long term. The profit motive will ultimately make the exclusion pool grow until private insurance would no longer be justified, leading-again to Single Payer if the race to cut customers leads to no one left in private insurance who is actually sick. This eventually becomes Medicare for All, but with easier passage and sudden adoption as private health plans are either banned or become bankrupt. Single-payer would then be what occurs when insurance companies are bailed out in bankruptcy, the public option covers everyone and insurance companies are limited to administering the government program on a state by state basis.

The financing of the Affordable Care Act should be broadened. It should neither be funded by the wealthy or by loan sharking student loan debtors. Instead, it should be funded by an employer-paid consumption tax, with partial offsets to tax payments for employer provided insurance and taxes actually collected funding a Public Option (which should also replace Medicaid for non-retirees). Medicaid for retirees and Medicare should be funded by a border adjustable goods and services tax, which should be broad based.

Why the difference? The goal is to not need a public option as employers do the right thing and cover every worker or potential worker. Using an employer based tax is an incentive to maximize employee coverage. Medicare, however, is an obligation on society as a whole.

Contact Sheet

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Committee on Ways and Means
Hearing on Health Care Price Transparency: A Patient's Right to Know
Tuesday, May 16, 2023, at 10:00 A.M.

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears:

This testimony is not submitted on behalf of any client, person or organization other than the Center itself, which is so far unfunded by any donations.

The Commonwealth Fund
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May 30, 2023

The Honorable Jason Smith
Chairman
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United States House of Representatives
1139 Longworth HOB
Washington D.C. 20515

The Honorable Richard Neal
Ranking Member
Committee on Ways and Means
United States House of Representatives
1129 Longworth HOB
Washington D.C. 20515

Chairman Smith and Ranking Member Neal,

Thank you for the opportunity to submit written comments to the House Committee on Ways and Means regarding your recent May 16 hearing on health care price transparency.

The Commonwealth Fund is a nonprofit, nonpartisan foundation dedicated to affordable, quality health care for everyone. We support independent research on health care issues and make grants to promote better access, improved quality, and greater efficiency in health care, particularly for society's most underserved communities.

Below we offer comments that draw on research by Commonwealth Fund grantees and staff, as well as other experts, regarding what we know about price transparency as a tool to promote consumer shopping and lower costs—and how it can be leveraged to strengthen competition and affordability in health care markets.[1]

Key stakeholders have suffered from a lack of price transparency in health care, particularly in the commercial market.

Historically, health care prices have not been readily available to many key stakeholders who could benefit from such data, including consumers who seek and pay for care, employers who select and pay for employees' insurance, policymakers who both pay for and regulate markets, and researchers who study cost and quality trends and drivers. This has meant that those who could act to control spending and improve affordability have been limited in their ability to understand market dynamics and design solutions that advance patient welfare and are fiscally responsible. And efforts to promote transparency in health care would be welcomed by many stakeholders.

[1] The views presented here are those of the authors and not necessarily those of the Commonwealth Fund or its directors, officers, or staff.

Price transparency is essential to competitive, well-functioning markets, but it is not a panacea for addressing high health care prices and spending.

Price transparency—coupled with quality information—is essential to properly functioning markets. It allows consumers to make purchasing decisions, creates competition, and puts downward pressure on prices among sellers who want to gain market share. However, there are several factors unique to health care that preclude price transparency from being an effective widespread tool for patient shopping and decision-making.[2]

First, experts estimate that only 30-40 percent of health care is "shoppable."[3] In other words, consumers don't have the time, ability, or necessary information to make an informed decision on the majority of the health care products and services they purchase. While consumers can take time to shop and plan for certain services like MRIs and some elective surgeries, this isn't feasible with emergency treatment and care for complex conditions. Consider a patient who needs back surgery for a herniated disc. To know the total cost of their care, the patient would need to anticipate the full range of services and products—not just the MRI for diagnosis, but the costs of the operating room, the surgeon, the anesthesiologist, any prescribed medications, and any post-op care.[4] Most patients have no way of knowing what that bundle of services will look like ahead of time to then compare costs and quality across all providers. For pricing information to be helpful to patients, it is incumbent on payers or providers to group products and services into units that patients can understand and are likely to consume—discrete episodes or bundles of care.

Second, pricing data on its own doesn't tell patients enough to make informed decisions without corresponding quality data. Price variation across physicians and hospitals is well-documented in the health policy literature, and increasingly, Americans recognize that higher prices are not necessarily signals of higher quality.[5] Combining price and quality data—and guiding patients on how to interpret them—would help patients better understand their options.

Further complicating things is the role of other actors in paying for care and the treatment decision-making process. Health insurance plays a distorting role for patients and prescribers of care.[6] Cost sharing shields patients from the total cost of care, which often renders prices less important for patients. And physicians and other prescribers are often the ones making treatment and referral decisions, yet they aren't on the hook for the cost and oftentimes don't know the cost of the care or providers they recommend to their patients.

Lastly, over the past several decades, increased consolidation of health care providers has left most Americans living in areas with concentrated health care markets—a trend which has led to higher prices

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[2] Lovisa Gustafsson and Shawn Bishop, "Hospital Price Transparency: Making It Useful for Patients," To the Point (blog), Commonwealth Fund, Feb. 12, 2019. https://doi.org/10.26099/qacm-j392

[3] Chapin White and Megan Eguchi, "Reference pricing: A small piece of the health care price and quality puzzle," National Institute for Health Care Reform Research Brief 18 (2014). https://nihcr.org/wp-content/uploads/2016/07/Research_Brief_No._18.pdf

[4] David Blumenthal, Lovisa Gustafsson, and Shanoor Seervai, "Price Transparency in Health Care Is Coming to the U.S. — But Will It Matter?," Harvard Business Review, published online July 3, 2019. https://hbr.org/2019/07/price-transparency-in-health-care-is-coming-to-the-u-s-but-will-it-matter

[5] Anna D. Sinaiko, Elizabeth Bambury, and Alyna T. Chien, Consumer Choice in U.S. Health Care: Using Insights from the Past to Inform the Way Forward (Commonwealth Fund, Nov. 2021). https://doi.org/10.26099/7xbc-sb06

[6] Blumenthal, Gustafsson, and Seervai.

without corresponding gains in quality and fewer choices.[7] As a result, patients may lack alternative providers to choose from, even for shoppable services.

Evidence suggests that efforts to harness consumer choice in health care to improve quality and affordability have disappointing results.[8]

Efforts to promote consumer choice in health care are predicated on the idea that patients can rationally assess the relative values of their medical care options and choose the highest value (i.e., highest quality and lowest cost) option in line with their best interests.

But the research on health care consumerism tells us that patients often make choices that don't appear to be in their best financial and clinical interests, given the complex and often high-stakes nature of wading through the health care choice landscape. For instance, increasing cost sharing is one strategy that intends to motivate patients to be more deliberate in using higher-value health care services. However, in practice, patients will cut back indiscriminately on both inappropriate *and* appropriate care when faced with higher deductibles—including valuable preventative services like cancer screenings or colonoscopies.[9] We also see inconsistencies in the insurance plan choices that patients make. People often choose plans with higher expected out-of-pocket costs compared to other plans with equivalent benefits;[10] others stay in the same plans even when better ones become available.[11]

While most consumers want more price information, they rarely use the tools made available to them, even when encouraged to do so by states, employers, or health plans.[12] The availability of this information has generally not led to patients accessing them, let alone the desired decreased spending or patient action to switch to lower-priced providers. Similarly, quality report cards are rarely used, with patients more readily defaulting to their physicians' recommendations or other informal sources.[13]

Price transparency does hold value as one component of broader efforts to promote competition, efficiency, and value in the health care system.

While there are limitations in patients' ability to effectively use pricing data and transparency tools, there are other benefits and use cases of health price transparency data.

Conducting research

Access to price data enables researchers and policymakers to better understand the drivers of high spending and design corresponding solutions. For instance, such data can unmask the level of price

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[7] B. D. Fulton, "Health Care Market Concentration Trends in the United States: Evidence and Policy Responses," Health Affairs, Sept. 2017 36(9):1530–38. https://doi.org/10.26099/e365-2k72

[8] Sinaiko, Bambury, and Chien.

[9] Sinaiko, Bambury, and Chien.

[10] Anna D. Sinaiko and Richard A. Hirth, "Consumers, health insurance and dominated choices," Journal of Health Economics 30.2 (2011): 450-457. https://www.sciencedirect.com/science/article/abs/pii/S016762961100004X

[11] Christopher C. Afendulis, Anna D. Sinaiko, and Richard G. Frank, "Dominated choices and Medicare Advantage enrollment," Journal of economic behavior & organization 119 (2015): 72-83. https://www.sciencedirect.com/science/article/abs/pii/S0167268115002000

[12] Gustafsson and Bishop.

[13] Sinaiko, Bambury, and Chien.

variation for a given good or service in a market and reveal opportunities for value-based purchasing initiatives or cost containment strategies.[14]

Regulating markets

Price data is essential for policymakers who are looking to strengthen market regulation and oversight. For example, several states have established health care cost growth targets to track and slow spending growth. Developing a data system for capturing price data is an important first step in this process, followed by detailed cost, quality, and utilization information.[15] Many other efforts that states and other regulators might take, such as restricting price increases over time, enhancing insurance rate review, capping out of network prices, and developing global budgets require deep understanding of current price and spending trends. Similarly, improving oversight of provider consolidation relies on pricing data to review the potential impacts of a transaction before it occurs[16] and to understand the impact of market changes over time.

Informing new insurance benefit designs

Patients are more likely to act like informed consumers when information about quality and prices is tied to incentives and presented in a simple, straightforward manner. To that end, incentivizing patients to use higher-value products and services through advanced insurance benefit designs have shown some success.

For example, reference pricing is "a payment scheme in which an insurer or employer determines a price that it is willing to pay for certain shoppable health care services based on an average or percentile of market-based prices."[17] The California Public Employees' Retirement System (CalPERS) and the Safeway grocery store chain are oft-cited examples of payers who found significant savings through their reference-based benefit programs.[18] Safeway's savings ranged from 10.5 percent (for MRI imaging) to 32 percent (for diagnostic lab testing) while the percentage of enrollees moving to lower-cost providers ranged from 9 percent to 29 percent. Savings in the CalPERS program ranged from 17 percent (for shoulder arthroscopy) to 21 percent (for colonoscopy). CalPERS also saw prices charged among higher-priced hip and knee replacement providers drop by an average of 34 percent.

These advanced benefit designs are not without limitations. Importantly, such approaches are less likely to be successful in markets with high provider consolidation and limited alternatives. Moreover, the degree of cost savings is dependent upon the number of shoppable services.

Supporting patient-provider conversations about treatment costs and trade-offs

Patients rely on their trusted providers to help them understand and navigate the pros and cons of different treatment options. Studies suggest that patients also want out-of-pocket costs to be a factor in these conversations, but this does not play out for various reasons (e.g., demands on physician time, lack

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[14] Sinaiko, Anna D., Pragya Kakani, and Meredith B. Rosenthal. "Marketwide price transparency suggests significant opportunities for value-based purchasing." Health Affairs 38.9 (2019): 1514-1522. https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05315

[15] Lisa Waugh and Douglas McCarthy, How the Massachusetts Health Policy Commission Is Fostering a Statewide Commitment to Contain Health Care Spending Growth (Commonwealth Fund, Mar. 2020). https://doi.org/10.26099/myt4-2630

[16] Ann Hwang et al., State Strategies for Slowing Health Care Cost Growth in the Commercial Market (Commonwealth Fund, Feb. 2022). https://doi.org/10.26099/m49y-2b09

[17] Hwang et al.

[18] Hwang et al.

of training on how to hold these conversations, lack of access to pricing information).[19] A growing body of research is helping identify the most effective strategies for providers to successfully have these conversations with patients.[20]

Incorporating price data into real-time benefit tools—along with quality data and a patient's cost sharing requirements under their coverage—could enable more informed decision-making by patients and providers. Integrating these tools into the clinical decision-making process without disrupting physician workflow or creating administrative burden is worth further development and testing.

Policy options for improving transparency in health care: Improving all-payer claims databases[21]

An all-payer claims database (APCD) collects health care claims and related data from all (or nearly all) entities that pay for health care services in a geographic area, including private and public health plans. According to the APCD Council, 23 states have existing APCDs, nine are implementing them, and several more have shown strong interest.[22]

APCDs are valuable tools that key stakeholders—potentially including consumers, employers, health care providers, insurers, researchers, and policymakers depending on the state rules—can use to understand and improve the system. Having systemwide data on costs, utilization, and quality of services is essential information that no single purchaser or payer can provide.[23]

However, certain limitations prevent APCDs from reaching their full potential, including the 2016 Supreme Court decision, *Gobeille v. Liberty Mutual Insurance Co.*[24] The Court held that states may not require data collection from nongovernmental self-insured group health plans, known as Employee Retirement Income Security Act (ERISA) plans. Given that these plans represent about a third of Americans, this creates a large gap in state APCDs. Moreover, while states' goals for creating APCDs may vary, these databases are generally underfunded and under-resourced for their operational, analytic, and reporting activities.[25] APCDs require staff with the right skills to administer, manage, and effectively analyze the data; several APCD leaders have emphasized the need for greater staff resources and expertise.[26] Having a patchwork of different state databases also poses challenges to aggregating and analyzing data across states.

There are several options for federal policymakers to improve APCDs:

1) **Enable state collection of self-insured data**. Congress could amend the Employee Retirement Income Security Act (ERISA) to enable states to collect data on the payment of health care claims

[19] Sinaiko, Bambury, and Chien.
[20] Caroline E. Sloan and Peter A. Ubel, "The 7 habits of highly effective cost-of-care conversations," Annals of internal medicine 170.9_Supplement (2019): S33-S35. https://www.acpjournals.org/doi/full/10.7326/M19-0537
[21] Christen Linke Young and Matthew Fiedler, "What Can Be Done to Improve All-Payer Claims Databases?," *To the Point* (blog), Commonwealth Fund, Oct. 23, 2020. https://doi.org/10.26099/7ZC6-6S62
[22] APCD Council, "Interactive State Report Map," https://www.apcdcouncil.org/state/map
[23] Douglas McCarthy, State All-Payer Claims Databases: Tools for Improving Health Care Value, Part 1 — How States Establish an APCD and Make It Functional (Commonwealth Fund, Dec. 2020). https://doi.org/10.26099/06qz-1m31
[24] Gobeille v. Liberty Mut. Ins. Co., 577 U.S. ___ (2016), https://supreme.justia.com/cases/federal/us/577/14-181/
[25] McCarthy.
[26] McCarthy.

and costs from self-funded plans.[27] While it wouldn't solve issues of fragmentation across states, it would enable each state to maximize the potential of its own APCD.

2) **Create a national APCD** to collect data from all payers in all states. This APCD could be subject to the same security and privacy protections as existing federal health care databases. A comprehensive database like this would help accelerate efforts to understand and address key drivers of spending. [28]

3) **Expand state APCD coverage, while integrating their data**. This hybrid approach would authorize state APCDs to collect self-insured data and provide grants to support the creation of new APCDs. States would be required to collect data in a standardized way and share them with a federal clearinghouse. [29]

Thank you again for the opportunity to provide comments for the record, and please do let us know if we can be of further assistance.

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[27] Elizabeth Y. McCuskey, State Cost-Control Reforms and ERISA Preemption (Commonwealth Fund, May 2022). https://doi.org/10.26099/1550-br29
[28] Matthew Fiedler and Christen Linke Young, *Federal Policy Options to Realize the Potential of APCDS,* USC-Brookings Schaeffer Initiative for Health Policy. Published at https://www.brookings.edu/research/federal-policy-options-to-realize-the-potential-of-apcds/
[29] Fiedler and Young.